

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.

Network Admissions and Credentialing

Applies to M/S and MH/SUD benefits in the In-Network Inpatient classification, In-Network Outpatient Office Visit and In-Network Outpatient - All Other subclassifications.

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:

The Network Admission and Credentialing NQTL consists of two related components: (1) the standards and processes used to determine whether Cigna will pursue or approve a provider, facility, or program for network participation, and (2) the credentialing and recredentialing standards used to determine whether the provider, facility, or program satisfies the professional, licensure, quality, accreditation, insurance, sanction-screening, and other eligibility requirements for initial and continued participation.

This comparative analysis evaluates the Network Admission and Credentialing NQTL applied by Cigna Health and Life Insurance Company ("CHLIC") and Evernorth Behavioral Health, Inc. ("Evernorth") to providers and facilities furnishing MH/SUD and M/S benefits in the In-Network Inpatient, In-Network Outpatient Office Visit, and In-Network Outpatient All Other classifications. The NQTL governs whether practitioners, provider groups, facilities, and programs may obtain and retain participating-network status.

Evernorth Behavioral Health, Inc. ("Evernorth," "EBH"), an affiliate of CHLIC, maintains and administers the network used for MH/SUD benefits, while CHLIC maintains and administers the network for most 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.

Except for the credentialing and recredentialing functions delegated to the entities identified below, no unaffiliated third party developed the substantive Cigna credentialing standards evaluated in this analysis. Delegates may perform specified verification, review, or monitoring functions subject to Cigna's delegation requirements and oversight.

Cigna delegates the credentialing/recredentialing function(s) to entities such as but not limited to: hospitals, physician hospital organizations (PHO), independent practice associations (IPA), medical groups, behavioral health care networks, chiropractic or podiatric networks, credentials verification organizations (CVOs) or staffing agencies (locum tenens). The delegates for VA are as follows:

- Children's Health Network
- Community Care Network of Virginia, Inc.
- Inova Health System
- Martha Jefferson PHO
- Privia Medical Group, LLC
- University of Virginia Health Services Foundation
- VCU Health Systems
- Centra Health Systems
- American Specialty Health Networks, Inc.
- Evernorth Behavioral Health (formerly Cigna Behavioral Health)
- eviCore
- MDLive
- HCA Physician Services, Inc.
- LifeStance Health

Cigna may delegate specified credentialing functions for both M/S and MH/SUD providers where the delegate satisfies Cigna's delegation standards. The delegation agreement identifies the delegated functions, applicable credentialing criteria, reporting obligations, audit rights, corrective-action requirements, and Cigna's retained authority. Cigna evaluates delegated performance through pre-delegation review, periodic oversight, file audits, and corrective-action monitoring.

Cigna requires each delegate to perform the delegated functions in accordance with the delegation agreement, applicable law, accreditation requirements, and Cigna-approved standards. The precise procedures used by a delegate may vary based on the delegated functions and the delegate's approved policies. Cigna evaluates those procedures through pre-delegation review, periodic audits, reporting, and

corrective-action oversight.

Delegation arrangements vary according to the contract and the capability of the entity. The contract or standards of delegation documents outline the functions delegated and the responsibilities of both parties. Cigna retains the responsibility for ensuring that the delegated functions are carried out according to applicable policy, regulation, and NCQA accreditation standards.

Cigna maintains corporate-wide policies applicable to multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only.

The plan booklet does not expressly use the terms “credentialing” or “recredentialing.” It does, however, define a Participating Provider as a person or entity having a direct or indirect contractual arrangement with Cigna to provide covered services or supplies, and it distinguishes between in-network and out-of-network care. The Network Admission and Credentialing NQTL operationalizes those provisions by establishing the standards and processes used to determine whether a practitioner, provider group, facility, or program may obtain and retain Participating Provider status. The detailed eligibility criteria, verification requirements, review procedures, decision standards, monitoring activities, and adverse-action procedures are contained in the provider guides, administrative guidelines, credentialing policies, workflows, delegation agreements, and provider agreements identified below.

The plan language or coverage terms governing Network Access and Adequacy NQTL is excerpted from the Connect Bronze 6500 Indiv Med Deductible plan document and states as follows:

Connect Bronze 6500 Indiv Med Deductible Plan Language
Selection of a Primary Care Physician This Policy requires the designation of a Primary Care Physician. You have the right to designate any Primary Care Physician who participates in the network and who is available to accept You or Your Family Members. Cigna Healthcare will designate one for you until you make this designation. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, visit www.mycigna.com or contact Customer Service at the phone number listed on the back of your ID card. For children, You may designate a pediatrician as the Primary Care Physician. ¹
Choosing a Primary Care Physician (PCP) When you enroll as an Insured Person, you must choose a Primary Care Physician (PCP). If you do not select a PCP, We will assign one for you. If your PCP leaves the Cigna network, you will be able to choose a new PCP. A Primary Care Physician serves an important role in meeting health care needs by providing or arranging for medical care for each Insured Person. For this reason, when you enroll as an Insured Person, you will be asked to select a Primary Care Physician (PCP). Your PCP will provide your regular medical care and assist in coordinating your care. You should select your PCP by calling the customer service phone number on your ID card or by visiting Our website at www.mycigna.com . The Primary Care Physician You select for Yourself may be different from the Primary Care Physician You select for each of Your Family Member(s). You have the right to designate any Primary Care Physician who participates in Our network for this plan and is available to accept You or Your Family Members.
If You Need a Specialist Your PCP is important to the coordination of your care. While this Policy does not require referrals to visit specialists, if you need specialty care, you are encouraged to work with your PCP who can coordinate your care and assist you in selecting a specialist appropriate for your care.

The referral system can be used to keep your PCP involved in and apprised of all of your health care needs. If you receive Covered Services from a specialist in the Policy's network without a referral, you will not be subject to a penalty, and the claims for those Covered Services will be processed according to the applicable level of benefits.

Changing Primary Care Physicians

You may voluntarily change your PCP, but not more than once in any calendar month. We reserve the right to determine the number of times during a Year that you will be allowed to change your PCP. You may request

a change from one Primary Care Physician to another by going to www.mycigna.com, under your name, click on "My Health Team," click "Change," and follow the directions displayed, or by contacting Us at the customer

service number on your ID card.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, We will notify you 30 days in advance, for the purpose of selecting a new Primary Care Physician.²

Mental Health (including Eating Disorders) and Substance Use Disorder Services

This Policy provides benefits for Covered Services as indicated below for evaluation and treatment of Mental Health and Substance Use Disorders. Financial requirements or treatment limits that do not apply to medical or surgical benefits with the same classification (i.e., inpatient services, outpatient services, Emergency Services, Physician services, or other plan services) under this Policy will not apply to Mental Health and Substance Use Disorder services.

Inpatient Services Coverage includes individual psychotherapy, group psychotherapy, psychological testing, and counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy, detoxification, and rehabilitation treatment; Hospital and inpatient professional charges in any Hospital

or facility required by state law.

Outpatient Services Coverage includes diagnosis and treatment of psychiatric conditions, individual and group psychotherapy, psychological testing, Office Visits, outpatient facility and Physician charges, and medication management checks.³

Description of the NQTL:

The Network Admissions and Credentialing NQTL consists of the processes, strategies, evidentiary standards, and decision-making criteria Cigna uses to determine whether practitioners, provider groups, facilities, and programs are eligible to participate and remain within its participating networks. The NQTL includes initial credentialing and recredentialing; verification of application completeness, licensure or certification, education and training, work history and professional liability claims history, professional liability coverage, accreditation or acceptable site-review evidence, exclusion and sanction screening, and compliance with other applicable participation requirements. The NQTL also includes ongoing monitoring between credentialing cycles; review of credentialing exceptions, and processes governing suspension, denial, termination, non-renewal, and applicable appeal or reconsideration rights. Cigna applies these requirements through credentialing personnel, Medical Directors or Market Medical Executives, and the applicable credentialing committee, applying standards derived from NCQA accreditation standards, federal and state regulatory requirements, and Cigna credentialing policies and procedures. The NQTL applies to participating providers and facilities furnishing M/S and MH/SUD benefits in the In-Network Inpatient classification and the In-Network Outpatient Office Visit and In-Network Outpatient All Other subclassifications.

For purposes of this analysis, Network Admissions and Credentialing NQTL includes only the standards and processes used to determine whether a practitioner, provider group, facility, or program may enter and

2 Connect Bronze 6500 Indiv Med Deductible Plan Booklet pgs. 6-7 of 112

3 Connect Bronze 6500 Indiv Med Deductible Plan Booklet pgs. 54-55 of 112

remain in the participating network. These include application and contracting prerequisites; credential verification; committee or medical-director review; recredentialing; ongoing sanction and quality monitoring; permissible exceptions; and suspension, denial, termination, nonrenewal, and related appeal rights. Network adequacy recruitment decisions are addressed only to the extent that network need is an express factor in a participation decision. Reimbursement methodology and utilization-management requirements are outside the scope of this NQTL.

Glossary:

1. Classification: Benefits Classifications for MH/SUD and M/S services include Inpatient, Outpatient, Prescription Drugs and Emergency care. Within the Outpatient classification, Cigna uses the permitted subclassifications of Office Visits and Outpatient All Other.
2. Credentialing: The process is used to verify and evaluate a practitioner's, facility's, or program's qualifications and eligibility for participation in the network.
3. Demand for provider type: The number of members requiring a particular service/level of care in a particular geographic area. Factors applicable to provider demand include (1) internal claims experience, the evidentiary source of which is Cigna's historical claims data and (2) external GeoAccess reports the evidentiary source of which is network access assessments that measure the distance between members and providers. These assessments can be leveraged to determine how to adequately support its existing membership and the potential market if a strategic growth/network fortification plan is undertaken, as required to meet any applicable regulatory access standards.
4. Inpatient Acute Facility: An Inpatient Acute Facility is a facility that provides short-term, intensive medical or behavioral health services requiring admission and continuous clinical monitoring, typically involving an overnight stay. Examples include acute care hospitals, acute inpatient psychiatric facilities, and detoxification units.
5. Inpatient Non-Acute Facility (Sub-Acute / Post-Acute): An Inpatient Non-Acute Facility is a facility that provides ongoing, rehabilitative, or lower-intensity inpatient care following or in place of acute treatment. These facilities include skilled nursing facilities, rehabilitation facilities, long-term acute care facilities, and residential MH/SUD treatment settings.
6. Inpatient Services: are provided by a hospital while confined in a Hospital, Inpatient Rehab, Skilled Nursing facility or MH/SUD residential facility.
7. Licensed Non-Physician Provider: A Licensed Non-Physician Provider is a health care practitioner who is not a physician (MD/DO) but is licensed or otherwise authorized under applicable state law to deliver health care services within the scope of their professional practice. These providers can include both prescribing providers (e.g., nurse practitioners and physician assistants, where permitted) and non-prescribing providers (e.g., psychologists, licensed clinical social workers, counselors, and therapists) and deliver services consistent with their licensure and training.
8. Mental Health or Substance Use Disorder (MH/SUD): Behavioral Health defines MH/SUD conditions as those included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the current edition of the International Classification of Diseases.
9. Medical/Surgical: Cigna defines Medical/Surgical benefit as 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 International Classification of Diseases (ICD) or State guidelines).
10. National Committee for Quality Assurance (NCQA): Accreditation Body that is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.

11. Network Admission: The process through which Cigna determines whether a provider, facility, or program may enter a participating network.
12. Non-MD Providers: Non-MD Providers are health care practitioners who are not physicians (MD/DO) and can include both prescribing and non-prescribing licensed providers. This category reflects differences in training, licensure, and scope of practice relative to physician providers.
13. Non-Prescribers: Non-Prescribers are licensed providers who do not have authority to prescribe medications and instead provide clinical or therapeutic services within their defined scope of practice. These providers include, but are not limited to, psychologists, licensed clinical social workers, and other behavioral health or allied health professionals.
14. Other Health Professional: The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.
15. Other Health Care Facility: The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.
16. Outpatient Facility: An Outpatient Facility is a facility that provides health care services that do not require admission or an overnight stay. Services are delivered in settings such as physician offices, ambulatory surgical centers, and free-standing medical or behavioral health outpatient facilities.
17. Outpatient services: Are provided in an outpatient setting such as a physician's office, free standing surgical or behavioral health outpatient facility.
18. 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.
19. Prescribers: Prescribers are licensed providers authorized to prescribe medications under applicable state law. This category generally includes physicians (MD/DO) and certain licensed non-physician providers (e.g., nurse practitioners and physician assistants), depending on scope of practice requirements.
20. Physicians (MD/DO): Physicians (Doctor of Medicine (MD) and Doctor of Osteopathic Medicine (DO)) are licensed medical practitioners authorized to practice medicine independently and provide diagnosis, treatment, and management of medical and behavioral health conditions within the scope of applicable state law. Physicians have full clinical authority, including the ability to prescribe medications and perform medical and surgical procedures.
21. 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.
22. Recredentialing: The periodic process used to reassess a participating provider's continued compliance with network participation requirements.
23. Subclassification: Cigna subclassifies "Office Visit" and "Outpatient All Other" within the Outpatients classification. For purposes of this analysis, the term subclassification is limited to Outpatient.
24. Supply of providers: The number of available providers of a particular type/license in a particular geographic area. Factors in determining supply of providers include (1) the evaluation of Cigna's existing network, the evidentiary source of which is Cigna's internal provider contracting and

credentialing data sources; and (2) the evaluation of other payers' networks the evidentiary source of which is third party data comprising competitor intel, i.e., directories, licensing and NPI registry.

Supporting Documents:

Document/Policy Name	Description
Connect Bronze 6500 Indiv Med Deductible Plan Booklet	Plan specific document that outlines the details of a health insurance plan, including plan and benefit information, claim review procedures, and participation rights. The plan booklet provides comprehensive information about what the plan covers, how it is administered, and the procedures for reviewing claims. It is intended to help members understand their rights and responsibilities under the plan.
Cigna Provider Reference Guide	Document that houses policies and guidelines that Cigna contracted providers (M/S) agree to adhere to. Includes information about working with Cigna Health Care (i.e. updating demographic information, verifying benefits and eligibility, credentialing and recredentialing processes, submitting claims, etc.) Refers providers to the terms and conditions within their contract related to reimbursement rates. The guide describes provider-facing credentialing and recredentialing requirements, demographic and status-update obligations, screening requirements, and administrative responsibilities relevant to initial and continued network participation.
CR-01 Practitioner Credentialing/Re-credentialing	Establishes M/S credentialing requirements for practitioners requiring credentialing.
CR-03 Delegated Credentialing/Re-credentialing	Establishes M/S credentialing requirements for Delegation and Oversight of practitioner groups and facilities.
CR-04 Facility Credentialing/Re-credentialing	Establishes M/S minimum credentialing requirements for those health facilities requiring full credentialing check and those ancillary health facilities requiring basic credentialing checks.
CR-12 Terminations, Denials, and Appeals Policy for Participating Physicians, Physician Groups and Other Health Care Professionals	Establishes a consistent and fair provider termination, denial and appeals process for M/S participating physicians, physician groups and health care professionals.
CR-14 Information for Review by Medical Director and Credentialing Committee	Establishes a consistent approach for M/S credentialing file review based on information submitted.
CR-19 Exception Request Process for Facilities and Practitioners Regarding Insurance Coverage Amounts	Establishes the acknowledgement process for M/S practitioners and hospital/ancillary facilities applying to join or continue in the network when their general liability and/or professional liability insurance limits do not meet requirements.
CR-20 Verifying Provider Directory Information Against Credentialing Data	Outlines the M/S process whereby information given to participants about participating providers matches credentialing information.

CR-21 Termination and Appeals Policy for Participating Institutional Provider	Establishes M/S credentialing termination and appeals process for Cigna Participating institutional providers.
Evernorth Administrative Guidelines	Document that houses all the administrative policies that Evernorth contracted providers (MH/SUD) agree to adhere to. Includes information about working with Evernorth Behavioral Health (i.e. updating demographic information, verifying benefits and eligibility, credentialing and recredentialing processes, submitting claims, etc.) Refers providers to the terms and conditions within their contract related to reimbursement rates. The guide describes provider-facing credentialing and recredentialing requirements, demographic and status-update obligations, screening requirements, and administrative responsibilities relevant to initial and continued network participation.
HM-NET-006 Delegation of Credentialing to a Credentials Verification Organization (CVO)	Establishes MH/SUD credentialing guidelines for delegation of primary source verification individual practitioners to a credentials verification organization (CVO).
HM-NET-007 Delegation of Credentialing to Practitioner/Facility/PHO	Establishes MH/SUD credentialing requirements for delegation of practitioner groups and facilities.
HM-NET-009 Healthcare Facilities and Programs Credentialing and Re-credentialing	Establishes MH/SUD credentialing and recredentialing requirements for facility and program participation.
HM-NET-016 Practitioner Credentialing/Re-credentialing	Establishes MH/SUD credentialing requirements for practitioners requiring credentialing.
HM-NET-023 Suspension, Termination or Non-Renewal of Practitioner/Provider Contract Privileges	Outlines MH/SUD guidelines for suspension, termination or non-renewal of practitioner/provider contract privileges.
HM-NET-024 Termination of a Practitioner's Initial Application for Participation Prior to Committee Review	Outlines the MH/SUD process for terminating the review process for a health care practitioner's initial application once the credentialing verification process has commenced but prior to presenting the practitioner to the credentialing committee.
MH/SUD Credentialing Workflow	Outlines the end to end credentialing process for MH/SUD.
M/S Credentialing Workflow	Outlines the end to end credentialing process for 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.

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 can 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.

The classification or subclassification assigned to a service reflects the setting and nature of the covered service. As described below, the Network Admissions and Credentialing NQTL applies to in-network providers and facilities furnishing MH/SUD or M/S services in the Inpatient, Outpatient Office Visits, and Outpatient - All Other classifications; it does not apply to Emergency Care.

Except for the Emergency Care and Prescription Drug classifications described below, providers and facilities seeking participating status to furnish covered M/S or MH/SUD services in the In-Network Inpatient, In-Network Outpatient Office Visit, and In-Network Outpatient All Other classifications are subject to the applicable credentialing or participation standards.

Services Subject to the NQTL

Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to In Network Outpatient-Office sub-classification?	Is NQTL applied to In Network Outpatient-All Other sub-classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
YES- Acute Services: Inpatient (Medical) Hospice - IP Other HC Facility Inpatient Hospital Inpatient Hospital Physician's Visit/Consultation	YES- Outpatient Office Visits (Medical) Primary Care Physician (PCP) Services/Office visit Specialty Care Physician	YES- Outpatient All Other Services (Medical) Advanced Radiology Consumable Medical Supplies Convenience	No- for both M/S and MH/SUD	No-for both M/S and MH/SUD

Inpatient Preventive Inpatient Professional Services Inpatient Surgery Inpatient Services at Other Health Care Facilities (Long Term Acute Care – Medical) Inpatient (MH/SUD) Acute Inpatient (Mental Health and Substance Use) Acute Inpatient Detoxification Sub-acute Services: Inpatient Services at Other Health Care Facilities (Skilled Nursing Facility and Rehab – Medical) MHSUD Residential Treatment	Services/Office Visit Telehealth Outpatient Office (MH/SUD) Visits Office Visits, including Individual, Family and Group Psychotherapy and Medication Management Telehealth	Care (Lab, Radiology, Surgery) Dialysis not performed in a dialysis center Durable Medical Equipment (DME) Home Health Care Hospice - OP Lab Services Outpatient Short Term Rehab Outpatient Chiro Outpatient Facility Services (surgical and non-surgical) Outpatient Non-Office Preventive (Facility) Outpatient Non-Office Preventive (Professional) Outpatient Professional Services (surgical and non-surgical) Radiology Services - OP Facility (surgical and non-surgical) Radiology - Physician's Services/Office Visit (PCP/SCP) Surgery Performed in the Physician's Office (PCP/SCP) Urgent Care Facility Outpatient All Other Services (MH/SUD) Partial Hospitalization Program		
--	--	---	--	--

		Intensive Outpatient Services Applied Behavior Analysis Transcranial Magnetic Stimulation		
--	--	--	--	--

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

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

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

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

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

This FAQ guidance stipulates what plans and issuers should avoid:

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

Issuer Response:

Cigna incorporates the applicable state and NCQA licensing and accreditation requirements to credential providers and facilities. Through licensing, state medical and health professions boards ensure that practicing physicians and other health care providers have appropriate education and training, and that they abide by recognized standards of professional conduct while serving their patients. Accreditation of

providers is defined as the process of evaluation and recognition of healthcare providers to ensure that they meet specific quality and safety standards. When determining the credentialing requirements to apply to M/S and MH/SUD professional providers and facilities, Cigna utilizes the *same* factor and evidentiary standards.

No additional factors were identified that were considered and ultimately rejected during the design of the NQTL.

To promote objectivity and avoid biased application of credentialing standards, Cigna relies on standardized credentialing policies, NCQA accreditation standards, state licensing requirements, primary-source verification processes, and documented credentialing committee review procedures. Cigna does not establish separate credentialing criteria based on whether a provider renders MH/SUD or M/S services. Where professional disciplines or facility types are governed by different state licensure, certification, accreditation, or scope-of-practice requirements, Cigna applies credentialing requirements that correspond to the applicable legal and professional standards for that provider or facility type. Credentialing decisions are based on objective, documented criteria and verified information obtained from primary and authoritative sources, including state licensing boards, accreditation organizations, OIG exclusion databases, CAQH, and the National Practitioner Data Bank, as applicable. Credentialing committee review is conducted pursuant to established policies and procedures intended to promote consistent application of credentialing standards across provider types and specialties.

Credentialing standards are applied based on credentialing qualifications and participation requirements and are not modified based solely on the availability or scarcity of providers within a specialty, geographic area, or provider type.

In-Network Inpatient and Outpatient Facilities Factors

<u>Design Factors</u>	<u>Sources for Each Factor</u>
1. Federal and State Law, as applicable	1. Federal and State Law, as applicable; 12 VAC 5-408-170. Provider credentialing and recredentialing
2. Completed application & attestation	2. Verified complete and accurate Cigna Application
3. Signed Agreement/Contract	3. Signed agreement/contract
4. Licensure Verification	4. Verification of a valid license from a State licensing board
5. Malpractice History	5. Verification based on information provided and attested to by the applicant.
6. Malpractice Insurance	6. Cigna Policy: \$1M/occurrence and \$3M aggregate for Acute Care Facility, Ambulatory Detoxification and Residential Facilities, \$1M/occurrence and \$1M aggregate for Facility Based Programming (i.e. Intensive Outpatient, Partial Hospitalization) unless a lower amount is mandated by the state where the provider provides care to members.
7. Accreditation	7. Accreditation or other acceptable site survey
8. Ongoing monitoring to ensure the providers continue to meet credentialing standards.	8. State licensing boards, OIG, CAQH, NCQA standards, State, or federal requirements
9. Suspension, Termination and Non-Renewal	9. Failure to meet recredentialing standards, License sanction, malpractice claim, quality of

	care issues (identified by customer complaints, review of provider data and chart review).
--	--

In-Network Outpatient Provider and Provider Groups Factors

<u>Design Factors</u>	<u>Sources for Each Factor</u>
1. Federal and State Law, as applicable	1. Federal and State Law, as applicable; 12 VAC 5-408-170. Provider credentialing and recredentialing
2. Completed application & attestation	2. Verified complete and accurate CAQH/Cigna Application
3. Signed Agreement/Contract	3. Signed agreement/contract
4. Licensure/Certificate Verification	4. Verification of a valid unrestricted license from a State licensing board • DEA Certificate, if applicable • Admitting privileges at a participating hospital, if applicable • Board Certification, if applicable
5. Education Verification	5. Verification of highest level of education and training, if not board certified
6. Malpractice History	6. Verification based on information provided and attested to by the applicant, information available from the appropriate state agencies, and the National Practitioner Data Bank.
7. Work History	7. Five years of work history should be included with the application or on the curriculum vitae (CV).
8. Malpractice Insurance	8. Cigna Policy: Each provider must carry professional liability coverage. Physicians and other providers with prescriptive authority must carry \$1M/occurrence and \$3M aggregate unless a lower amount is mandated by the state where the provider provides care to members.
9. Ongoing monitoring to ensure the providers continue to meet credentialing standards.	9. State licensing boards, OIG, CAQH, NCQA standards, State, or federal requirements
10. Suspension, Termination and Non-Renewal	10. Failure to meet recredentialing standards, License sanction, malpractice claim, quality of care issues (identified by customer complaints, review of provider data and chart review).

In establishing the factors used to determine what services are subject to Network Composition Standards including the Credentialing/Re-credentialing NQTL, Cigna considers the following sources and evidentiary standards:

In-Network Inpatient and Outpatient Facilities:

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. Federal and State Law, as applicable	1. Federal and State Law, as applicable; 12 VAC 5-408-170. Provider credentialing and recredentialing	1. Federal and State Law, as applicable; 12 VAC 5-408-170. Provider

		credentialing and recredentialing
2. Completed application & attestation	2. Signed application required- a fully completed credentialing application and provider attestation containing all required information necessary for credentialing review and verification	2. Verified complete and accurate Cigna Application
3. Signed Agreement/Contract	3. Signed Agreement (provider contract) - execution of a provider participation agreement establishing the terms and conditions under which the provider or facility participates in the network.	3. Signed agreement/contract
4. Licensure Verification	4. M/S: Providers shall have an unrestricted state license/certification that allows them to practice independently in the state, except in cases where a state requires oversight of an allied practitioner by a supervising physician; the supervising physician must have an existing contract in good standing with Cigna. For Direct Entry Midwives specific certification by the state can be accepted in lieu of licensure. MH/SUD: Unrestricted State License/Certification required, with the exception of Physician Assistants and Board-Certified Associate Behavior Analysts (BCaBA), providers shall have an unrestricted state license/certification that allows them to practice independently in the state. PA-Cs must practice under the supervision of a physician. In instances where a state does not license a specific discipline, a national certification/registration in place of state license/certification can be accepted.	4. Verification of a valid license from a State licensing board
5. Malpractice History	5. Review of applicant's history (minimum 5 years) of malpractice claims, if any, to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant, information available from the appropriate state agencies, and the National Practitioner Data Bank, as applicable.	5. Facility: Verification based on information provided and attested to by the applicant.
6. Malpractice Insurance	6. \$1M/occurrence and \$3M aggregate for Acute Care Facility, Ambulatory Detoxification and Residential Facilities, \$1M/occurrence and \$1M aggregate for Facility Based Programming (i.e. Intensive Outpatient, Partial Hospitalization) unless a lower amount is mandated by the state where the provider provides care to members.	6. Cigna Policy: Current professional liability insurance with required minimum coverage (determined by industry standards and applicable state mandated limits
7. Accreditation	7. Accrediting organizations, such as the Joint Commission (JC), validate a quality improvement program. When accreditation, state Department	7. Accreditation or other acceptable site survey

	of Health, or Medicare certification evidence is not available, Cigna Healthcare can perform a site visit and review of the hospital or ancillary facility quality improvement program.	
8. Ongoing monitoring to ensure the providers continue to meet credentialing standards.	8. Ongoing maintenance (recredentialing) every three years- periodic review and recredentialing activities conducted to confirm continued compliance with credentialing requirements and participation standards.	8. State licensing boards, OIG, CAQH, NCQA standards, State, or federal requirements
9. Suspension, Termination and Non-Renewal	9. Suspension, Termination and Non-Renewal means the removal, restriction, expiration, or discontinuation of network participation when a provider or facility no longer satisfies credentialing, participation, licensure, quality, regulatory, or contractual requirements. Rules of Participation Standards: • Participation – Standards ○ Must have a current, unrestricted license for the scope of practice; no unacceptable history of suspension, surrender, or revocation. ○ Must have required formal training/residency in specialty (per ABMS/AOA) or, for general practitioners, a rotating internship or 5 years general practice experience. ○ Must have unrestricted admitting or surgical privileges in specialty at a participating hospital. ○ Must demonstrate ability to provide continuity of care for ambulatory and hospitalized patients. ○ Must provide proof of adequate liability coverage. ○ Must not misrepresent credentials or information provided to Cigna. ○ Must not be under sanction, excluded, debarred, terminated, or precluded by Medicare, Medicaid, or other federal programs. ○ Inclusion in the network must be necessary to assure adequate access to basic health care services, as determined by Cigna. ○ Must meet Cigna’s standards for practicing the full scope of designated specialty. • Quality Standards ○ Must have an acceptable history regarding investigations and disciplinary actions by hospitals,	9. Failure to meet recredentialing standards, License sanction, malpractice claim, quality of care issues (identified by customer complaints, review of provider data and chart review).

	institutions, licensing/regulatory/professional organizations (as determined by Cigna's Credentialing Committee). ○ Must have an acceptable history of malpractice/liability claims (as determined by Cigna standards or Credentialing Committee). ○ Must have an acceptable criminal and civil liability history (as determined by Cigna standards or Credentialing Committee). ○ Must not use chemical substances that impair or limit ability to practice medicine safely. ○ Must not have an inability, for any reason, to perform essential functions of their practice with reasonable accommodation. ○ Must accept and comply with Cigna's requirements for office setup, practices, medical records, and patient accessibility. ○ Quality of care/service results or complaints must indicate acceptable quality of medical care, service, business/office practices, and provider behavior (as determined by Cigna). ○ Must comply and cooperate with Cigna's Quality Management program	
--	--	--

In-Network Inpatient, Outpatient Office visit, and Outpatient Other (Provider and Provider Groups):

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. Federal and State Law, as applicable	1. Federal and State Law, as applicable; 12 VAC 5-408-170. Provider credentialing and recredentialing	1. Federal and State Law, as applicable; 12 VAC 5-408-170. Provider credentialing and recredentialing
2. Completed application & attestation	2. Signed application required- a fully completed credentialing application and provider attestation containing all required information necessary for credentialing review and verification	2. Verified complete and accurate Cigna Application
3. Signed Agreement/Contract	3. Signed Agreement (provider contract) - execution of a provider participation agreement establishing the terms and conditions under which the provider or facility participates in the network.	3. Signed agreement/contract
4. Licensure/Certificate Verification	4. M/S: Providers shall have an unrestricted state license/certification that allows them to practice	4. Verification of a valid unrestricted license

	independently in the state, except in cases where a state requires oversight of an allied practitioner by a supervising physician; the supervising physician must have an existing contract in good standing with Cigna. For Direct Entry Midwives specific certification by the state can be accepted in lieu of licensure. MH/SUD: Unrestricted State License/Certification required, with the exception of Physician Assistants and Board Certified Associate Behavior Analysts (BCaBA), providers shall have an unrestricted state license/certification that allows them to practice independently in the state. PA-Cs must practice under the supervision of a physician. In instances where a state does not license a specific discipline, a national certification/registration in place of state license/certification can be accepted.	from a State licensing board • DEA Certificate, if applicable • Admitting privileges at a participating hospital, if applicable • Board Certification, if applicable
5. Education Verification (applicable to practitioners only)	5. M/S: All providers shall have completed the required level of education as mandated by the applicable state licensing board and training for each requested specialty. This includes graduation from medical or professional school, residency (if applicable), or board certification. MH/SUD: With the exception of PAs, BCaBAs and substance use professionals, each non-physician provider will have obtained a minimum of a master's degree in mental health or substance use field. PAs shall have completed training at a program accredited by the Commission on Accreditation of Allied health Education Programs and have been certified by the National Commission of Certification of Physician Assistants. BCBAAs must have a bachelor's degree and have completed rigorous training in applied behavior analysis. Substance use providers can have a variety of educational backgrounds.	5. Verification of highest level of education and training, if not board certified.
6. Malpractice History	6. Review of applicant's history (minimum 5 years) of malpractice claims, if any, to determine whether acceptable risk exposure exists. The review is based on information provided and attested to by the applicant, information available from the appropriate state agencies, and the National Practitioner Data Bank, as applicable.	6. Practitioner: Verification based on information provided and attested to by the applicant, information available from the appropriate state agencies, and the National Practitioner Data Bank.
7. Work History	7. Five years of work history should be included with the application or on the curriculum vitae	7. Five years of work history should be

	(CV). Any gaps in work history greater than 6 months must be explained either orally or in writing. All gaps in work history greater than one year must be clarified in writing.	included with the application or on the curriculum vitae (CV).
8. Malpractice Insurance	8. \$1M/occurrence and \$3M aggregate for Acute Care Facility, Ambulatory Detoxification and Residential Facilities, \$1M/occurrence and \$1M aggregate for Facility Based Programming (i.e. Intensive Outpatient, Partial Hospitalization) unless a lower amount is mandated by the state where the provider provides care to members.	8. Cigna Policy: Current professional liability insurance with required minimum coverage (determined by industry standards and applicable state mandated limits
9. Ongoing monitoring to ensure the providers continue to meet credentialing standards.	9. Ongoing maintenance (recredential) every three years - periodic review and recredentialing activities conducted to confirm continued compliance with credentialing requirements and participation standards.	9. State licensing boards, OIG, CAQH, NCQA standards, State, or federal requirements.
10. Suspension, Termination and Non-Renewal	10. Suspension, Termination and Non-Renewal means the removal, restriction, expiration, or discontinuation of network participation when a provider or facility no longer satisfies credentialing, participation, licensure, quality, regulatory, or contractual requirements. Rules of Participation Standards: • Participation – Standards ○ Must have a current, unrestricted license for the scope of practice; no unacceptable history of suspension, surrender, or revocation. ○ Must have required formal training/residency in specialty (per ABMS/AOA) or, for general practitioners, a rotating internship or 5 years general practice experience. ○ Must have unrestricted admitting or surgical privileges in specialty at a participating hospital. ○ Must demonstrate ability to provide continuity of care for ambulatory and hospitalized patients. ○ Must provide proof of adequate liability coverage. ○ Must not misrepresent credentials or information provided to Cigna. ○ Must not be under sanction, excluded, debarred, terminated, or precluded by Medicare, Medicaid, or other federal programs. ○ Inclusion in the network must be necessary to assure adequate access	10. Failure to meet recredentialing standards, License sanction, malpractice claim, quality of care issues (identified by customer complaints, review of provider data and chart review).

	to basic health care services, as determined by Cigna. ○ Must meet Cigna’s standards for practicing the full scope of designated specialty. ● Quality Standards ○ Must have an acceptable history regarding investigations and disciplinary actions by hospitals, institutions, licensing/regulatory/professional organizations (as determined by Cigna’s Credentialing Committee). ○ Must have an acceptable history of malpractice/liability claims (as determined by Cigna standards or Credentialing Committee). ○ Must have an acceptable criminal and civil liability history (as determined by Cigna standards or Credentialing Committee). ○ Must not use chemical substances that impair or limit ability to practice medicine safely. ○ Must not have an inability, for any reason, to perform essential functions of their practice with reasonable accommodation. ○ Must accept and comply with Cigna’s requirements for office setup, practices, medical records, and patient accessibility. ○ Quality of care/service results or complaints must indicate acceptable quality of medical care, service, business/office practices, and provider behavior (as determined by Cigna). ○ Must comply and cooperate with Cigna’s Quality Management program.	
--	--	--

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 maintains an open network participation model and offers participation opportunities to providers and facilities that satisfy applicable credentialing, contracting, licensure, accreditation, and participation requirements.

No credentialing factor is assigned a weighted value. Providers and facilities must satisfy all applicable

credentialing requirements. Failure to satisfy a required factor may result in denial, termination, suspension, non-renewal, or escalation for committee review. Accordingly, the factors operate as minimum participation standards rather than weighted criteria.

The credentialing factors operate as interrelated participation requirements. Federal and state law establish the baseline requirements, while application, licensure, education, training, work history, malpractice history, insurance, accreditation, and other credentialing requirements are evaluated collectively to determine whether a provider or facility satisfies participation standards. Ongoing monitoring and recredentialing serve as continuing mechanisms to verify compliance with those same requirements throughout network participation.

Factors are applied in the following order:

1. Submission of credentialing application and attestation and execution of a participation agreement.
2. Verification of applicable licensure, education, training, work history, malpractice history, malpractice insurance, accreditation, and other credentialing requirements.
3. Medical Director review of completed credentialing file.
4. Credentialing Committee review where required.
5. Approval, denial, termination, suspension, or non-renewal determination, as applicable.
6. Ongoing monitoring and periodic recredentialing.

Credentialing Application Process:

The credentialing process is triggered when a provider/facility signs an agreement/contract to participate in the Cigna network, submits a complete credentialing application (CAQH or other appropriate application) to Cigna's Onboarding team. CAQH is a nonprofit alliance of America's leading health plans. CAQH Provider Data Portal allows practitioners to submit one application to meet the needs of all the health plans and hospitals participating in the CAQH effort. To maintain the accuracy of the data, CAQH sends practitioners a reminder every 90 days to re-attest to their information. Health plans and hospitals designated by practitioners obtain application information directly from the CAQH database. This eliminates the need for multiple organizations to contact the practitioner for the same information. CAQH gathers and stores detailed data for more than 1 million practitioners nationwide. Cigna uses CAQH ProView for credentialing all practitioner types and CAQH Proview is compliant with state-required credentialing applications.

The Onboarding team reviews the practitioners'/facilities' information to ensure it is complete, then forwards the information to the Credentialing team for processing and approval/denial based on established criteria. The average timeline from receipt of provider's information to approval/denial is 45 days.

Cigna's M/S and MH/SUD Credentialing/Re-Credentialing policies are based on NCQA, state and federal guidelines. There are no differences in the credentialing requirements and/or admissions standards for physician providers that are employed by clinics or hospitals as contrasted with *"independently practicing practitioners"*. Unless the physician is hospital-based/hospitalist – neither of which requires credentialing per NCQA standards (attached).

There are no differences in credentialing and/or admission to the network standards for non-physician providers that are independent practitioners, or employees of clinics, hospitals or other provider types, unless the physician is hospital-based-which does not require credentialing. Providers can be "independently practicing" and still "employed/affiliated with a hospital/clinic". Below is the language from

the NCQA credentialing standards for providers who do not require credentialing:

Practitioners who do not need to be credentialed include:

- Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.
- Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.
- Covering practitioners (e.g., locum tenens).
- Locum tenens who do not have an independent relationship with the organization are outside NCQA's scope of credentialing.
- Practitioners who do not provide care for members (e.g., board-certified consultants who provide a professional opinion to the treating practitioner).
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

The factors identified in Step 2 are applied sequentially during the credentialing process. Federal and state law establish the baseline participation requirements. Providers and facilities must submit a complete application and execute a participation agreement. Cigna then verifies licensure, education, training, work history, malpractice history, malpractice insurance coverage, accreditation (where applicable), and other credentialing criteria through primary-source verification and review of authoritative data sources. Providers and facilities that satisfy all required criteria proceed through credentialing review and approval. Ongoing monitoring and recredentialing processes are subsequently used to confirm continuing compliance with credentialing standards and participation requirements. Suspension, termination, or non-renewal standards are applied when a provider or facility no longer satisfies credentialing, legal, regulatory, quality, or participation requirements. These factors are applied in the same manner to MH/SUD and M/S providers and facilities, except where differences are required by applicable licensure, accreditation, certification, scope-of-practice, or legal requirements.

Credentialing Decision Making Process

Cigna credentialing staff collect and review information to assess whether a provider satisfies the minimum credentialing requirements applicable to the provider's practice location and specialty. For initial credentialing and recredentialing applications that satisfy all credentialing criteria, Credentialing staff forward the completed credentialing file to the Medical Director for approval. If an application does not satisfy all credentialing criteria, the Medical Director forwards the credentialing file and the supporting documentation to the Credentialing Committee for final review and determination. Cigna maintains two credentialing committees for this purpose: the National Credentialing Committee ("NCC") – Medical and the Behavioral Health Credentialing Committee ("BHCC") (NCC and BHCC collectively "Credentialing Committee").

Although credentialing standards are substantively aligned, separate committees are used because the practitioners and facilities reviewed by each committee involve different professional disciplines and licensure structures. The separate committee structures permit review by individuals possessing expertise relevant to the provider types under review and are not intended to establish different credentialing standards for MH/SUD and M/S providers.

a. National Credentialing Committee (Medical Surgical)

The M/S credentialing framework operates under formal corporate credentialing policies applicable to Cigna's credentialing staff and the NCC. As described above, the Credentialing staff conduct primary source verification, prepare credentialing files, and categorize applications based on NCQA-established criteria before routing them to the Medical Director or the NCC for review. The credentialing process incorporates oversight from the Medical Director/Market Medical Executive (MME) and the NCC which serves as a peer review body responsible for final decision-making for certain cases. The NCC is composed of participating network physicians (e.g., PCPs and SCPs) who apply clinical expertise and community standards in an objective, nondiscriminatory manner. The authority in the NCC is delegated to the Medical Director who reviews and approves practitioners who meet all established credentialing criteria and serves as Chair (or designee) of the NCC. The NCC makes final determinations on practitioners who do not meet criteria or require further review and acts as the formal peer review decision-making body.

The NCC employs a two-tiered decision model which includes an initial review. Applications that meet all credentialing requirements are reviewed and approved at this level, and these are typically referred to as "clean files" (no issues identified). The Second step (as needed) is Committee review. Applications that do not meet criteria, involve exceptions, or present risk factors are escalated. The NCC reviews, discusses, and renders a final decision (approval, denial, or other action). NCC confirms decisions and documents outcomes in meeting minutes. Credentialing decisions must reflect thorough review and objective clinical judgment. This reflects a consistent escalation-based model, where only non-routine or higher-risk cases require full committee deliberation. In summary, the M/S credentialing process is a structured, policy-driven system with clearly defined authority: routine approvals are handled by the Medical Director/MME; NCC provides oversight and final decision-making for complex or exception cases. The process ensures consistency, clinical rigor, and regulatory compliance through a two-tiered review and documented governance model.

b. Behavioral Health Credentialing Committee

The BHCC is a specialized, clinically driven decision-making body with defined authority over behavioral health provider participation, operating through a two-tiered review process and embedded within a broader behavioral health oversight framework, but organizationally separate from the M/S committee. The BHCC operates as a distinct behavioral health governance body with its own defined structure, authority, and processes, separate from the NCCC, while maintaining and aligned overall framework. The is a formally organized, behavioral health-specific committee with defined leadership and multidisciplinary clinical representation. It is led by two co-chairs (both Medical Directors within Behavioral Health) and a vice chair, reflecting a dual clinical and operational leadership model. Membership includes staff clinicians and contracted practitioners across behavioral health disciplines, such as psychiatry, psychology, nursing, and master's-level clinicians, ensuring subject-matter expertise in mental health and substance use disorder care. A quorum requires a simple majority of members, including at least one psychiatrist, reinforcing the clinical authority embedded in decision-making.

Like the NCC, authority within the BHCC framework is tiered and clearly delineated: Medical Director Level: The Medical Director (under the National Medical Director's clinical oversight) has authority to approve practitioners who meet all credentialing standards and established exceptions. BHCC Level: the BHCC exercises ultimate decision-making authority for practitioners who do not meet standard criteria, as well as for exceptions, high-risk cases, and terminations. It also oversees delegated credentialing activities and implementation of credentialing policy. The national Medical Director maintains clinical oversight, while the Director of Credentialing Operations provides operational oversight. BHCC activities are reported quarterly to the Behavioral Quality Committee, creating an additional layer of enterprise governance. This establishes the MH/SUD committee as the final decision-making authority for non-routine or exception-based credentialing determinations, distinct from but parallel to the NCC structure. Also, like the NCC the BHCC credentialing process follows a structured, two-level review pathway: Primary Review and Approval where applications that meet all credentialing standards are reviewed and approved

by the Medical Director. These approvals can proceed to contracting prior to committee review but are subsequently reported to the Committee for affirmation. The second step is escalation to BHCC for applications that do not meet standards, involve exceptions, or present risk considerations are escalated to the BHCC for full review and determination (approval or denial). The BHCC also reviews contract terminations and high-profile or complex cases, typically after initial national Medical Director review.

The BHCC meets monthly to review cases, deliberate, and vote. Members are responsible for pre-reviewing materials, presenting cases, and ensuring follow-up on incomplete or pended applications. Providers and facilities are recredentialed at least every three years. Regional Medical Executives perform preliminary reviews and refer issues to the Committee, which makes final determinations on continued participation, termination, or other actions. Ongoing monitoring includes complaint review and compliance with credentialing standards.

Each committee makes credentialing decisions pursuant to the applicable policies; MH/SUD policies HealthCare Facilities and Programs Credentialing and Recredentialing (HM-NET-009) and Practitioner Credentialing and Recredentialing (HM-NET-016) and M/S policy Information for Review by Medical Director and Credentialing Committee (CR-14), which are substantively aligned. See Section II(C)(2), below, for the composition of the Credentialing Committee. Both the M/S National Credentialing Committee and the Behavioral Health Credentialing Committee have discretion to request missing information or to deny an application as incomplete and subsequently request further information if necessary to decide. Upon receipt of a complete application, the respective Credentialing Committee will render a decision in accordance with the timeframes as specified by the applicable MH/SUD policies HealthCare Facilities and Programs Credentialing and Recredentialing (HM-NET-009) and Practitioner Credentialing and Recredentialing (HM-NET-016) and M/S policies Facility Credentialing/Re-credentialing (CR-04) and Practitioner Credentialing / Re-credentialing (CR-01). The timeframes for credentialing decisions are identical for M/S and MH/SUD providers. Credentialing decisions are then communicated to the applicant. If an application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. Cigna permits appeals from adverse credentialing or sanctions monitoring decisions as required by the NCQA, the Center for Medicare and Medicaid Services (CMS), and other applicable state and federal regulatory authorities. Any appeal process related to the non-acceptance, termination, suspension, or non-renewal of providers/facilities will be communicated to the affected provider/facility with the notice of non-acceptance, termination, suspension, or non-renewal.

Credentialing exceptions can be considered only where otherwise permitted by applicable policy and where core licensure, legal, accreditation, and quality requirements continue to be satisfied.

As explained above, the Credentialing Committee is responsible for making credentialing decisions about inclusion of providers and facilities in the network. The following members comprise the Credentialing Committee. The Credentialing Committee includes members with MH/SUD training and qualifications.

Behavioral Health Credentialing Committee Roster 2025 (MH/SUD)

Role	Degree	Specialty
Chair	MD	Psychiatry
Chair	MD	Psychiatry
Member	MD	Family Medicine
Member	LCPC	Professional Counselor
Member	LPC	Professional Counselor
Member	LPC	Case Manager
Member	LPC	Professional Counselor
Member	MD	Psychiatry
Member	ARNP	Nurse Practitioner

Member	LPC	Social Worker
Member	LPC	Professional Counselor
Member	LPC	Psychology

National Credentialing Committee Roster 2025 (M/S)

Role	Degree	Specialty
Chair	MD	Internal Medicine
Chair	MD	Family Practice, Obstetrics, Internal Medicine
Chair	MD	Family Practice
Chair	MD	Family Practice
Market Co-Chair	MD	Pediatric
Market Co-Chair	MD	Internal Medicine
Member	MD	Pediatric
Member	MD	Family Practice
Member	MD	Family Practice
Member	MD	Surgeon
Member	MD	Family Practice
Member	MD	Internal Medicine
Member	MD	Obstetrics and Gynecology
Member	MD	Endocrinology
Member	NP	Pediatric Nurse Practitioner
Member	MD	Family Practice

The NCC and BHCC differ in membership because they review different provider populations. The NCC relies primarily on physicians with M/S expertise. The BHCC includes psychiatry and other licensed behavioral-health disciplines so that reviewers possess expertise relevant to MH/SUD practitioners and facilities. In both systems, routine files satisfying all criteria may be approved by an authorized Medical Director; nonroutine files are referred to the applicable committee; committee decisions are documented; and adverse decisions are communicated with applicable review rights.

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 maintains an open network participation model and offers participation opportunities to providers and facilities that satisfy applicable credentialing, contracting, licensure, accreditation, and participation requirements. When met, the Cigna Provider Reference Guide (M/S) and the Evernorth Administrative Guidelines (MH/SUD) outline updating demographic information, verifying benefits and eligibility, credentialing and recredentialing processes, submitting claims, etc.

Evernorth maintains NCQA Managed Behavioral Healthcare Organization (“MBHO”) Accreditation. MBHO Accreditation includes standards for Behavioral Health Care Credentialing/Re-credentialing, Provider Contracting and Satisfaction.

CHLIC also maintains NCQA accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members’ Rights & Responsibilities.

While NCQA accreditation provides external validation that credentialing programs meet accreditation standards, the comparability analysis below independently assesses whether the factors, evidentiary standards, processes, and governance requirements applicable to MH/SUD providers are comparable to and no more stringent than those applicable to M/S providers.

Except where differences are required by state licensure requirements, accreditation requirements, scope-of-practice laws, provider type, or applicable legal requirements, the credentialing factors, evidentiary standards, review processes, and participation requirements are applied in the same manner to MH/SUD and M/S providers and facilities.

The credentialing processes are functionally comparable, but they are not textually identical. Differences arise from profession-specific licensure, scope-of-practice rules, accreditation availability, facility type, and the clinical expertise required to review the applicant. Cigna treats those differences as neutral provider-type distinctions rather than MH/SUD-specific restrictions. The analysis below identifies each difference and evaluates whether the MH/SUD standard is more restrictive than the corresponding M/S standard.

Credentialing Factor	M/S	MH/SUD	Comparable?
Application	Required	Required	Yes
Agreement	Required	Required	Yes
Licensure	Required	Required	Yes
Education	Required	Required	Yes
Work History	Required	Required	Yes
Accreditation (where applicable)	Required	Required	Yes
Malpractice History	Reviewed	Reviewed	Yes
Professional Liability Insurance	Required	Required	Yes
Recredentialing	Every 3 years	Every 3 years	Yes
Committee Review	Medical Director + NCC	Medical Director + BHCC	Yes
Appeals	Available	Available	Yes

Recredentialing Cycle	Required	Required	Yes
Suspension/Termination	Applicable	Applicable	Yes

Documentation supporting application of these credentialing factors is maintained through credentialing files, credentialing committee records, provider applications, primary source verification materials, recredentialing records, and delegated credentialing oversight documentation.

Credentialing standards for provider admission to participate in a network are designed and maintained by the Quality Programs & Accreditation (“QP&A”) team, which serves as an Accreditation Center of Excellence working with independent agents, such as the National Committee for Quality Assurance (“NCQA”), Utilization Review Accreditation Commission (“URAC”), the Centers for Medicare and Medicaid Services (“CMS”) and the National Alliance of HealthCare Purchaser Coalitions (“NAHPC”). Accreditation, certification and recognition by these organizations provides Cigna with the external validation needed to evidence quality and meet nationally recognized industry standards.

Cigna maintains a suite of Credentialing Policy and Procedures applicable to M/S and MH/SUD, which documents its policy for credentialing and recredentialing of providers (professional and facilities). 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. QP&A has the authority to revise and approve the Credentialing policy and procedure. Cigna's credentialing policies for both Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) providers demonstrate a comparable framework for credentialing, oversight, and decision-making.

The M/S credentialing process is governed by the CR 01 Practitioner Credentialing Recredentialing Policy and CR 04 Facility Credentialing Recredentialing Policy, while the MH/SUD process is governed by HM NET 016 Practitioner Credentialing and Recredentialing Policy and HM NET 009 HealthCare Facilities and Programs Credentialing and Recredentialing Policy. Although the policies are maintained separately to address the unique clinical characteristics of each provider type, both establish formal credentialing programs that ensure providers meet established participation standards.

For both M/S and MH/SUD, credentialing activities are overseen by formal Credentialing Committees with defined leadership and governance structures. In the M/S process, a Credentialing Committee chaired by the Market Medical Executive (MME) or designee confirms practitioner approvals and makes final credentialing decisions, while the MH/SUD process utilizes a dedicated Credentialing Committee led by co-chairmen and a vice chairman and supported by Medical Directors and credentialing staff. In both cases, the committees are responsible for reviewing practitioner participation and making final credentialing determinations.

Committee membership in both programs includes licensed clinicians who apply professional expertise and clinical judgment during credentialing reviews. The M/S committee includes participating primary care physicians (PCPs), specialty care physicians (SCPs), and physician members who evaluate providers using objective and nondiscriminatory standards. Similarly, the MH/SUD committee includes Medical Directors, staff clinicians, and contracted practitioners with expertise in mental health and substance use disorder treatment, including psychiatrists and representatives from diverse behavioral health disciplines. While the specific clinical disciplines represented differ based on the services provided, both committees ensure that credentialing decisions are informed by appropriate clinical expertise.

The credentialing decision-making process is also comparable across both provider groups. For M/S

providers, practitioners who meet established credentialing criteria are reviewed and approved by the MME, while practitioners who do not fully meet standards are referred to the Credentialing Committee for final review and determination. Under the MH/SUD process, practitioners meeting established standards are approved by a Medical Director, while those not meeting requirements are escalated to the Credentialing Committee for approval or disapproval. Accordingly, both programs utilize a two-tier review process consisting of an initial Medical Director/MME review followed, when necessary, by committee-level review for exceptions, high-risk cases, or providers requiring additional consideration.

In addition, both programs assign comparable oversight responsibilities to Credentialing Committees and medical leadership. Each committee reviews credentialing and recredentialing files, addresses exceptions and concerns, documents decisions, and oversees ongoing compliance with credentialing requirements. Regional Medical Executives participate in recredentialing reviews and refer cases requiring additional scrutiny to the full committee in both the M/S and MH/SUD processes. The MH/SUD committee additionally oversees delegated credentialing activities and reviews high-risk cases and terminations, reflecting the specialized nature of behavioral health operations rather than a substantive difference in review rigor.

The recredentialing requirements for facilities and programs are likewise aligned. Both M/S and MH/SUD facilities undergo recredentialing every three years and must demonstrate continued compliance with applicable credentialing standards. The M/S process includes verification of licensure, accreditation or Medicare certification, and exclusion screening, while the MH/SUD process evaluates ongoing compliance with participation standards and considers participant complaints and quality information as part of continued monitoring. In both cases, organizations are subject to periodic review and ongoing oversight to ensure continued qualification for network participation.

Overall, the MH/SUD and M/S credentialing programs demonstrate comparable committee structures, governance processes, clinical oversight, credentialing review pathways, and recredentialing requirements. Both rely on licensed clinical professionals, employ a consistent two-level review process involving Medical Director/MME review and committee oversight, and maintain aligned approaches for credentialing, exception handling, and recredentialing. Any differences are limited to the inclusion of specialized clinical expertise and governance roles necessary to address the unique characteristics of behavioral health services, rather than differences in the substance or rigor of the credentialing process.

Credentialing Physicians: Credentialing criteria is determined by the National Committee for Quality Assurance (NCQA), state, and federal standards. Requirements for physician credentialing include:

- A completed signed and dated application via Counsel for Affordable Quality Healthcare (CAQH) or state approved application
- A completed, signed, and dated authorization and release form (if not included in the application form)
- Documented work history for the past 5 years (initial cred only)
- Current unrestricted license to practice
- Current unrestricted DEA/CDS certificate (if applicable)
- Board Certification (if board certified)
- Verifiable education/training (if not board certified)
- Unrestricted admitting privileges to at least one Cigna participating hospital (if provider admits patients). Exceptions can be granted (i.e., an applicant's specialty does not typically require admitting privileges, satisfactory alternative mechanism has been established as determined by Cigna Healthcare and industry standards)

- Current professional liability insurance with required minimum coverage (determined by industry standards and applicable state mandated limits)
- Acceptable history of professional liability claim experience from the National Practitioner Data Bank (NPDB)
- Acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization.

Cigna's Credentialing Committee will evaluate exceptions to the credentialing criteria on a case-by-case basis. Typical exceptions include hospital privileges for providers that do not typically admit and waiving DEA for providers who do not prescribe. Cigna also confirms that the provider continues to be in good standing with state and federal regulatory bodies at the time of initial credentialing, recredentialing (every 36 months), and in between credentialing cycles.

Credentialing of Non-Physicians: Non-physician practitioners include physician assistants, naturopaths, nurses, acupuncturists, Psychologist, LCSW and midwives (subject to state laws). The credentialing criteria for non-physicians is also determined by NCQA, state, and federal standards. Cigna's Credentialing Committee evaluates exceptions to the credentialing criteria on a case-by-case basis. Exceptions include hospital privileges for providers that do not typically admit, and waiving DEA for providers who do not prescribe. Providers must be in good standing with state and federal regulatory bodies at the time of initial credentialing, recredentialing (every 36 months), and in between cycles.

Credentialing of Facilities: Hospitals and ancillary facilities must be credentialed for participation in a Cigna Healthcare network. Participating hospitals and ancillary facilities must maintain an ongoing quality improvement program that monitors and evaluates the quality and appropriateness of patient care, pursues improvement opportunities, and resolves problems. Accrediting organizations, such as the Joint Commission (JC), validate a quality improvement program. When accreditation, state Department of Health, or Medicare certification evidence is not available, Cigna Healthcare can perform a site visit and review of the hospital or ancillary facility quality improvement program.

In accordance with the Cigna's national credentialing requirements, hospitals and ancillary facilities must apply for participation by completing a standard application form and satisfactorily meeting the established criteria. The Cigna Healthcare credentialing and recredentialing policies and procedures are reviewed at least annually and revised as necessary, including revisions to reflect state and local quality assurance standards for facility types, including but not limited to, hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, residential medical/behavioral facilities, ambulatory services, inpatient, etc. The plan standards for facilities include:

- Copy of unrestricted state license, permit, or state operating certificate, as applicable
- Copy of current accreditation letter or certificate.
- Proof of current professional and general liability insurance coverage that meets Cigna Healthcare minimum guidelines
- National Provider Identifier
- Any explanation requested on application, including a list of malpractice settlements and judgments
- If not accredited, a copy of the most recent Centers for Medicare & Medicaid Services (CMS) evaluation report
- Onsite assessment, if not accredited or Medicare and Medicaid certified
- Copy of the quality management plan, if not accredited or Medicare and Medicaid certified
- List of available services that can be rendered by facility
- Absence of current sanctions from Medicaid or Medicare

If an ancillary facility is not subject to state licensure requirements, the Cigna Credentialing Committee will determine if the facility meets remaining credentialing standards for participation in the Cigna network.

Credentialing/Re-credentialing

Cigna's methodology for credentialing for M/S and MH/SUD physician providers are the same. Cigna credentialing standards for licensed physicians follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. Cigna does not maintain separate standards for MH/SUD providers. Moreover, the standard credentialing process is used for both licensed physician providers and licensed non-physician providers, whether they are M/S or MH/SUD providers. Re-credentialing is required every 36 months from the month of the initial credentialing or prior re-credentialing decision, unless mandated differently by law for all providers, and except for work history and education and training verification, requires providers to meet the same criteria as the initial credentialing process, unless a new specialty is being requested.

The credentialing application process is consistent between physicians and facilities providing M/S and MH/SUD services and the required licensing, experience, CAQH application and verifications are indistinguishable. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD physician providers, and, as relevant for certain MH/SUD services or specialties, Cigna does not require that MH/SUD practitioners or facilities be licensed or accredited if such a license or accreditation would not be required by state law. Consistency in credentialing standards and process evidence compliance with the NQTL in-writing requirement.

Exceptions to Credentialing Requirements

Cigna's credentialing policies for both Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) providers incorporate defined processes for granting exceptions to standard credentialing criteria. These processes are embedded within practitioner and facility credentialing frameworks, including CR-01, CR-04, and CR-19 for M/S providers and HM-NET-016 and HM-NET-009 for MH/SUD providers, and are designed to allow for flexibility in applying credentialing standards while maintaining appropriate oversight and regulatory compliance.

For M/S providers, the policies establish that exceptions to credentialing criteria can be granted based on defined circumstances and documented justification. For example, CR-01 permits exceptions related to hospital admitting privileges for certain specialties or practice types where such privileges are not typically required and allows alternative arrangements such as coverage by hospitalists or affiliated providers. Exceptions can also be granted for practitioners without board certification when other factors—such as unique capabilities or ability to meet member needs—support participation. In addition, CR-19 provides a formalized process for requesting and approving exceptions, including those related to insurance coverage requirements, with involvement from senior management and, as applicable, corporate counsel.

For MH/SUD providers, HM-NET-016 similarly establishes defined exception standards and identifies categories of exceptions that can be accepted without requiring full committee review, such as specific malpractice history scenarios or non-clinical administrative matters that do not raise concerns regarding provider suitability. The policy further provides that practitioners who do not meet standard credentialing criteria or applicable exceptions are referred to the Credentialing Committee for review and determination. In addition, both HM-NET-016 and HM-NET-009 rely on the Credentialing Committee (or comparable governance structure) to evaluate and approve providers who fall outside standard criteria, thereby ensuring oversight of exceptions within the credentialing process.

Across both M/S and MH/SUD frameworks, exceptions are reviewed within established credentialing governance structures, including Medical Director review and Credentialing Committee oversight, and are

applied on a case-by-case basis. The policies indicate that exceptions can be considered where appropriate based on provider characteristics, documented mitigating factors, or network considerations, while still requiring that providers meet core regulatory and quality standards (e.g., licensure, absence of disqualifying sanctions).

Importantly, the structure and application of credentialing exceptions are comparable across M/S and MH/SUD policies. Both sets of policies:

- Allow for exceptions to standard credentialing criteria under defined circumstances
- Require documentation and justification supporting the exception
- Utilize Credentialing Committee and/or Medical Director oversight for review and approval
- Maintain core eligibility and regulatory requirements that must be met regardless of exceptions

As a result, the factors, processes, and evidentiary standards governing credentialing exceptions are applied consistently across M/S and MH/SUD provider types. Accordingly, the credentialing exception framework, as written, is comparable and is not applied more stringently to MH/SUD providers than to M/S providers.

Removal of a Provider from the Network

Cigna's policies governing termination of provider and facility participation in the network are structured through parallel frameworks for Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) providers. For M/S providers, termination processes are established in CR-12 (physicians and health care professionals) and CR-21 (institutional providers), while for MH/SUD providers, comparable termination provisions are incorporated within HM-NET-023 (suspension, termination, or non-renewal of practitioner/provider contract privileges) and HM-NET-024 (termination of a practitioner's initial application prior to committee review).

For M/S providers, CR-12 and CR-21 establish that termination can occur based on defined factors, including failure to meet credentialing or participation standards, quality or performance concerns, or other permissible bases consistent with applicable law and contractual requirements. These policies require that providers receive written notice of termination, including the specific reasons supporting the decision, and provide an opportunity for appeal or review, as required by regulatory and accreditation standards.

For MH/SUD providers, HM-NET-023 similarly governs suspension, termination, or non-renewal of participation, while HM-NET-024 addresses the termination of applications prior to final credentialing committee review. These policies operate within the broader behavioral health credentialing framework and reflect comparable decision points, including termination based on failure to meet credentialing requirements or other participation standards. As with M/S policies, termination decisions are communicated to the provider, and processes for review and appeal are incorporated through the credentialing and participation framework.

Across both M/S and MH/SUD policies, termination determinations are administered through established credentialing governance structures, including Medical Director and Credentialing Committee oversight. Termination decisions are tied to the evaluation of provider qualifications, performance, and compliance with participation requirements, and are subject to documentation, notification, and appeal requirements consistent with NCQA, CMS, and applicable state and federal laws.

Importantly, the structure and application of termination policies are comparable across M/S and MH/SUD provider types. Both frameworks:

- Define termination triggers tied to credentialing and participation standards
- Require written notice with rationale for termination decisions
- Provide opportunities for appeal or review, where applicable
- Utilize committee-based governance and oversight for termination determinations
- Incorporate regulatory and accreditation requirements into termination processes

Accordingly, the factors, processes, and evidentiary standards governing provider and facility termination, as written, are applied consistently across M/S and MH/SUD provider types. The termination framework is therefore comparable and is not more stringently applied to MH/SUD providers than to M/S providers.

Appeal of Provider Termination based on Credentialing

Cigna's provider appeals process is embedded within its enterprise credentialing and participation policies governing both Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) providers, including CR-series policies for M/S providers and HM-NET policies for MH/SUD providers. These policies establish that adverse participation determinations—such as non-acceptance, termination, suspension, or non-renewal—trigger a standardized notification and appeals framework.

Under this framework, providers and facilities are issued written notice of the adverse determination, which includes the specific reason(s) supporting the decision. The notification also communicates the availability of an appeal and provides instructions for exercising that right. Providers are afforded the opportunity to appeal adverse credentialing or sanctions-related decisions in accordance with National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and applicable state and federal requirements.

As written, the appeal process is administered through established credentialing governance structures, including committee-based review, to ensure that determinations are evaluated consistently and in accordance with defined credentialing criteria. These policies promote transparency, due process, and accountability by requiring clear communication of decisions and providing a formal mechanism for reconsideration.

Importantly, the credentialing and appeals framework is structured comparably across M/S and MH/SUD provider types. Parallel policies governing practitioner and facility credentialing (e.g., CR-01 and CR-04 for M/S, and HM-NET-016 and HM-NET-009 for MH/SUD) establish consistent participation standards and processes, including those related to adverse determinations and appeals. As a result, the factors, processes, and evidentiary standards used to administer appeals are applied uniformly across M/S and MH/SUD providers, supporting that the appeals process, as written, is comparable and not more stringently applied to MH/SUD benefits than to M/S benefits.

Virginia Specific Credentialing Standards:

Virginia's provider-network requirements establish standards governing credentialing and recredentialing, adverse network-participation decisions, behavioral health appointment accessibility, and behavioral health network availability. These requirements are incorporated into the following M/S and MH/SUD policies.

Practitioner Credentialing and Recredentialing

For M/S practitioners, Virginia-specific requirements are contained in CR-01, Practitioner Credentialing and Recredentialing Policy. For MH/SUD practitioners, the corresponding requirements are contained in HM-NET-016, Practitioner Credentialing and Recredentialing Policy. These policies establish the same core Virginia requirements governing application processing, reimbursement during the credentialing period, provider continuity, transparency, and record retention.

Under CR-01 and HM-NET-016, online applicants receive confirmation through the credentialing system when an application is submitted and attested to, while paper applicants receive an acknowledgment by mail or email within 10 days. Effective January 1, 2024, an application is deemed complete within 30 days after receipt unless the carrier provides notice that the application is incomplete. A completed application must be approved or denied within 60 days.

When an applicant is ultimately credentialed and contracted, CR-01 and HM-NET-016 require claims for eligible covered services rendered while the completed application was pending to be adjudicated and paid no later than 40 days after credentialing and contracting. These reimbursement protections apply only when a contractual relationship exists with the applicant or the entity employing or engaging the applicant. Eligible services must be reimbursed at the applicable in-network rate the applicant would have received if credentialed when the services were rendered.

Before billing for pending-period services, the applicant must provide the prescribed Virginia credentialing notice to the member. Member cost sharing is limited to the applicable in-network amount. If the application is denied, the affiliated contracted entity generally may not collect cost sharing for services rendered during the pending period.

Both CR-01, Practitioner Credentialing and Recredentialing Policy, and HM-NET-016, Practitioner Credentialing and Recredentialing Policy, require continued participation when a credentialed provider changes employment or practice location, remains in the same specialty, and provides the required information within 60 calendar days. Both policies also require that providers be given an opportunity to provide feedback regarding credentialing and recredentialing, timely access to information used to alter participation conditions, and access to the applicable application and credentialing policy upon written request. Credentialing records must be retained for at least seven years, and recredentialing must consider member complaints, quality reviews, utilization-management reviews, and satisfaction-survey information, as applicable.

The M/S policy, CR-01, additionally requires qualified athletic trainers to be credentialed and prohibits denial of reimbursement solely because a covered service was performed by a licensed athletic trainer. The MH/SUD policy, HM-NET-016, expressly recognizes Virginia-mandated credentialing eligibility for additional behavioral health practitioner types, including licensed acupuncturists, certified alcoholism counselors, certified drug counselors, certified substance abuse counselors, certified substance abuse counseling assistants, professional counselors, and clinical nurse specialists rendering mental health services, subject to applicable independent-practice licensure requirements. The any-willing-provider attachment to HM-NET-016 also identifies Virginia provider categories that include hospitals, physicians, chiropractors, optometrists, opticians, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, clinical nurse specialists rendering mental health services, audiologists, speech pathologists, certified nurse midwives, marriage and family therapists, and licensed acupuncturists.

These differences reflect Virginia-recognized provider categories and lawful scopes of practice rather than more restrictive credentialing standards for MH/SUD providers.

Termination, Denial, Suspension, and Nonrenewal

For M/S providers, Virginia-specific adverse participation requirements are set forth in CR-12, Terminations, Denials, and Appeals Policy for Participating Physicians, Physician Groups, and Other Health Care Professionals. For MH/SUD providers, the corresponding provisions are contained in HM-NET-023, Suspension, Termination, or Non-Renewal of Practitioner/Provider Contract Privileges Policy.

The Virginia addenda to CR-12 and HM-NET-023 are substantively aligned. Under both policies, a provider's application for network participation may not be denied, and a provider's network participation may not be terminated, based on gender, race, age, sexual orientation, gender identity, religion, or national origin. Neither policy establishes an additional Virginia-specific notice, appeal, or termination timeframe beyond the generally applicable policy requirements and governing state law.

Comparability and Stringency Conclusion

The Virginia-specific provisions in CR-01, Practitioner Credentialing and Recredentialing Policy, and HM-NET-016, Practitioner Credentialing and Recredentialing Policy, apply the same application-processing deadlines, reimbursement protections, continuity requirements, transparency obligations, record-retention requirements, and recredentialing review standards to M/S and MH/SUD providers.

Similarly, the nondiscrimination provisions in CR-12, Terminations, Denials, and Appeals Policy for Participating Physicians, Physician Groups, and Other Health Care Professionals, and HM-NET-023, Suspension, Termination, or Non-Renewal of Practitioner/Provider Contract Privileges Policy, are substantively identical.

Accordingly, the processes, strategies, evidentiary standards, and other factors reflected in the Virginia-specific policies are comparable for MH/SUD and M/S benefits and are not applied more stringently to MH/SUD benefits.

Delegated Credentialing:

The M/S Delegated Credentialing and Recredentialing Policy (CR-03) and the MH/SUD policies, Delegation of Credentialing to Practitioner/Facility/PHO (HM-NET-007) and Delegation of Credentialing to a Credentials Verification Organization (HM-NET-006), each govern the delegation of credentialing activities to outside entities.

The M/S Delegated Credentialing and Recredentialing Policy (CR-03) applies to practitioner groups and facilities and identifies hospitals, physician-hospital organizations (PHOs), independent practice associations, medical groups, behavioral health care networks, chiropractic and podiatric networks, CVOs, and organizational provider networks as potential delegates. The MH/SUD Delegation of Credentialing to Practitioner/Facility/PHO policy (HM-NET-007) focuses on practitioner groups, facilities, PHOs, and the practitioners and facilities or programs within their delegated networks. While MH/SUD Delegation of Credentialing to a Credentials Verification Organization policy (HM-NET-006) applies only when primary-source verification for individual practitioners is delegated to an NCQA-certified CVO.

The MH/SUD Delegation of Credentialing to a Credentials Verification Organization (HM-NET-006), delegated activities include providing access to the designated application, receiving completed applications, verifying credentials through NCQA-acceptable primary sources, documenting completion within required timeframes, and submitting progress reports. Additionally, the MH/SUD Delegation of Credentialing to Practitioner/Facility/PHO (HM-NET-007), the delegate may collect credentialing and recredentialing

materials, perform primary-source verification or external-agency queries, operate a structured credentialing committee, make participation or continued-participation determinations, and maintain the supporting policies and procedures. The M/S Delegated Credentialing and Recredentialing Policy (CR-03) similarly permits delegation of some or all credentialing and recredentialing functions, including applications and reapplications, collection of NCQA data elements, complaint-related site visits, ongoing monitoring, and credentialing decisions.

Baseline Standards:

MH/SUD Delegation of Credentialing to a Credentials Verification Organization (HM-NET-006) requires the CVO to be NCQA-certified and to use primary sources acceptable to NCQA. Delegation of Credentialing to Practitioner/Facility/PHO (HM-NET-007) requires adherence to Behavioral Health participation requirements, NCQA Managed Behavioral Health Organization standards, applicable laws and regulations, and federal marketplace downstream-entity requirements. The M/S Delegated Credentialing and Recredentialing Policy (CR-03) requires compliance with Cigna credentialing standards, recognized accreditation requirements, applicable governmental mandates, and more stringent state requirements. Both HM-NET-007 and CR-03 expressly preserve the right to approve, deny, suspend, or terminate individual practitioners, facilities, or sites. HM-NET-006 likewise states that Behavioral Health remains fully accountable, although it does not describe retained decision rights in the same detail.

Written Agreement Requirement:

M/S Delegated Credentialing and Recredentialing Policy (CR-03) requires a mutually agreed document defining delegated activities, responsibilities, performance expectations, reporting, oversight, remedies, revocation grounds, and Cigna's retained authority. The MH/SUD Delegation of Credentialing to Practitioner/Facility/PHO policy (HM-NET-007) similarly requires a Delegation of Credentialing Agreement that describes each party's responsibilities, Behavioral Health oversight, and retained approval or denial rights. The MH/SUD Delegation of Credentialing to a Credentials Verification Organization policy (HM-NET-006) describes CVO selection, contracting, and implementation but does not enumerate the same detailed agreement provisions.

Oversight:

Oversight under Delegation of Credentialing to Practitioner/Facility/PHO (HM-NET-007) and the M/S Delegated Credentialing and Recredentialing Policy (CR-03) is materially similar. Both require pre-delegation evaluation, ongoing policy and file review, annual credentialing-information-integrity monitoring, periodic reporting, committee governance, corrective action, and potential termination or retraction of delegation. HM-NET-007 requires quarterly or semiannual reports and at least semiannual roster information; CR-03 requires at least semiannual reports or rosters. Both employ NCQA-based sampling. HM-NET-007 uses the 8/30 methodology or 5% or 50 files, whichever is less, with minimum credentialing and recredentialing samples when available and proportional representation of delegated disciplines. CR-03 applies 10-file credentialing and recredentialing samples for delegations of 200 or fewer practitioners, subject to review of the smaller available universe, and the 8/30 methodology for larger delegations; it also permits the 5% or 50-file approach for information-integrity monitoring.

Governance and Remediation:

MH/SUD Delegation of Credentialing to Practitioner/Facility/PHO (HM-NET-007) and the M/S Delegated Credentialing and Recredentialing Policy (CR-03) both use the Delegation Oversight Committee to consider audit results and continued delegation, and both permit specified high-scoring audits to be approved by the committee Chairperson. HM-NET-007 expressly gives a deficient delegate 90 days to submit a corrective action plan and evidence of correction and provides for effectiveness testing 3–6 months after the annual audit. CR-03 requires follow-up until deficiencies are corrected, permits corrected files to be returned to committee, monitors formal corrective action through the Delegation Oversight Committee, and authorizes retraction when serious deficiencies remain unresolved. By contrast, Delegation of Credentialing to a Credentials Verification Organization (HM-NET-006) does not state a detailed corrective-action timeline and

relies principally on NCQA certification, productivity and compliance reports, regular progress reports, and updated certification following surveys.

Finally, the M/S Delegated Credentialing and Recredentialing Policy (CR-03) contains controls not expressly addressed in the two MH/SUD policies, including annual evaluation of sub-delegation, PHI safeguards when protected health information is exchanged, and detailed de-delegation requirements. The MH/SUD Delegation of Credentialing to Practitioner/Facility/PHO policy (HM-NET-007) contains program-specific roster, database, referral, claim-payment, while Delegation of Credentialing to a Credentials Verification Organization (HM-NET-006) contains a detailed competitive CVO selection process. Overall, the policies demonstrate that delegation occurs for both MH/SUD and M/S credentialing and that the principal accountability and oversight controls are substantially comparable.

Step 5: Demonstration of comparability and stringency in operation.

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

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

benefits and medical/surgical benefits, including:

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

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

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #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:

In Operation:

Cigna evaluated credentialing activity occurring between January 1, 2025 and December 31, 2025. Data were obtained from credentialing systems used to administer initial credentialing and recredentialing processes. Metrics evaluated included credentialing requests, approvals, denials, denial appeals, appeal outcomes, and credentialing turnaround times. Turnaround time was defined as the number of calendar days between receipt of a complete credentialing application and final credentialing determination.

To evaluate whether the Network Admissions and Credentialing NQTL operates comparably and is applied no more stringently to MH/SUD providers than to M/S providers, Cigna reviewed operational credentialing data for providers subject to the credentialing process during the review period. The analysis included initial credentialing and recredentialing applications, credentialing outcomes, requests for additional information, referrals to credentialing committees, adverse determinations, and credentialing processing timeframes. Cigna evaluated these data to assess whether MH/SUD providers were subject to different operational requirements, heightened scrutiny, or more restrictive application of the credentialing process than similarly situated M/S providers.

The operational review confirmed that MH/SUD and M/S providers were subject to the same credentialing requirements, primary source verification procedures, review standards, approval criteria, escalation protocols, and decision-making authorities. Credentialing staff applied the same credentialing policies and procedures when reviewing provider applications regardless of whether the applicant sought participation as an MH/SUD provider or an M/S provider. Similarly, the Medical Director, Market Medical Executive ("MME"), National Credentialing Committee ("NCC"), and Behavioral Health Credentialing Committee ("BHCC"), as applicable, reviewed applications pursuant to established credentialing criteria and committee governance requirements rather than provider type. The operational review did not identify separate credentialing standards, additional approval requirements, or different escalation thresholds applicable to MH/SUD providers.

Cigna also evaluated credentialing outcomes to determine whether the operation of the credentialing process produced material differences in access to network participation for MH/SUD providers as compared to M/S providers. Specifically, Cigna reviewed: (i) approval rates; (ii) denial rates; (iii) requests for additional information; (iv) referrals to credentialing committees; (v) processing timeframes; and (vi) other relevant credentialing outcomes. The review did not identify evidence that MH/SUD providers were systematically subject to more restrictive review processes, increased credentialing burdens, or more stringent application of credentialing requirements than M/S providers.

To the extent differences in operational outcomes were observed, Cigna evaluated whether those differences were attributable to the operation of the credentialing NQTL or to provider-specific factors

unrelated to the credentialing standards themselves, including application completeness, responsiveness to requests for information, state licensure requirements, specialty-specific credentialing considerations, accreditation requirements, or other individualized circumstances. Based on this review, Cigna did not identify evidence that any observed differences were caused by the application of more restrictive credentialing standards to MH/SUD providers.

Cigna further assessed whether the operation of the credentialing process contributed to material differences in access to in-network MH/SUD benefits as compared to in-network M/S benefits. The review did not identify evidence that the credentialing process, as applied, created material differences in network participation opportunities for MH/SUD providers or otherwise restricted access to MH/SUD benefits through the operation of the credentialing NQTL.

Percentage of Applications Approved

Cigna evaluated credentialing outcomes for the period of January 1, 2025 – December 31, 2025, including credentialing approvals, denials, appeals, and credentialing turnaround times.

In Virginia, Cigna processed 1,140 MH/SUD credentialing requests and 1,951 M/S credentialing requests. Approval rates were comparable, with 99.74% of MH/SUD applications approved and 99.95% of M/S applications approved. Denials were rare for both provider groups, representing one M/S credentialing request and three MH/SUD credentialing requests. Average credentialing approval turnaround times were also comparable, averaging 11.14 days for MH/SUD providers and 12.96 days for M/S providers.

Cigna also reviewed credentialing outcomes across its commercial book of business. During the review period, Cigna processed 35,335 MH/SUD credentialing requests and 59,261 M/S credentialing requests. Approval rates remained substantially comparable, with 99.67% of MH/SUD applications approved and 99.87% of M/S applications approved. Denial rates were low for both provider groups, representing 0.33% of MH/SUD applications and 0.13% of M/S applications. Average credentialing approval turnaround times were 11.58 days for MH/SUD providers and 14.07 days for M/S providers.

Cigna reviewed these operational results to determine whether MH/SUD providers were subject to more restrictive credentialing standards, heightened scrutiny, or materially different credentialing outcomes than similarly situated M/S providers.

Although approval and denial rates differed slightly, the differences were small in absolute magnitude and did not indicate materially more stringent application of credentialing requirements to MH/SUD providers. To the extent differences in outcomes were observed, the differences were not of a magnitude that suggests the credentialing process operates more restrictively for MH/SUD providers.

Virginia credentialing metrics for 2025 include all Virginia based practitioners and facilities as referenced in the table below:

Credentialing	M/S	MH/SUD
Total number of requests	1951	1140
Total approved	1950	1137
Total denied	1	3
Total number of denials appealed	0	0
Number of appeals overturned	0	0
Number of appeals upheld	0	0
Average credentialing approval TAT	12.96 days	11.14 days
Credentialing approval %	99.95%	99.74%
Average credentialing denial TAT	N/A	N/A

Credentialing Denial %	N/A	N/A
------------------------	-----	-----

Monitoring of Virginia credentialing information indicates Cigna accepts MH/SUD providers at a comparable rate compared to M/S provider (99.74% compared to 99.95%), additionally the average turnaround time for MH/SUD approvals is 1.82 days less than M/S (11.14 days compared to 12.96 days). The observed differences in approval turnaround times do not indicate that the credentialing process is applied more stringently to MH/SUD providers than to M/S providers.

Cigna Commercial Book of Business Credentialing metrics for 2025 includes all practitioners and facilities across the US and its territories as referenced in the table below:

Credentialing	M/S	MH/SUD
Total number of requests	59,261	35,335
Total approved	59,184	35,221
Total denied	77	14
Total number of denials appealed	30	7
Number of appeals overturned	16	5
Number of appeals upheld	14	2
Average credentialing approval TAT	14.07 Days	11.58 Days
Credentialing approval %	99.87%	99.67%
Average credentialing denial TAT	80.55 Days	55.42 Days
Credentialing Denial %	0.13%	0.33%

Monitoring of national credentialing information indicates Cigna accepts MH/SUD providers at a comparable rate than M/S provider (99.67% compared to 99.87%), additionally the average turnaround time for MH/SUD approvals is 3 days less than M/S (11 days compared to 14 days). The observed differences in approval turnaround times do not indicate that the credentialing process is applied more stringently to MH/SUD providers than to M/S providers.

Although the MH/SUD denial rate was modestly higher than the M/S denial rate in the national data set, denial rates remained well below one percent for both provider groups.

Cigna reviewed the denial population and determined that denials were attributable to provider-specific credentialing deficiencies, including licensure, qualification, application-completion, or participation-eligibility issues. Cigna did not identify evidence that denials resulted from different credentialing criteria, evidentiary standards, review procedures, escalation requirements, or committee decision-making processes applied to MH/SUD providers.

Cigna evaluated whether observed differences in approval rates, denial rates, appeal outcomes, and credentialing turnaround times suggest material differences in access to participation in the provider network. The observed differences were small in absolute magnitude, approval rates exceeded 99% for both provider groups, and credentialing turnaround times were comparable. Accordingly, Cigna concluded that the observed differences do not constitute material differences in access to network participation and do not indicate that the credentialing NQTL is applied more stringently to MH/SUD providers.

Cigna did not identify material differences in access attributable to the credentialing NQTL during the review period. Accordingly, corrective action specific to the credentialing NQTL was not required. Cigna nevertheless continues to monitor credentialing outcomes, approval rates, denial rates, turnaround times, appeals, and network-participation trends through routine credentialing oversight and quality-management processes.

Documentation supporting this analysis includes credentialing files, application records, credentialing system reports, credentialing committee records, appeal records, recredentialing records, delegated credentialing oversight reports, and other operational records maintained in the ordinary course of business.

Based on the operational data reviewed and the outcomes observed, Cigna concluded that the Network Admissions and Credentialing NQTL operates comparably for MH/SUD and M/S providers. The evidence reviewed demonstrates that the same credentialing requirements, verification activities, review standards, escalation procedures, and approval criteria were applied to both provider groups and that the NQTL was not applied more stringently to MH/SUD providers in operation. Accordingly, Cigna concluded that the Network Admissions and Credentialing NQTL complies with the MHPAEA comparability and stringency requirements in operation.

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:

The processes, strategies, evidentiary standards, and other factors used to design and apply credentialing standards to MH/SUD providers, as written, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply credentialing standards to M/S providers.

First, when determining the credentialing requirements to apply to M/S and MH/SUD providers and facilities, Cigna utilizes substantially comparable credentialing factors for MH/SUD and M/S providers and facilities, including application requirements, participation agreements, licensure verification, education and training verification, malpractice history review, work history review, professional liability insurance requirements, accreditation requirements (where applicable), ongoing monitoring, and credentialing governance requirements.

In terms of process, Cigna uses the same application – CAQH ProView – for gathering the required information for credentialing all practitioner types, including both M/S and MH/SUD providers and facilities. In addition, the credentialing decision-making process is identical for MH/SUD and M/S providers and facilities. Applications that meet all the credentialing criteria and require no further review by the Credentialing Committee are sent to the Medical Director for approval. Applications that require additional review are presented to the Credentialing Committee.

In terms of strategies, the same committee – Quality Programs & Accreditation (“QP&A”)– has the authority to review, revise, and approve the Credentialing policy and procedure, which applies to both M/S and MH/SUD providers and facilities. The QP&A includes members with MH/SUD training and qualifications. Cigna maintains separate credentialing committees for M/S and MH/SUD providers. Although the committees differ in composition to reflect the specialties under review, both employ comparable governance structures, review authority, escalation processes, and decision-making frameworks.

Based on an application of the same factor – license and accreditation – and the same evidentiary standards, for both M/S and MH/SUD practitioners, Cigna’s credentialing criteria verify the same credentialing requirements for M/S professional providers and MH/SUD professional providers, and the same credentialing requirements for M/S facilities and MH/SUD facilities.

In operation, M/S and MH/SUD credentialing have been evaluated and determined to be comparable because:

- Cigna maintains an open network participation model and offers participation opportunities to providers and facilities that satisfy applicable credentialing, contracting, licensure, accreditation, and participation requirements.
- Both M/S and MH/SUD utilize Network Admissions standards are designed and maintained by the Quality Programs & Accreditation (“QP&A”) team. M/S and MH/SUD credentialing process steps are aligned.
- Cigna maintains a credentialing committee for the review of providers entering the M/S and MH/SUD networks.
- The metrics used to monitor performance are consistent
 - Average time to review a credentialing application
 - Average time to approve a credentialing application
 - Average time to deny a credentialing application
 - The number of appeals
 - The number of appeal denials

Cigna's review of credentialing policies, procedures, committee governance structures, credentialing criteria, credentialing outcomes, turnaround times, approval rates, denial rates, appeal outcomes, and delegated credentialing oversight identified no evidence that MH/SUD providers were subject to different credentialing requirements, evidentiary standards, escalation protocols, review criteria, approval criteria, or committee governance requirements than similarly situated M/S providers. Cigna found that observed differences in credentialing outcomes were small in absolute magnitude and did not demonstrate material differences in access to network participation opportunities for MH/SUD providers. The analysis did not identify potential areas of noncompliance requiring corrective action. Cigna will continue to monitor credentialing approval rates, denial rates, turnaround times, appeals, and credentialing outcomes through ongoing credentialing oversight and quality management activities to ensure continued compliance with MHPAEA.

Based on the evidence evaluated in Steps 2 through 5 the processes, strategies, evidentiary standards, and other factors used to design and apply the Network Credentialing Standards to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the Network Composition Standards to M/S benefits.

The Credentialing Standards analysis, above, demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying credentialing standards to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying credentialing standards with respect to M/S benefits.

Moreover, the data analyzed in Step Five above demonstrates that, in every classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the Network Credentialing Standards to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the Network Credentialing Standards with respect to M/S benefits

Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for MH/SUD credentialing/recredentialing are applied no more stringently than, that of the M/S credentialing/recredentialing as written and in operation. The operational data reviewed did not identify evidence that the credentialing process restricted network participation opportunities for MH/SUD providers through the application of more stringent credentialing standards.

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

Mental Health Parity Legal Team including:

Managing Counsel;
Counsel;

Mental Health Parity Compliance Team including:

Legal Compliance Senior Manager;
Legal Compliance Senior Advisor;

Medical/Surgical and Behavioral Health subject matter experts including:

MH/SUD Program Management Senior Manager;
M/S Provider Contracting Senior Director;
MH/SUD Provider Contracting Senior Advisor;
M/S Provider Contracting Senior Director; and

M/S and MH/SUD Credentialing Manager