NQTL: Network Adequacy

Classification(s): Inpatient In Network, Outpatient Office In Network, Outpatient All-Other In Network, Emergency In Network, Prescription

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

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

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

For both its M/S provider network and its MH/SUD provider network, Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance. standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties, as prescribed by NCQA. Assessing supply and demand of M/S facilities, provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.

Cigna considers the composition of its current M/S network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate M/S provider network to meet the clinical needs of its customers. Network adequacy analysis considers geographic area, time/distance standards, provider/enrollee ratio, provider type and/or specialty and supply/demand.

Cigna Network is open to all interested providers who sign and agree to contract terms (including rates) and meet all credentialing requirements (which may vary based on provider type). Network Adequacy is leveraged to inform the Network Admissions NQTL. Where there are network deficiencies, Cigna may scrutinize the factors and evidentiary standards of its Network Admissions NQTL to ensure such standards are comparable. When a provider meets credentialing standards and agrees to contractual terms including reimbursement, they are admitted to the network.

Where there are network shortages, Cigna utilizes the following strategies to identify potential providers for network recruitment purposes:

1. Review out-of-network utilization
2. Review of competitor provider directories
3. If competitor provider directories show no other option available (i.e., Cigna has contracted with all available providers in the market), an internet search is conducted

to see if there are any other non-participating providers that can be added for recruitment

In addition, Wellfleet applies Out of Network Provider Paid at In Network Level Guideline to address provider shortages for our members.

Plan documents:
Member plan documents include instructions on how to locate the provider directory, such as "Preferred Provider Organization: To locate an In-Network Provider in Your area, consult Your Provider Directory or call toll-free 877-657-5030, TTY 711 or visit Our website at www.wellfleetstudent.com."

In addition, plan documents explain how the member's benefits work with respect to in and out of network providers, such as:

- "This Certificate provides benefits based on the type of health care provider the Insured Student selects. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits."
- "Continuity of Care If You are undergoing an active course of Treatment with an In-Network Provider, You may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider Organization. We shall notify You of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of at least 90 days from the date of the notice to You of the termination except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pregnancy. The transitional period must extend through the provision of postpartum care directly related to the pregnancy."

Plan documents are available on Wellfleetstudent.com.

Identify the M/S benefits and services for which the NQTL applies:	***Identify the MH/SUD benefits and services for which the NQTL applies***:
The NQTL applies to mental health and/or substance use disorder ("MH/SUD") services, and/or providers of such services, and to medical/ surgical ("M/S") services and/or providers of such services, for all in-network inpatient and outpatient benefit classifications and sub-classifications, as well as the emergency and prescription classifications, and is incorporated into plans insured by Wellfleet.	The NQTL applies to mental health and/or substance use disorder ("MH/SUD") services, and/or providers of such services, and to medical/ surgical ("M/S") services and/or providers of such services, for all in-network inpatient and outpatient benefit classifications and subclassifications, as well as the emergency and prescription classifications, and is incorporated into plans insured by Wellfleet.

Step 2 – Identify the factors used to determine that the NQTL will apply to the M/S or MH/SUD benefits	
M/S: Factors 1. State and Federal Law, as applicable 2. Provider Availability 3. Provider Accessibility 4. Out of Network Provider Member Request **Factors Considered but rejected (same for M/S and MH/SUD):** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** There is no differentiation of weight between the factors. There is no Artificial Intelligence application utilized for the NQTL design. **Pharmacy (M/S):** 1. State and Federal Law, as applicable 2. Lack of Pharmacy Availability 3. Pharmacy Accessibility **Factors Considered but rejected (same for M/S and MH/SUD):** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** There is no Artificial Intelligence application utilized for the NQTL design.	**MH/SUD**: Factors 1. State and Federal Law, as applicable 2. Provider Availability 3. Provider Accessibility 4. Out of Network Provider Member Request **Factors Considered but rejected (same for M/S and MH/SUD):** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** There is no differentiation of weight between the factors. There is no Artificial Intelligence application utilized for the NQTL design. . **Pharmacy (M/S):** 1. State and Federal Law, as applicable 2. Lack of Pharmacy Availability 3. Pharmacy Accessibility **Factors Considered but rejected (same for M/S and MH/SUD):** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** There is no Artificial Intelligence application utilized for the NQTL design.
Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.	

M/S	MH/SUD
1. Factor 1: State and Federal Law, as applicable o **Source**: Enacted State and Federal requirements applicable to the Plan. o **Evidentiary Standard:** State and Federal Law, as applicable 2. Factor 2: Provider Availability o **Source**: o Provider to Enrollee Ratio Standards - Calculation of # of Enrollees covered under all health benefit plans issued by the carrier in the applicable state divided by # of Providers with practice locations in the applicable state. o **Evidentiary Standard**: o Provider to Enrollee Ratio Standards: Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, Cigna divides the customer count by the Provider count. For example, for an area with 3,000 customers and 30 Providers, – the ratio would be 1:100. In remote or rural areas, occasionally geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Annually, the Quality Management team reviews and assesses the behavioral health care professional network to determine if goals are met and if the network is robust enough to meet the needs of its customers. NCQA requires certain measures to assess availability for urban/suburban, rural, and ratio (behavioral health care professional to customers) across its networks. Likewise, the Network team reviews and assesses the medical health care professional network to determine if goals are met in 90% of the zip codes within the service area for each provider specialty category for PCPs, High Volume Specialist, High Impact Specialists, and Hospitals.	o Factor 1: State and Federal Law, as applicable o **Source**: Enacted State and Federal requirements applicable to the Plan. o **Evidentiary Standard**: State and Federal Law, as applicable o Factor 2: Provider Availability o **Source**: o Provider to Enrollee Ratio Standards - Calculation of # of Enrollees covered under all health benefit plans issued by the carrier in the applicable state divided by # of Providers with practice locations in the applicable state. o **Evidentiary Standard**: o Provider to Enrollee Ratio Standards: Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, Cigna divides the customer count by the Provider count. For example, for an area with 3,000 customers and 30 Providers, – the ratio would be 1:100. In remote or rural areas, occasionally geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Annually, the Quality Management team reviews and assesses the behavioral health care professional network to determine if goals are met and if the network is robust enough to meet the needs of its customers. NCQA requires certain measures to assess availability for urban/suburban, rural, and ratio (behavioral health care professional to customers) across its networks. Likewise, the Network team reviews and assesses the medical health care professional network to determine if goals are met in 90% of the zip codes within the service area for each provider specialty category for PCPs, High Volume Specialist, High Impact Specialists, and Hospitals. o **Source for Evidentiary Standard**

- **Source:**
  - Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Cigna uses Quest Analytics to conduct this reporting/analysis.
- **Evidentiary Standard**:

Health Care Professional Type	Mileage Radius
PCP	25 miles
Specialist	25 miles
Acute Inpatient, Long Term, Hospice	50 miles
Ancillary Health Care Professional, Dialysis • Skilled Nursing Facility • Acute Medical Inpatient Rehab	25 miles

- **Source for Evidentiary Standard**:
  - State specific standards, as applicable
  - Cigna/Evernorth Policies PS-8 Measuring Availability of Providers for Insured Products, HMNET-032 Measuring Availability of Behavioral Practitioners and Providers

3. Factor 3: Provider Accessibility
   - **Source**:
     - Appointment Wait Time Standards- Time from request of an appointment to appointment, as determined through provider surveys conducted twice per year. Cigna considers the composition of its current network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate provider network to meet the clinical needs of its customers. Network adequacy analysis considers geographic area, time/distance standards, provider/enrollee ratio, provider type and/or specialty and supply/demand
   - **Evidentiary Standard**:

Health Care Professional Type	Appointment Availability
PCP	Urgent: Within 48 hours Routine: Within 14 days

  - Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Cigna uses Quest Analytics to conduct this reporting/analysis.
  - State specific standards, as applicable
  - Cigna/Evernorth Policies PS-8 Measuring Availability of Providers for Insured Products, HMNET-032 Measuring Availability of Behavioral Practitioners and Providers
- **Evidentiary Standard**:

Health Care Professional Type	Mileage Radius
Behavioral Health Care Professional	Urban/Suburban: 15 miles Rural: 25 miles
BH Inpatient Facility and Ambulatory Program	Urban: 25 miles Suburban: 30 miles Rural: 40 miles
BH Residential Facility	Urban: 25 miles Suburban: 30 miles Rural: 40 miles

- **Source for Evidentiary Standard**:
- State specific standards, as applicable
- Cigna/Evernorth Policies PS-8 Measuring Availability of Providers for Insured Products, HMNET-032 Measuring Availability of Behavioral Practitioners and Providers

- Factor 3: Provider Accessibility
  - **Source**:
    - Appointment Wait Time Standards- Time from request of an appointment to appointment, as determined through provider surveys conducted twice per year. Cigna considers the composition of its current network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate provider network to meet the clinical needs of its customers. Network adequacy analysis considers geographic area, time/distance standards, provider/enrollee ratio, provider type and/or specialty and supply/demand
  - **Evidentiary Standard**:

Health Care Professional Type	Appointment Availability

	Preventive Screening & Physical: Within 30 days
Specialist	Urgent: Within 48 hours hours Routine: Within 14 days Preventive Screening & Physical: Within 30 days. Obstetric Prenatal Care (Non-high risk and non-urgent): • 1 st trimester: Within 14 days • 2 nd trimester: Within 7 days • 3 rd trimester: Within 30 day
Acute Inpatient, Long Term, Hospice	Urgent: Within 48 hours Routine: Within 14 days
Ancillary Health Care Professional, Dialysis • Skilled Nursing Facility • Acute Medical Inpatient Rehab	Urgent: Within 48 hours Routine: Within 14 days

- **Source for Evidentiary Standard**:
  - State specific standards, as applicable
  - PS-6 Measuring Accessibility of Medical Services and HM-NET031 Measuring Accessibility of Behavioral Services.

4. Factor 4: Out of Network Member Request
   - **Source:** Wellfleet Out of Network Paid at In-Network Guideline
   - **Evidentiary Standard**: Member request

Pharmacy

1. Factor 1: State and Federal Law, as applicable
   - **Source**: Internal RegEd Notification & External notification from the PBM
   - **Evidentiary Standard**: Enacted State and Federal Law, as applicable

2. Factor 2: Provider Availability
   - **Source**: Notice from Student Health Administrative Office at each individual school or Notice from the member; Performance Guarantee within Wellfleet's Master Contract with Express Scripts, which states "The removal of a chain pharmacy from Sponsor's (Wellfleet's) network will not create disruption that impacts (i) more than 5% of all Sponsor's.

Behavioral Health Care Professional	Urgent: Within 48 hours Routine: Within 14 days Preventive Screening & Physical: Within 30 days
BH Inpatient Facility and Ambulatory Program	Urgent: Within 48 hours Initial Routine: Within 10 business days Follow-up Routine: Within 30 days
BH residential Facility	Urgent: Within 48 hours Initial Routine: Within 10 business days Follow-up Routine: Within 30 day

- **Source for Evidentiary Standard**:
  - State specific standards, as applicable
  - PS-6 Measuring Accessibility of Medical Services and HM-NET031 Measuring Accessibility of Behavioral Services.

5. Factor 4: Out of Network Member Request
   - **Source**: Wellfleet Out of Network Paid at In-Network Guideline
   - **Evidentiary Standard**: Member request

Pharmacy

4. Factor 1: State and Federal Law, as applicable
   - **Source**: Internal RegEd Notification & External notification from the PBM
   - **Evidentiary Standard**: Enacted State and Federal Law, as applicable

5. Factor 2: Provider Availability
   - **Source**: Notice from Student Health Administrative Office at each individual school or Notice from the member; Performance Guarantee within Wellfleet's Master Contract with Express Scripts, which states "The removal of a chain pharmacy from Sponsor's (Wellfleet's) network will not create disruption that impacts (i) more than 5% of all Sponsor's.
   - **Evidentiary Standard**: A **single** Client or Member Notification expressing difficulty with finding an in-network pharmacy ; Performance Guarantee

o **Evidentiary Standard**: A **single** Client or Member Notification expressing difficulty with finding an in-network pharmacy ; Performance Guarantee with Express Scripts - Network changes may not negatively impact more than **5%** of a single client's membership 3. Factor 3: Provider Accessibility o **Source**: Notice from Student Health Administrative Office at each individual school or Notice from the member; Performance Guarantee within Wellfleet's Master Contract with Express Scripts, which states "The removal of a chain pharmacy from Sponsor's (Wellfleet's) network will not create disruption that impacts (i) more than 5% of all Sponsor's Members and (ii) more than 5% of a single group's (schools) Members o **Evidentiary Standard**: A **single** Client or Member Notification expressing difficulty with accessing an in-network pharmacy ; Performance Guarantee with Express Scripts - Network changes may not negatively impact more than **5%** of a single client's membership	with Express Scripts - Network changes may not negatively impact more than **5%** of a single client's membership 6. Factor 3: Provider Accessibility o **Source**: Notice from Student Health Administrative Office at each individual school or Notice from the member; Performance Guarantee within Wellfleet's Master Contract with Express Scripts, which states "The removal of a chain pharmacy from Sponsor's (Wellfleet's) network will not create disruption that impacts (i) more than 5% of all Sponsor's Members and (ii) more than 5% of a single group's (schools) Members o **Evidentiary Standard**: A **single** Client or Member Notification expressing difficulty with accessing an in-network pharmacy ; Performance Guarantee with Express Scripts - Network changes may not negatively impact more than **5%** of a single client's membership
Step 4(a) – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, <u>as written</u>, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.	
Overall, Cigna and Evernorth each maintain separate but aligned policies regarding measuring access and availability of providers and services to ensure that provider availability and accessibility is comparable to and no more stringently designed and applied to MH/SUD benefits, as written. The separate policies are maintained due to variations that may exist between MH/SUD and M/S standards from a federal, state, or internal standard perspective. Additionally, Cigna has separate contracting, compliance and monitoring teams that separately assess compliance with requirements for MH/SUD and M/S networks. However, both the MH/SUD and M/S teams work together to ensure parity compliance both in writing, by at least annually assessing and comparing their policies and in operation by at least annually assessing in operation compliance with travel distance and appointment standards. M/S and MH/SUD policy owners work together to assess policy changes and implement similar policies and processes, where appropriate, and the M/S and MH/SUD have representative on the policy committee to ensure awareness of and compliance with parity from a policy and	Overall, Cigna and Evernorth each maintain separate but aligned policies regarding measuring access and availability of providers and services to ensure that provider availability and accessibility is comparable to and no more stringently designed and applied to MH/SUD benefits, as written. The separate policies are maintained due to variations that may exist between MH/SUD and M/S standards from a federal, state, or internal standard perspective. Additionally, Cigna has separate contracting, compliance and monitoring teams that separately assess compliance with requirements for MH/SUD and M/S networks. However, both the MH/SUD and M/S teams work together to ensure parity compliance both in writing, by at least annually assessing and comparing their policies and in operation by at least annually assessing in operation compliance with travel distance and appointment standards. M/S and MH/SUD policy owners work together to assess policy changes and implement similar policies and processes, where appropriate, and the M/S and MH/SUD have representative on the policy committee to ensure

standards perspective. The Behavioral Network Compliance team, led by a Senior Manager with 10+ years of experience in Behavioral Health Network/Provider Contracting/Provider Relations/Compliance, intakes and assesses all new and changing regulations related to Network Adequacy. This team also maintains internal policies housing this information, in consultation with various business owners, such as the Behavioral Network Contracting Director and Behavioral Network Provider Relations & Strategy Director (15+ years industry experience). After business assessment of the policy contents, all policies are formally governed by Cigna's policy committee. This committee is composed of representatives from multiple business areas that provide oversight of and approval for Cigna's policies. Medical and BH policies are managed by the same committee. Policies are reviewed at least annually but may be updated more frequently due to changes in regulations, requirements, or business processes. Time spent maintaining policies is highly variable depending on the volume of changes being required and whether implementation/corrective actions are needed. 1. State and federal law, as applicable- To ensure network adequacy for both MH/SUD and M/S networks Cigna drafts a single Network Adequacy Plan for both MH/SUD and M/S individual plan type networks for submission annually in July. Requirements for such Network Adequacy Plan submissions are reflected in the PS-8 Measuring Availability of Providers for Insured Products applicable to the medical network for M/S benefits and HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers, applicable to the behavioral health network for MH/SUD benefits. The Network Adequacy Plan includes requirements for both Provider Availability and Provider Accessibility. In its review of Provider Accessibility, Cigna reviewed the above-mentioned policies (PS-8 and HM-NET-32) to ensure State specific Appointment Wait Time Standards were reflected in writing for M/S and MH/SUD providers. 2. Provider Availability- Cigna conducts quality management activities for both medical and behavioral healthcare products. Evernorth maintains NCQA Managed Behavioral Healthcare Organization ("MBHO") Accreditation and	awareness of and compliance with parity from a policy and standards perspective. The Behavioral Network Compliance team, led by a Senior Manager with 10+ years of experience in Behavioral Health Network/Provider Contracting/Provider Relations/Compliance, intakes and assesses all new and changing regulations related to Network Adequacy. This team also maintains internal policies housing this information, in consultation with various business owners, such as the Behavioral Network Contracting Director and Behavioral Network Provider Relations & Strategy Director (15+ years industry experience). After business assessment of the policy contents, all policies are formally governed by Cigna's policy committee. This committee is composed of representatives from multiple business areas that provide oversight of and approval for Cigna's policies. Medical and BH policies are managed by the same committee. Policies are reviewed at least annually but may be updated more frequently due to changes in regulations, requirements, or business processes. Time spent maintaining policies is highly variable depending on the volume of changes being required and whether implementation/corrective actions are needed. 1. State and federal law, as applicable- To ensure network adequacy for both MH/SUD and M/S networks Cigna drafts a single Network Adequacy Plan for both MH/SUD and M/S individual plan type networks for submission annually in July. Requirements for such Network Adequacy Plan submissions are reflected in the PS-8 Measuring Availability of Providers for Insured Products applicable to the medical network for M/S benefits and HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers, applicable to the behavioral health network for MH/SUD benefits. The Network Adequacy Plan includes requirements for both Provider Availability and Provider Accessibility. In its review of Provider Accessibility, Cigna reviewed the above-mentioned policies (PS-8 and HM-NET-32) to ensure State specific Appointment Wait Time Standards were reflected in writing for M/S and MH/SUD providers. 2. Provider Availability- Cigna conducts quality management activities for both medical and behavioral healthcare products. Evernorth maintains NCQA

conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA requirements. M/S and MH/SUD Network Adequacy monitoring uses separate but aligned policies (Measuring Availability of Providers for Insured Products policy (PS-8) Measuring Availability of Behavioral Practitioners and Providers policy (HM-NET-032)). M/S and MH/SUD utilize the same geo-access software (Quest Analytics) for measuring and assessing Network Adequacy standards. Use of the same system ensures comparability of the tools and methodologies used for implementing policy changes. MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care, Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and 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 (approximately 250 documents). This evidence spans a period of 2 years and much of the evidence must be reviewed and approved by our Medical Management Quality Committee ("MMQC"), Integrated Health Management Quality Committee ("IHMQC"), and Clinical Advisory Committee ("CAC"). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records). NCQA Requirements dictate that Cigna monitors MH/SUD and M/S provider availability and accessibility utilizing various elements including: o The use of ratios such as the number of each type of practitioners to number of members or the number of primary care practices accepting new patients to number of members. o The geographic distribution of practitioners that are within an acceptable distance to a practitioner's office or within an acceptable drive time. o A Quantitative and qualitative analysis that includes initial measurements to analyze data, then subsequent remeasurements if quantitative analysis demonstrates that stated goals were not met.	Managed Behavioral Healthcare Organization ("MBHO") Accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA requirements. M/S and MH/SUD Network Adequacy monitoring uses separate but aligned policies (Measuring Availability of Providers for Insured Products policy (PS-8) Measuring Availability of Behavioral Practitioners and Providers policy (HM-NET-032)). M/S and MH/SUD utilize the same geo-access software (Quest Analytics) for measuring and assessing Network Adequacy standards. Use of the same system ensures comparability of the tools and methodologies used for implementing policy changes. MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care, Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and 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 (approximately 250 documents). This evidence spans a period of 2 years and much of the evidence must be reviewed and approved by our Medical Management Quality Committee ("MMQC"), Integrated Health Management Quality Committee ("IHMQC"), and Clinical Advisory Committee ("CAC"). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records). NCQA Requirements dictate that Cigna monitors MH/SUD and M/S provider availability and accessibility utilizing various elements including: o The use of ratios such as the number of each type of practitioners to number of members or the number of primary care practices accepting new patients to number of members. o The geographic distribution of practitioners that are within an acceptable distance to a practitioner's office or within an acceptable drive time. o A Quantitative and qualitative analysis that includes initial

3. Provider Accessibility- See above. In addition, Policies PS_6 and HM_NET_031 demonstrate establishing national accessibility standards and a national methodology for assessing performance against those standards. The use of customer surveys and complaints and measuring results against metrics established by the state or the national accessibility standard. A continuous quality improvement process is used to identify opportunities for improvement. Each provider panel shall meet the wait time standards for at least 95% of the enrollees covered under the plan. When clinically appropriate, telehealth may be utilized. When access to care standards are not met, Cigna engages in active recruitment of the relevant provider type and/or specialty at issue. 4. Out of Network Member Request- Wellfleet Insurance Company Out of Network paid at in network level guideline applies to both MS and MHSUD providers. Wellfleet will approve member requests to have an Out of Network provider reimbursed at In Network level when there are no specialists or non-physician specialists in the provider network with the professional training and expertise to treat the condition at issue. . <u>Pharmacy</u> Express Scripts provides the management of the pharmacy network available to Wellfleet customers, as agreed upon in the Performance Guarantee of our vendor contract. There is no distinction within the Pharmacy contracting process, the Performance Guarantee, or the Pharmacy Network Listing, between M/S and MH/SUD related prescriptions, nor are pharmacies classified as M/S or MH/SUD. The Wellfleet pharmacy information is housed with the Prescription Drug formulary, Prior Authorization listings, and other pertinent Prescription Drug information and serves as a convenient single point of access for its members. In the instance of any of the factors listed above being triggered, Express Scripts will perform outreach to pharmacies local to our members to initiate contract negotiations. Again, these negotiations do not include whether the pharmacy dispenses MH/SUD or M/S drugs.	measurements to analyze data, then subsequent remeasurements if quantitative analysis demonstrates that stated goals were not met. 3. Provider Accessibility- See above. In addition, Policies PS_6 and HM_NET_031 demonstrate establishing national accessibility standards and a national methodology for assessing performance against those standards. The use of customer surveys and complaints and measuring results against metrics established by the state or the national accessibility standard. A continuous quality improvement process is used to identify opportunities for improvement. Each provider panel shall meet the wait time standards for at least 95% of the enrollees covered under the plan. When clinically appropriate, telehealth may be utilized. When access to care standards are not met, Cigna engages in active recruitment of the relevant provider type and/or specialty at issue. 4. Out of Network Member Request- Wellfleet Insurance Company Out of Network paid at in network level guideline applies to both MS and MHSUD providers. Wellfleet will approve member requests to have an Out of Network provider reimbursed at In Network level when there are no specialists or non-physician specialists in the provider network with the professional training and expertise to treat the condition at issue. <u>Pharmacy</u> Express Scripts provides the management of the pharmacy network available to Wellfleet customers, as agreed upon in the Performance Guarantee of our vendor contract. There is no distinction within the Pharmacy contracting process, the Performance Guarantee, or the Pharmacy Network Listing, between M/S and MH/SUD related prescriptions, nor are pharmacies classified as M/S or MH/SUD. The Wellfleet pharmacy information is housed with the Prescription Drug formulary, Prior Authorization listings, and other pertinent Prescription Drug information and serves as a convenient single point of access for its members. In the instance of any of the factors listed above being triggered, Express Scripts will perform outreach to pharmacies local to our members to initiate contract negotiations. Again, these

The factors, sources, and evidentiary standards utilized to support any potential pharmacy network shortages are applied in a comparable manner and no more stringently for MHSUD as compared to M/S, as written.	negotiations do not include whether the pharmacy dispenses MH/SUD or M/S drugs. The factors, sources, and evidentiary standards utilized to support any potential pharmacy network shortages are applied in a comparable manner and no more stringently for MHSUD as compared to M/S, as written.
***Step 4(b):* Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, <u>in operation</u>, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.**	
Cigna maintains an open network and will contract with any MH/SUD or M/S provider or facility. Cigna does not limit parties with whom it will contract and negotiate rates. The Behavioral Health medical cost budget and M/S cost budgets are established using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed in order to set budget metrics. Cigna does negotiate rates with parties that represent groups or sets of providers. There is no difference in how this process is handled for MH/SUD vs. M/S providers or representatives. When applicable, Cigna uses the same Consultant Agreement for both MH/SUD and M/S. A review of Cigna's Network Adequacy reports for Cigna's national network revealed sufficient access to M/S and MH/SUD providers. Cigna meets adequacy and accessibility requirements for M/S and MH/SUD providers using comparable standards, with M/S providers subject to more stringent standards. Cigna's Quality Programs and Accreditation team defines quality monitoring standards and provides guidance in initiating improvement initiatives when deficiencies are identified. Quality studies are designed and documented to objectively and systematically monitor, evaluate and improve the quality and appropriateness of care and service. Monitoring and driving improvements in quality of care and service to our customers is an integral component of Behavioral Accreditation, which reflects the Cigna commitment to continuous quality improvement throughout the organization.	Cigna maintains an open network and will contract with any MH/SUD or M/S provider or facility. Cigna does not limit parties with whom it will contract and negotiate rates. The Behavioral Health medical cost budget and M/S cost budgets are established using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed in order to set budget metrics. Cigna does negotiate rates with parties that represent groups or sets of providers. There is no difference in how this process is handled for MH/SUD vs. M/S providers or representatives. When applicable, Cigna uses the same Consultant Agreement for both MH/SUD and M/S. A review of Cigna's Network Adequacy reports for Cigna's national network revealed sufficient access to M/S and MH/SUD providers. Cigna meets adequacy and accessibility requirements for M/S and MH/SUD providers using comparable standards, with M/S providers subject to more stringent standards. Cigna's Quality Programs and Accreditation team defines quality monitoring standards and provides guidance in initiating improvement initiatives when deficiencies are identified. Quality studies are designed and documented to objectively and systematically monitor, evaluate and improve the quality and appropriateness of care and service. Monitoring and driving improvements in quality of care and service to our customers is an integral component of Behavioral Accreditation, which reflects the Cigna commitment to continuous quality improvement throughout the organization.

Both Cigna/Evernorth considers the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which Cigna/Evernorth has providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e, urgent appointment within 72 hours). Cigna/Evernorth each conduct oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards. When access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue. Both Cigna and Evernorth use Quest Analytics software program to determine the travel distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks. Both Cigna and Evernorth monitor network adequacy on at least an annual basis and create recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties or geographies. Upon determination of a deficiency, Cigna utilizes a variety of resources, including but not limited to: state licensing boards, competitor provide directories, out-of-network claims/utilization reports and internet searches to identify provider/facility contracting leads. Applicable leads are routed to the appropriate contracting teams for recruitment, Network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability are also used to assess network adequacy and inform corrective action plans. Recruitment plans to address network adequacy are developed and modified as needed throughout the year. Provider appointment availability requirements are monitored for both MH/SUD and M/S via a Plan initiated survey twice per year. Survey format is similar, but differs due to differences in the required appointment availability standards (i.e. M/S 30 calendar days, MH/SUD 10 calendar days). Results are compiled and analyzed at the end of each survey route. Recruitment and corrective action plans are created to address any deficiencies.	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Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section	

Cigna maintains a robust behavioral health network of in person and virtual providers including child, adolescent, and adult psychiatrists; clinical psychologists; clinical social workers; psychiatric nurse practitioners (with and without prescription-writing privileges); mental health/substance abuse counselors; and marriage and family therapists as in alignment with regulatory requirements. Cigna measures behavioral health network adequacy based upon three categories of providers: prescribers, psychologists, and master's level clinicians. This encompasses all the MH/SUD provider types contracted in the network. Given MH/SUD provider shortages, Cigna considers every contracted MH/SUD provider specialty high-volume.

Provider availability and accessibility monitoring is conducted on an ongoing basis and an analysis is performed annually to ensure that established accreditation, state, and federal standards for reasonable geographical location, number of providers, appointment availability, and provision for emergency care are measured. Monitoring activities may include evaluation of satisfaction surveys, evaluation of complaint and appeal reports, and evaluation of provider to customer ratios. An assessment of the provider network is also performed to ensure that the network meets the cultural, ethnic, racial, and linguistic needs and preferences of customers. Specific deficiencies are addressed with a corrective action plan and follow up activities are conducted to reassess compliance.

Cigna assesses supply and demand of both M/S and MH/SUD provider types and/or specialties based upon the same indicators including NCQA and NAIC, and federal/state, network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; customer complaint data. The conclusion of such assessments may result in an increase or decrease in the provider's reimbursement rate.

Cigna continues to invest in the breadth of the behavioral network. Cigna supplements its network with access to over 250,000 virtual behavioral healthcare. The virtual care behavioral health network includes large provider groups including, but not limited to Alma, Headspace, Headway, Talkspace and many smaller groups/clinics and independent providers. Over the past several years Cigna has conducted a comprehensive review of its MH/SUD network admission standards, including network access standards, contracting processes and reimbursement rates applicable to Network Providers. Cigna's behavioral health network remains open, and Cigna accepts all credentialed behavioral health providers who request to join the network. Any variances in contracting processes as well as a range of reimbursement rates based on percentages of Medicare RVUs as compared to M/S reimbursement rates were identified and analyzed for adherence to the NQTL requirement. Cigna may agree to non-standard contracts and increased reimbursement rates as necessary to meet access needs, particularly in specialty provider board certification shortage areas such as psychiatry and child and adolescent care.

In connection with its ongoing NQTL compliance efforts, Cigna has taken proactive, additional steps to continually ensure the comparability of standards for provider admissions into the MH/SUD provider network, including reimbursement rate methodology, to ensure the processes, strategies and evidentiary standards implemented are not more stringent for MH/SUD services than M/S services. Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, adequacy, and provider reimbursement rates for inpatient and outpatient services are comparable to, and applied no more stringently than, that of the M/S provider network as written and in operation. Put differently, Cigna's network has the ability to meet the MH/SUD services needs of enrollees by providing reasonable access to a sufficient number of in-network providers for both inpatient and outpatient services.