**NQTL: Provider Reimbursement (SHIP)**

**Classification(s):** Inpatient In Network & Out of Network, Outpatient Office In Network & Out of Network & Outpatient All Other In Network & Out of Network, Emergency In Network & Out of Network

**Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification**

***Provide a clear description of the specific NQTL, plan terms, and policies at issue***:

Wellfleet Insurance Company and/or Wellfleet New York Insurance Company("Wellfleet") utilizes the Cigna Health and Life Insurance Company ("Cigna") provider network for non-pharmacy benefits. Evernorth Behavioral Health ("Evernorth" or "EBH," formerly Cigna Behavioral Health), an affiliate of Cigna, performs all aspects of addressing network adequacy for the MH/SUD Network, while Cigna performs all aspects of addressing network adequacy for the Med/Surg Network. References to "Cigna" contained herein include Evernorth Behavioral Health unless otherwise noted separately.

Policies and Procedures

Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules. The fee schedules are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. **MH/SUD HM NET 011Provider Fee Schedules Policy** shows the guidelines for consistent provider alignment based on their licensure and educational background.

Plan Documents:

Member plan documents include a description of the difference in cost sharing/ reimbursement for in and out of network providers. For instance:

> The Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. The Certificate provides access to both In-Network Providers & facilities and Out-of-Network Providers and facilities. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers and facilities versus Out-of-Network Providers and facilities, as shown in the [State] SHIP Schedule of Benefits. The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider & Facility will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider & Facility for the same health care service in the same geographic region.
>
> Usual and Customary Charge is the amount of an Out-of-Network provider or facility charges that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage. The Usual and Customary Charge depends on the geographic area where You receive the service or supply. The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider or facility will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider or facility for the same health care service in the same geographic region. The table below shows the method for calculating the Usual and Customary Charge for specific services or supplies:

| Service or Supply | Usual and Customary Charge |
|---|---|
| Professional services and other services or supplies not mentioned below | The Reasonable amount rate |
| Services of hospitals and other facilities | The Reasonable amount rate |

In addition, plan documents indicate the following with respect to reimbursement policies:

Our reimbursement policies are based on Our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice;
- The views of Physicians and dentists practicing in the relevant clinical areas.

Plan documents are available on Wellfleetstudent.com.

| ***Identify the M/S benefit classifications for which the NQTL applies:*** | ***Identify the MH/SUD benefit classifications for which the NQTL applies:*** |
|---|---|
| The NQTL applies to the following classifications and sub-classifications: Inpatient INN & OON, Outpatient Office INN & OON & Outpatient All Other INN & OON, and Emergency. | The NQTL applies to the following classifications and sub-classifications: Inpatient INN & OON, Outpatient Office INN & OON & Outpatient All Other INN & OON, and Emergency. |
| **Step 2 – Identify the factors used to determine that the NQTL will apply to M/S or MH/SUD benefits** | |
| **Medical/Surgical**:<br><br>**In-Network**<br>**Factors**<br>1. State and Federal Law<br>2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement.<br>3. Medicare Baseline Rates<br>4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy)<br>5. Geographic Market<br>6. Scope and Type of services<br>7. Medical Cost Budget<br>8. Utilization<br>9. Competitive insights, when available<br>10. Correct Coding<br><br>**Factors Considered but rejected (same for M/S and MH/SUD):**<br>No other factors were considered and rejected.<br><br>**Weight (same for M/S and MH/SUD):**<br>Each factor holds the same weight.<br><br>There is no Artificial Intelligence application utilized for the NQTL design. | **MH/SUD**:<br><br>**In-Network**<br>**Factors**<br>1. State and Federal Law<br>2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement.<br>3. Medicare Baseline Rates<br>4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy)<br>5. Geographic Market<br>6. Scope and Type of services<br>7. Medical Cost Budget<br>8. Utilization<br>9. Competitive insights, when available<br>10. Correct Coding<br><br>**Factors Considered but rejected (same for M/S and MH/SUD):**<br>No other factors were considered and rejected.<br><br>**Weight (same for M/S and MH/SUD):**<br>Each factor holds the same weight.<br><br>There is no Artificial Intelligence application utilized for the NQTL design. |

| | |
|---|---|
| **Out-Of-Network**<br>1. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement.<br>2. Services and/or Procedures Performed<br>3. Geographical location<br>4. Industry Benchmark Rates/Methodology<br>5. Correct Coding<br><br>**Factors Considered but rejected:**<br>There are no rejected factors.<br><br>**Weight of Factors:**<br>Each factor holds the same weight.<br><br>There is no Artificial Intelligence application utilized for the NQTL design. | **Out-Of-Network**<br>1. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement.<br>2. Services and/or Procedures Performed<br>3. Geographical location<br>4. Industry Benchmark Rates/Methodology<br>5. Correct Coding<br><br>**Factors Considered but rejected:**<br>There are no rejected factors.<br><br>**Weight of Factors:**<br>Each factor holds the same weight.<br><br>There is no Artificial Intelligence application utilized for the NQTL design. |
| **Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Quantity Limits to mental health or substance use disorder benefits and medical or surgical benefits.** | |
| **Medical/Surgical**:<br><br>**In-Network**<br>Factors<br>1. State and Federal Law<br>• **Source:** State or Federal Law<br>• **Evidentiary Standard**: State or Federal law<br>2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement.<br>• **Source:** M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic and practitioner) and/or specialty (e.g. physician practitioners v. non-physician practitioner v. facility<br>• **Evidentiary Standard** Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Providers with higher degree levels, may merit higher reimbursement, for example, in BH Psychiatrists are MD/DO while a therapist is a Master's Level degree. Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g., physician practitioner v. non-physician practitioner).<br>**For Inpatient (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: CMS.gov). Applicable to Facility Inpatient and Facility Outpatient benefit | **MH/SUD**:<br><br>**Same as M/S** |

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 factor in the contract. 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.

**For Inpatient (Facility), Outpatient Office, and Outpatient All Other**: ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually:

- **For Inpatient (Facility), Outpatient Office, and Outpatient All Other**: [(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) =Cigna RBRVS geographically adjusted fee Reimbursement
- **For Inpatient (Facility)** Percent of Charge – percent of covered billed charges
- **For Inpatient (Facility)** Per Diem – a per day, all-inclusive reimbursement rate for all covered services provided on that day

3. Medicare Baseline Rates

**Inpatient (Facility)**

- **Source:** Medicare Geographical Practice Cost Index ("GPCI").
- **Evidentiary Standard:** For codes with assigned Medicare Relative Value Unit ("RVU"): Unit values are assigned to each service (CPT code) by area of specialty and for some codes, different RVUs for site of service: facility and non-facility.

**Outpatient Office, Outpatient All Other**

- **Source:** CMS Medicare Resources Based Relative Value" scale ("RBRVS") system
- **Evidentiary Standard:** ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: [(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically

4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy)

- **Source:** Internal analysis of market dynamics and network need including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends.
- **Evidentiary Standard** Supply of providers is determined using state licensing sites to verify licensure and

existence of provider. Competitor directories (i.e. Aetna, Blue Cross) are used to identify available providers. These external sources, along with Plan's internal sources (i.e. existing network, utilization history) establishes the availability of providers. Demand can be determined by Plan's internal review of utilization/claims data.

5. Geographic Market
   - **Source:** Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty
   - **Evidentiary Standard:** 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 Data Base (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. Scope and Type of services
   - **Source:** Type of Service are identified by CPT, HCPC and Revenue codes and Internal Cigna Data
   - **Evidentiary Standard:** Provider specific fee schedules are used for multispecialty 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.
7. Medical Cost Budget
   - **Source:** Medical cost budgets - MH/SUD and M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers.
   - **Evidentiary Standard:** MH/SUD and M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers.
8. Utilization
   - **Source:** Internal Cigna historical claims data
   - **Evidentiary Standard**: Utilization/claims history is used to determine need of provider related to meeting network access/patient preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences.
9. Competitive insights, when available
   - **Source:** Coordination of Benefits or Transparency data
   - **Evidentiary Standard**: Data is used to determine fair market reimbursement rates. No specific threshold, this data is only available in some instances, but will be used when available.
10. Correct Coding

- **Source:** Edits are sourced via a myriad of industry-recognized sources, such as CMS, ICD -10 CM®, NCCI, AMA, NCD/LCD, CPT®, and HCPCS codes.
- **Evidentiary Standard**: Team of clinicians performs ongoing reviews of clinical and regulatory guidelines and sources to maintain the edits.

**Out-Of-Network**

1. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement.
   - **Source:** Taxonomy
   - **Evidentiary Standard:** The provider type; facility
2. Services and/or Procedures Performed
   - **Source:** Revenue Codes will have claim paid without reasonable and customary cutback based upon the out of network level of benefit in the plan. If a claim has a CPT/HCPCS, then R&C will be applied. Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database.
   - **Evidentiary Standard:** Utilize the most current version of industry standard CPT or HCPCS code set or Revenue codes.
3. Geographical location
   - **Source:** Revenue Codes will have claim paid without reasonable and customary cutback based upon the out of network level of benefit in the plan. If a claim has a CPT/HCPCS, then R&C will be applied. Zelis pricing solutions - Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database.
   - **Evidentiary Standard:** Zip code of the facility sending the claim.
4. Industry Benchmark Rates/Methodology
   - **Source:** Fair Health and CMS
   - **Evidentiary Standard:** Utilize Reasonable and Customary (R&C) data when CPT/HCPCS are billed. If Revenue codes are only billed, no R&C will be applied.
     - Wellfleet uses Fair Health for R&C Data. Wellfleet downloads Fair Health data bi-annually and uses that coding data to reimburse out of network services according to the specific plans out of network benefit level.
     - Fair Health's rich data repository and independence make it a valued resource for reliable, objective data. FH® Charge Benchmarks provide up- to-date, actionable data based on recent claims from 493 distinct geographic regions nationwide. Fair Health has been consulted by numerous federal officials including those from the White House, the Department of Health and Human Services, the Department of Labor, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Department of Commerce, the Department of Agriculture and the Congressional Budget Office. Fair Health data has been used to address a broad range of issues including:
       - Bureau of Labor Statistics in developing its medical pricing indices.
       - Government Accountability Office to support studies of air ambulance and dental service
       - Office of National Drug Control Policy under President Obama
       - The President's Commission on Combating Drug Addiction and the Opioid Crisis under

| | |
|---|---|
| President Trump<br>• Zelis is a pricing solution that utilizes many data points, including but not limited to CMS data for savings opportunities.<br>5. Correct Coding<br>• **Source:** Edits are sourced via a myriad of industry-recognized sources, such as CMS, ICD -10 CM®, NCCI, AMA, NCD/LCD, CPT®, and HCPCS codes.<br>• **Evidentiary Standard**: Team of clinicians performs ongoing reviews of clinical and regulatory guidelines and sources to maintain the edits. | |
| **Step 4(a): Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, <u>as written:</u>** | |
| **In Network Reimbursement**<br><br>Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology as demonstrated in the In-Network Reimbursement Methodology Standard Operating Procedure (available upon request from Cigna) for MH/SUD and M/S providers. As previously noted, the factors considered in every negotiation include state/federal law, geographic market, provider type and supply, Medicare baseline rates, scope and type of service, cost budget, and utilization.<br><br>Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules. The schedules are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. **MH/SUD HM NET 011Provider Fee Schedules Policy** shows the guidelines for consistent provider alignment based on their licensure and educational background.<br><br>Both MH/SUD and M/S negotiations are based upon provider and information availability at a single point in-time. Negotiations depend on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. – many of these additional factors can be evidenced by the review of Competitive insights, when available, to ensure a fair market reimbursement rate is offered. It is important to note that different providers and facilities may have vastly different negotiating or so-called bargaining power. Both MH/SUD and M/S provider's bargaining power depends on the same factors which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty (i.e. network adequacy); and the reputation, name recognition, and/or quality of the provider. When referencing "vastly different negotiating or so- called bargaining power" Cigna acknowledges the fact that large provider groups whether MH/SUD or MED/SURG have the ability to serve a larger customer base, hence giving them bargaining power to negotiate. | **Same as M/S** |

Both Standard and Non-Standard (negotiated) fee schedules are developed based upon the same factors, including provider or facility's negotiation request. For both MH/SUD and M/S standard and non-standard reimbursement the following factors are considered in all negotiations, where applicable:

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

- Type of provider (i.e., hospital, clinic and practitioner) and/or specialty
- Medicare baseline rates
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty, i.e. Network Adequacy)
- Scope and Type of Services
- Medical cost budgets
- Utilization
- Competitive Insights, where available

For both MH/SUD and M/S providers any revisions to the standard reimbursement rates for both in network facility-based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Manager or Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. 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. Per the **MH/SUD Fee Exceptions HM-NET-010 policy**, behavioral health has established clear guidelines/criteria for negotiating fee exceptions such as provider specialty, language/cultural skills, populations served etc. The aim of the exception process is to allow the contract negotiators to engage or retain practitioners who are essential to the integrity of the network.

Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Per the factors listed above, Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. Cigna's preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. It is more favorable because MH/SUD providers are reimbursed at the same rate for all plan/product types. M/S providers typically have a rate decrement from the standard, dependent upon the product type. There is no such decrement for MH/SUD; thus, making the reimbursement to MH/SUD providers more favorable. For example,

MHSUD pays the same rate for a Medicare provider as it does for a commercial provider. MS rate reduction may be negotiated upon plan request.

In determining any rate in both the M/S and MH/SUD facility agreements, Cigna assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. That is, Cigna's reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area.

With respect to coding, Wellfleet contracts with Zelis to perform coding reviews. Zelis' dedicated team of clinicians performs ongoing reviews of clinical and regulatory guidelines and sources to maintain the edits. Edits are sourced via a myriad of industry-recognized sources, such as CMS, ICD -10 CM®, NCCI, AMA, NCD/LCD, CPT®, and HCPCS codes. In addition, Zelis sources rely on specialty associations and colleges when CMS and other sources may be silent. All edit rules are configurable to ensure alignment with Wellfleet's provider contracts and medical, payment, and benefit policies. Moreover, Zelis makes every effort to release clinical and compliance updates in the next available release; off-cycle releases may be done when a high-priority update is needed.

<u>Out of Network (Facility and Practitioner)</u>

To determine Out of Network (OON) Rates, Wellfleet utilizes Zelis to apply R&C reimbursement rates to all OON outpatient facility M/S & MHSUD benefits that are billed with CPT/HCPCS codes (typically provider claims). If billed with Revenue codes only (typically with facility claims), no R&C will be applied, and it is paid at the benefit level in the plan.

OON outpatient facility and provider claims as well as all original OON inpatient benefit claims are sent to Zelis. Zelis applies their pricing solutions, which include continuous discount agreements, supplemental networks, out of network negotiations and ERS savings. Zelis reviews all claims submitted by providers that billed with a CPT or a Healthcare Common Procedure Coding System (HCPCS) code to confirm such claims are coded and billed accurately in accordance with nationally recognized coding guidelines, primarily set by the Centers for Medicare and Medicaid Services, National Correct Coding Initiative, and American Medical Association. Zelis will discuss the recommended edits with Wellfleet for their approval. Wellfleet's policy for payment of out-of-network claims is a percent of the Fair Health allowable charge, for both M/S and MH/SUD providers. Zelis will recommend an out of network repriced amount based on a secured savings agreement, Zelis' Established Reimbursement Solution (ERS), a percentage of Medicare fee schedule, negotiated amount, or a percentage of charges made by providers of such service or

supply in the geographic area where received as complied in FAIR Health database. Zelis performs the service for OON claims and upon completion of review, the claim is sent to Wellfleet with the discount applied for processing.

For both MH/SUD and M/S OON services, when no CPT/HCPCS is identified, no R&C will be applied to the revenue code, and Wellfleet will pay the claim based solely on the benefit level of the plan.

With respect to coding, Wellfleet contracts with Zelis to perform coding reviews. Zelis' dedicated team of clinicians performs ongoing reviews of clinical and regulatory guidelines and sources to maintain the edits. Edits are sourced via a myriad of industry-recognized sources, such as CMS, ICD -10 CM®, NCCI, AMA, NCD/LCD, CPT®, and HCPCS codes. In addition, Zelis sources rely on specialty associations and colleges when CMS and other sources may be silent. All edit rules are configurable to ensure alignment with Wellfleet's provider contracts and medical, payment, and benefit policies. Moreover, Zelis makes every effort to release clinical and compliance updates in the next available release; off-cycle releases may be done when a high-priority update is needed.

***Step 4(b): Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, <u>in operation</u>. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).***

Wellfleet performed an analysis of all 2024 In-network claims to calculate weighted average of M/S vs. MH/SUD reimbursement rates compared to Medicare.

The data comparison of M/S vs MH/SUD shows the weighted average of Medicare reimbursement is greater for MHSUD non-physicians, non-specialists, and specialists in the in-network and out-of-network categories, as shown in the grid below. Parity is shown in operation.

**Weighted average of MedSurg vs. MH/SUD reimbursement rates compared to Medicare**

| | INN MedSurg | INN MH/SUD | OON MedSurg | OON MH/SUD |
|---|---|---|---|---|
| **Non Physician**<br>MedSurg=Chiro/OT/PT<br>MH/SUD=LCSW | 66% | 120% | 226% | 471% |
| **Non Specialists**<br>MedSurg=Fam Med/Internist/Ped<br>MH/SUD=Psychologist | 124% | 181% | 223% | 692% |
| **Specialists**<br>MedSurg = Orth Surg/Endo/Neuro/Derm/Podiatrist<br>MH/SUD = Psychiatrist | 161% | 177% | 201% | 502% |

Same as M/S

Moreover, the data comparison of M/S vs. MH/SUD coding edits demonstrates parity in operation.

**CODING EDITS**

Jan – Dec 2024:

| Zelis Claim Stats | M/S | MH/SUD |
|---|---|---|
| Total Claim Count | 144,271 | 39,360 |
| Total Claims with Edits | 45,427 | 5,346 |
| % Edits per total claims | 31% | 13% |

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

As per the analysis above, the factors considered in every negotiation include state/federal law, geographic market, provider type and supply, Medicare baseline rates, scope and type of service, cost budget, and utilization. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules. The schedules are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. **MH/SUD HM NET 011Provider Fee Schedules Policy** shows the guidelines for consistent provider alignment based on their licensure and educational background. Thus, the factors, sources, and evidentiary standards for in-network provider reimbursement demonstrate parity, as written.

Moreover, over the past several years, Cigna has implemented new rate negotiations with MH/SUD practitioners, which has correlated to reimbursement increases, as evidenced by the upward trend in MH/SUD reimbursement rates as compared to Medicare over those years. This trend is reflective of the steps Cigna has taken because of an internal review of its MH/SUD network demonstrating comparability and representative of comparable network access outcomes between M/S and MH/SUD benefits. In fact, the data comparison of M/S vs MH/SUD demonstrates parity, in operation.

Wellfleet has assessed the methodology for calculating out-of-network reimbursement amounts and has concluded that it is designed and applied comparably, and no more stringently, as-written and in-operation across MH/SUD and M/S benefits. Wellfleet's methodology for determining out-of-network M/S provider reimbursement rates and out-of-network MH/SUD provider reimbursement rates are comparable and applied no more stringently to MH/SUD providers than to M/S providers as-written. As described in the foregoing, the plans establish in their terms one methodology, including the percentile or percentage, if any, applied to the MRC for the service that uniformly applies to MH/SUD and M/S benefits. There are not different methodologies for identifying the charge, or, as applicable, the percentile applied to the charge, used to calculate the amount the plan agrees to reimburse for the service rendered by an out-of-network provider. The charges used to calculate MH/SUD benefits are subject to the same percentile or percentage as applies to M/S benefits (e.g., 80% of the MRC for the service).

Likewise, enrollees enjoy the protection from balance-billing afforded by any indirect rate arrangement accessed by the plan, whether the provider with which the plan has an indirect rate arrangement renders MH/SUD services or M/S services to the enrollees. Wellfleet does not limit application of these out-of-network rate arrangements to M/S services, and the indirect rate arrangements with MH/SUD providers leverage, just like M/S providers and where available, rates obtained by third party vendors and derived from third party databases that compile charges for the same or similar providers in the geographic area. Specifically, across MH/SUD and M/S providers the charges for services differ as-between inpatient and outpatient facilities and among different licensure/training levels, including physician and non-physician practitioners (e.g. MD/PhD v. psychologists), and across geographic areas.

Moreover, Wellfleet has assessed the methodology for applying coding edits and has concluded that it is designed and applied comparably, and no more stringently, as-written and in-operation across MH/SUD and M/S benefits. In fact, the data demonstrates that coding edits were applied to MH/SUD claims at a significantly lower rate than to M/S claims.