2019 QUALITY, COST EFFICIENCY, AND CIGNA CARE DESIGNATION METHODOLOGY

For physicians and physician groups
June 2018

Together, all the way.™

Cigna®

Table of contents

THN-2018-338. © 2018 Cigna. Some content provided under license.

Introduction

Many of our customers want to know more about physician quality and cost-efficiency. To help provide Cigna customers with relevant information to make their own health care decisions, we evaluate quality and cost-efficiency information by using a methodology consistent with national standards and incorporating physician feedback on contracted providers in 21 specialty types. Physicians who meet Cigna's specific quality and cost-efficiency criteria can receive the Cigna Care Designation (CCD) for a given specialty. CCD information may also be utilized as part of a tiered benefit plan option.

This whitepaper explains the methodology used to measure the quality and cost-efficiency results of individual physicians and physician groups, and provides details regarding the information used on the provider directory displays.

Cigna quality and cost-efficiency display principles

We follow three key principles when providing our quality and cost-efficiency information to customers, employers, and physicians.

1. **Standardized performance measures using the most comprehensive data set available.** We use nationally recognized measures derived from those endorsed by the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data Information Set (HEDIS®[1]), or developed by national physician organizations.

2. **Responsible use of the information.** The displays only reflect a partial assessment of quality and cost efficiency based on our claims data, and should not be the sole basis for decision-making as such measures have a risk of error. Our customers are encouraged to consider all relevant factors and to consult with their treating physician when selecting a provider for care. In general, Cigna-participating providers are independent practitioners; they are not employees or agents of Cigna. Treatment decisions are made exclusively by the treating physician and the patient. We provide our customers with helpful information to allow them to make informed decisions. The quality and cost-efficiency markers used in evaluating physicians for CCD are intended for that purpose only. We do not guarantee the quality or cost efficiency of the actual services provided by contracted physicians, even those that qualify for CCD.

3. **Collaboration and improvement enablement.** We are committed to providing information and solutions that can help support access to quality health care. A detailed description of our methodology, information about the summary metrics, and ongoing data to help improve performance is available to physicians and physician groups. We also continue to have ongoing discussions with key physician organizations, ranging from national associations to large physician groups, which provide input for future design changes.

Frequency of Reviews

The methodology for determining the quality and cost-efficiency displays is subject to change as tools and industry standards evolve, and physician feedback is obtained and periodically updated. We used dates of services from January 1, 2016 through December 31, 2017 for the review period to assess for 2019 quality and cost-efficiency displays. This review includes claims data from Cigna Managed Care and PPO plans.

---

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

External certification

Cigna earned the Physician and Hospital Quality Certification for the fifth time in July 2017. The NCQA Physician and Hospital Quality (PHQ) certification program evaluates how well health plans measure and report the quality and cost of physicians and hospitals. NCQA Quality Certification Standards meet New York state requirements implemented in November 2007 concerning physician performance measurement, reporting, and tiering programs.

Specialty types assessed for quality and cost-efficiency displays

The 21 physician specialty types are identified in the table below. A physician can only be assigned one specialty, tax identification number (TIN), and geographical market for quality and cost-efficiency displays. The physician's primary specialty, as determined by Cigna, is used to establish the specialty to evaluate physicians with multiple specialties.

Assessed specialty types

Allergy and immunology	Cardiology	Cardio-thoracic surgery
Dermatology	Ear, nose, and throat (ENT)	Endocrinology
Family practice	Gastroenterology	General surgery
Hematology and oncology*	Internal medicine	Nephrology
Neurology	Neurosurgery	Obstetrics and gynecology
Ophthalmology	Orthopedic surgery	Pediatrics
Pulmonary	Rheumatology	Urology
*Does not include radiation oncology		

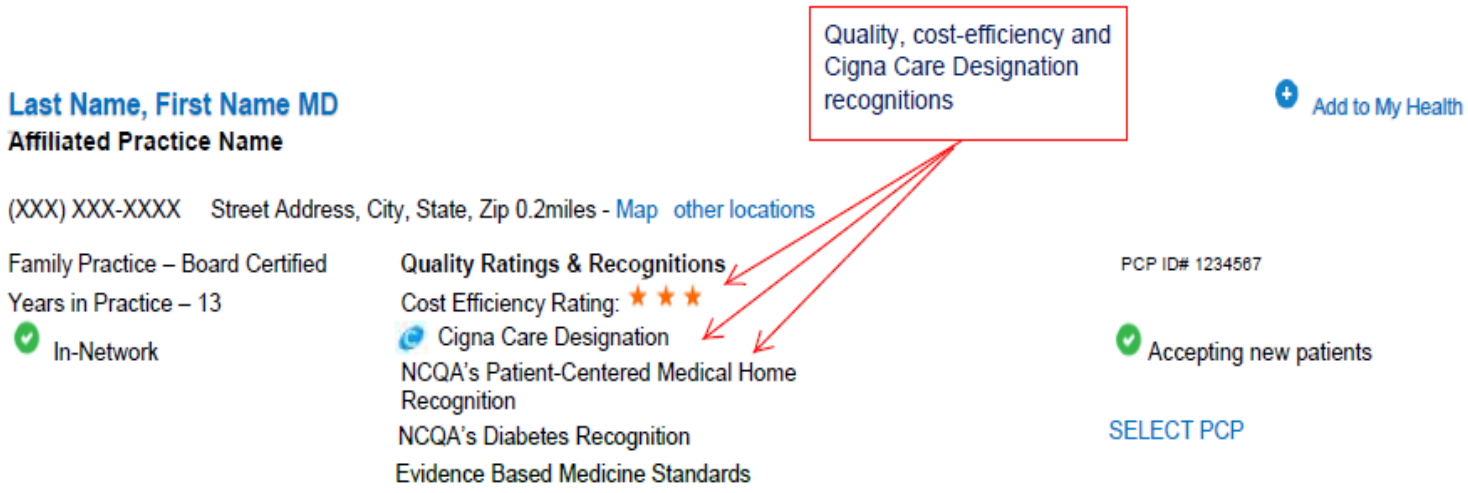
Note: Cigna evaluates providers at the group level. Geriatric physicians, nurse practitioners, and physician assistants who deliver primary care services as part of the group will be evaluated as part of the group.

Market availability

Our Network Contracting and Market Medical Executive teams defined the 2019 geographical markets in which CCD is recognized. The zip code of a physician's primary office address is used to align a physician with a given market. The physician's primary specialty and geographic market is then used to determine the physician peer group for comparison of quality and cost-efficiency outcomes.

Please see Appendix 1 for a list of markets, and the volume and percent of physicians reviewed in each market, which are CCD providers effective January 1, 2019.

Sample: Online health care professional directory display (myCigna.com)



Quality evaluation and displays

Providers are evaluated on a number of criteria that we believe are markers of provider practice quality. Information relative to specific quality criteria met by a physician is displayed in the online provider directory on both the public website (Cigna.com) and secure customer website (myCigna.com). We use three quality indicators to review participating physicians in the 21 specialty types. Each physician qualifying for a specific quality indicator is identified in our online health care professional directory.

1. **Group board certification**
   Group board certification criteria are based on the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) certification information, and are consistent with our Practitioner Credentialing and Recredentialing Policy. Board certifications criteria help determine whether board-certified physicians in the group predominantly provide patient care. This standard is met if:

   - Either 80 percent of physicians within a group are board certified and provide 50 percent of the care, or at least 80 percent of the care is provided by board-certified physicians, *or*
   - For groups (practices) with four or fewer physicians, either 65 percent of physicians within a group are board certified and provide 50 percent of the care, or at least 65 percent of the care is provided by board-certified physicians

2. **Adherence to evidence-based medicine rules**
   The quality of physician care is evaluated using a claims-based assessment for 91 evidence based medicine (EBM) rules derived from rules endorsed by the National Quality Forum (NQF), Healthcare Effectiveness Data Information Set (HEDIS), or developed by physician organizations. These rules span 43 diseases and preventive cares conditions (see Appendix 3), and are potentially applicable to the care provided by physicians in 15 specialty types. For a list of the specialty types that are covered by Evidence Based Medicine (EBM) rules, please see the chart on page six.

3. **National Committee for Quality Assurance (NCQA) Physician Recognition**
   NCQA Physician Recognition Programs assess clinicians and practices to ensure they support the delivery of high-quality care, and provide medical services that adhere to evidence-based, nationally recognized clinical standards of care. We identify physicians in our online provider directory who have received recognition in any of these four NCQA Physician Recognition Programs:
   - NCQA Diabetes Recognition Program (DRP)
   - NCQA Heart/Stroke Recognition Program (HSRP)
   - NCQA Patient-Centered Medical Home Recognition (PCMH - 2 versions)
   - NCQA Patient Centered Specialty Practice Recognition (PCSP)

Additional information about these programs is available on the NCQA website (https://ncqa.org > Programs > Recognition).

Evidence-based medicine (EBM) assessment process

The EBM rules used in the 2019 evaluation apply to 15 primary care and non-primary care specialties. Currently there are no EBM rules that apply to dermatology. In 2017, the EBM assessment process for gastroenterology, general surgery, neurosurgery, ophthalmology, and orthopedic surgery was removed because fewer than two percent of groups with these specialty types had sufficient volume to assess.

Overall, approximately 12.8 percent of physicians in all assessed specialty types are associated with groups that do not have sufficient volume to assess adherence to the EBM rules. However, they have sufficient volume to assess cost efficiency. Similarly, 5,955 or almost one percent of physicians are associated with groups that do not have sufficient volume to assess cost efficiency and, as a result, are assessed based on adherence with the EBM rules alone.

Specialty types covered by EBM rules

Allergy and immunology	Cardiology	Cardiothoracic surgery
Endocrinology	Family practice	Hematology and oncology
Internal medicine	Nephrology	Neurology
Obstetrics and gynecology (OB/GYN)	Otolaryngology (ENT)	Pediatrics
Pulmonary	Rheumatology	Urology

The 2019 EBM assessment component review includes measuring compliance with 91 EBM rules (see Appendix 3), where applicable, for the medical conditions displayed in the following table:

Disease and preventive care conditions covered by EBM rules		
Adolescent well-care	Chronic kidney disease	Pharyngitis, appropriate testing for children
Adult access to preventive/ambulatory health services	Congestive heart failure	Pneumonia, community-acquired bacterial (CAP)
Alcohol and other drug dependence	Chronic obstructive pulmonary disease (COPD) exacerbation, pharmacotherapy management	Potentially harmful drug-disease interactions in the elderly
Antidepressant medication management	Coronary artery disease (including statin therapy)	Pregnancy management
Asthma (includes use of appropriate medications)	Diabetes (including statin therapy)	Prenatal and postpartum care
Atrial fibrillation (includes use of Anticoagulation Medications)	Epilepsy	Prostate cancer
Attention deficit hyperactivity disorder (ADHD)	Human papillomavirus vaccine for adolescents	Rheumatoid arthritis
Breast cancer	Hypertension	Sickle Cell Anemia
Breast cancer screening	Low back pain	Sinusitis (acute)
Bronchitis (acute)	Migraine headache	Tonsillectomy
Cardiac surgery	Multiple sclerosis	Upper respiratory infection
Cerebral vascular accident and transient cerebral ischemia	Osteoporosis	Well-child visits in the first 15 months of life
Cervical cancer screening	Otitis externa (acute)	Well-child visits in the third, fourth, fifth, and sixth years of life
Child and adolescent access to primary care	Otitis media (acute)	
Chlamydia screening	Persistence of beta-blocker treatment after a heart attack	

Definitions used in the following methodology description:

1. **Physician specialty type:** Any one of the 21 specialty types listed in the table of assessed specialty types found on page four

2. **Group specialty type:** Any one of the 21 specialty types listed in the table of assessed specialty types found on page four. The provider group that is evaluated may include physicians with the same

specialty, or the provider group may be evaluated using one of the following mixed-specialty group designations, as applicable: multispecialty medical group (mixture of multiple non-PCP specialists), mixed specialty medical group (mixture of PCPs and non-PCP specialists), primary care medical group (mixture of PCP specialists)

3. **Specialty category:** Primary care specialties (family practice, internal medicine, and pediatrics), or non-primary care specialties (the 18 other specialties assessed for CCD)

We determine the extent to which an individual physician or provider group complies with EBM rules according to the following conventions:

Peer or market EBM rule adherence for each geographic market

- In order for an EBM rule to be included for review at the geographic market level for a physician or physician group, there must be at least 20 opportunities for the rule within the specialty category (primary care or non-primary care specialties) and market for the most recent two-year data review period. For 2019 displays, that period is January 1, 2016 through December 31, 2017.

- The average adherence rate for each EBM rule is calculated for the specialty category (primary care or non-primary care specialties) for each geographic market to derive the peer market-average result.

Individual physician or group practice EBM rule adherence

- Opportunities and successes for each eligible EBM rule are aligned to the appropriate individual physician (using the visit requirements outlined below and relevant specialty type category).

  Visit requirements: A physician is considered responsible for adherence to the EBM rule if the following conditions are met:
  - The EBM rule is relevant to the physician's specialty (see Appendix 3). For example, the cervical cancer screening EBM rule is relevant to OB/GYN, family practice, and internal medicine, but it is not relevant to other specialties.
  - There have been at least two office visit encounters for a patient with Cigna coverage during the claim review period.
  - At least one of the office visit encounters occurred in the last 12 months of the claim review period.

Note: 28 of our EBM measures require only one office visit encounter in the last 12 months of the claim review period. These measures are identified by an asterisk [*] in Appendix 3.

- Individual physicians are aligned to medical groups, and EBM rule opportunities, successes, and expected successes are then summed to obtain medical group totals.

- A **Quality Index** for the medical group is calculated by dividing the physician's or physician group's number of actual EBM rule adherence successes by their number of expected EBM rule-adherence successes. Expected EBM rule-adherence successes are derived by applying the geographic market-average EBM rule adherence-success rates to that physician medical group's particular rule mix opportunities.

- EBM (quality) measures are not risk adjusted because the EBM rules have explicit definitions for both the

numerator and the denominator of each measure. The denominator explicitly defines the population that is at risk; thus, risk adjustment is incorporated into the definition of the measure.

- A 90 percent confidence interval around the Quality Index is determined, allowing EBM quality performance to be measured with a strong degree of certainty. The lower bound of the 90 percent confidence interval for a particular physician or physician group is defined as the **Adjusted Quality Index** for that physician medical group.

- Physician groups that meet the Cigna group board-certification criteria have 30 or more total EBM rule-adherence opportunities. In addition, at least 50 percent of their treatment episodes (used in the physician's or medical group's cost-efficiency (ETG) analysis) are attributed to the physician specialty types that are assessed for EBM rule adherence, and are ranked using the Adjusted Quality Index score.

- Physicians or physician groups with an Adjusted Quality Index score in the top 34 percent of their medical group specialty type and geographic market are placed in the highest performance category for EBM rule adherence. They will have "Evidence Based Medicine Standards" displayed next to their names in the provider directory. Physicians or physician groups that have results in approximately the bottom 2.5 percent for the medical group specialty types in the market where there are at least 20 medical groups of that medical group specialty type in the market are placed in the bottom category. The remainder is in the middle category.

- A threshold is set for each market and for each medical group specialty type within a market. These thresholds are determined by specific market considerations such as geography, specialty volume, access to specialty care, and contract requirements. Thresholds range from approximately 30 percent to 70 percent. The use of threshold adjustments allows individual market factors to be taken into account. However, it is important to note that when such market-specific threshold adjustments are made, all other physician medical groups in that market with the same medical group specialty type that meets the revised market threshold value will then be deemed to have met the quality requirement for CCD.

Credit for utilizing Cigna Centers of Excellence

We evaluate hospital-stay outcomes and cost-efficiency information for Cigna customers through the Cigna Centers of Excellence (COE) program for all practices. Utilization of COEs by a reviewable physician practice provides credit towards the quality component of CCD. If a practice has at least one COE admission and a minimum Quality Index of 0.70 during the data analysis period, then a five percentage-point increase in the Quality Index will be granted. The increased Quality Index is then used to determine eligibility for CCD. COE admissions must be consistent with the specialty of the physician providing the COE-related care in order to qualify.

Cost-efficiency evaluation and displays

Participating providers are evaluated for their cost efficiency using an industry-standard methodology (i.e., episode treatment groups) that determines the average cost of treating an episode of care for a variety of medical conditions and surgical procedures. The episode costs are compared to other physicians and physician groups of the same specialty in the same geographical market. The results of this evaluation are displayed by using stars (★) in our online provider directory and myCigna.com, the secure website for Cigna customers.

Cost-efficiency stars communicate cost-efficiency results. Three stars for cost efficiency represent the top 34 percent of physicians or physician groups when compared to other physicians and physician groups of the same group specialty type within the geographic market. Two stars represent physicians or physician groups in the middle 33 percent for cost efficiency. Physician groups that are in the bottom 33 percent for cost efficiency receive one star. Providers who do not meet the volume criteria for the cost-efficiency assessment will have a message next to their name in the provider directory indicating that there was not enough claim volume to assess their cost efficiency.

Cost-efficiency symbols

★★★ Results in top 34 percent for cost efficiency
★★ Results in middle 33 percent for cost efficiency
★ Results in the bottom 33 percent for cost efficiency

Please see Appendix 2 for the geographical markets and volume of physicians reviewed for quality and cost-efficiency displays beginning January 1, 2019.

We use ETG methodology, an industry standard available through Optum, to evaluate the cost efficiency of individual physicians and medical groups. The methodology incorporates case-mix and severity adjustment, and claims are clustered into more than 500 different episodes of care. Additional information about the OptumInsight Episode Treatment Groups, including a complete listing of the ETGs, is available at etg.optum.com/etg-links/episode-treatment-groups/.

Using the ETG methodology, we can determine how a physician medical group's cost-efficiency compares to other physician medical groups of the same group specialty type (primary care physician group, single-specialty group, mixed specialty group, or multi-specialty group) in the same geographic market. For example, in the case of single-specialty primary care medical groups, the medical group's cost-efficiency performance is compared to the performance of other single-specialty primary care medical groups in the same market (i.e., family practice medical groups are compared to other family practice medical groups, internal medicine groups to internal medicine groups, and pediatric medical groups to pediatric medical groups). A physician or physician group's performance is a result of its fee schedule, utilization patterns and referral patterns (e.g., use of hospitals and other facilities).

ETG assessment requirements

- There must be at least 10 occurrences of a specific ETG (e.g., incorporating episode severity and treatment level, co-morbidity, complications, or the presence of pharmacy benefits) within the geographic market and specific physician specialty type in order to determine the market average cost for that ETG to include it in the market's analysis.

- The peer or market average for each specific ETG is established for each market and physician specialty type.

- To reduce variation within cost-efficiency results, several ETGs are excluded from the assessment process, including routine immunizations and other inoculations, transplants, and ETGs with low volume or wide cost variation. Episodes with a severity level of four (the highest severity level assigned by the OptumInsight ETG software) are also excluded from analysis, for most conditions.

Example: For the Nashville market during the data analysis period, 15 occurrences of ETG XX (with the same severity, treatment level, co-morbidity, complications, and presence of pharmacy benefits) are attributed to family physicians. The average cost of ETG XX for family physicians in the Nashville market is established by computing the numerical average of the cost of all 15 occurrences of this ETG subject to the application of outlier trimming methodology outlined in the following section. This process is replicated for each ETG with at least 10 occurrences in the Nashville market for a given physician specialty type in order to determine the market cost average for each ETG that is eligible for evaluation in the market.

ETG assessment process

- Individual physician medical groups must have at least 30 total episodes of care during the review period in order to be assessed for cost efficiency. In order for an episode to be attributed to a physician (responsible physician), two criteria must be met:

    1. The physician must be responsible for more costs for medical or surgical management services than any other physician providing care for the episode, and
    2. the medical or surgical management costs for the physician must be at least 30 percent of the total episode medical or surgical management costs.

  If these two criteria are *not* met, the episode is excluded from analysis. While only the costs associated with physicians' provision of management services are used to attribute the episode to a particular physician, total costs (physician management costs + all ancillary costs (e.g., lab, X-ray, hospital, ambulatory surgery, and physical therapy) are used to characterize the total cost of the episode.

- The actual cost of an episode of care for each physician group and for the physicians within that group is compared to the market average cost of an episode of care, which is derived using their unique mix of ETGs and the peer averages.

- The sum of all actual ETG episode costs for a medical group divided by the sum of all corresponding ETG episode market-average costs is the physician group's **Performance Index**.

  Example: The ABC Physician Group consisting of three family physicians in the Nashville market has five episodes of care belonging to two unique ETGs (ETG1 and ETG2) that are attributable to the group. For simplicity, disregard the requirement that the physician or physician group must have a minimum of 30 attributable episodes in order to be reviewed for cost efficiency. Average episode costs for ETG1 and ETG2 have been established for all other primary care physicians or groups practicing in the Nashville market. Three episodes of ETG1 are attributable to the ABC Physician Group and two episodes of ETG2 are attributable to the ABC Physician Group.

In the table below, the physician group's cost per episode is displayed for each of the three occurrences of ETG1 and for each of the two occurrences of ETG2, along with the market average cost for an episode for ETG1 and ETG2 for all family physicians in the Nashville market.

	Actual episode cost	Market average cost
ETG 1	2,000	3,500
ETG 1	1,000	3,500
ETG 1	4,000	3,500
ETG 2	15,000	19,000
ETG 2	18,000	19,000
Average	8,000	9,700

Performance Index = 8,000/9,700 = 0.825

Dividing the average cost of all episodes of care attributable to the physician group by the average of all market-average episode costs for the ETGs on which the physician group's cost-efficiency performance is being evaluated yields a Performance Index (PI) of 0.825. The PI for the physician group can be interpreted as Medical Group ABC is 17.5 percent more cost efficient than other family medicine physician groups in the Nashville market.

- A 90 percent confidence interval around the PI is used to determine a range of performance within which the medical group's true performance would fall with a high level of confidence. The upper bound of the confidence interval is defined as the Adjusted Performance Index and is used to compare cost-efficiency performance among physician medical groups. The upper bound of the 90 percent confidence interval is used to ensure that the physician group's performance is at least as good as, or better than the upper bound threshold.

- A threshold is set for each market and for each medical group specialty type within a market. These thresholds are determined by specific market considerations such as geography, specialty volume, access to specialty care, and contract requirements. Thresholds range from approximately 30 percent to 70 percent. The use of threshold adjustments allows individual market factors to be taken into account. However, it is important to note that when such market-specific threshold adjustments are made, all other physician medical groups in that market with the same medical group specialty type that meets the revised market threshold value will then be deemed to have met the quality requirement for CCD.

2019 Outlier methodology

In order to portray physicians' cost-efficiency performance in the most accurate manner, the cost-efficiency evaluation includes a methodology to account for outlier episodes. Outlier episodes are substantially different from the market expected amounts. High cost episodes (ETGs) that are greater than 1.5 times the market specialty averages are reduced to 1.5 times the market specialty average. Low cost outlier episodes are determined by the Optum software, or are episodes of less than $25 and are excluded from the evaluation.

THN-2018-338. © 2018 Cigna. Some content provided under license.

Level of evaluation (unit of analysis)

While we review participating physicians at the individual level, the majority of the assessments are performed at the physician group or practice, or group TIN level. Individual physicians who are not part of a group are assessed if volume criteria are met. This approach provides robust data for evaluation and is consistent with the assumption that:

- Patients with Cigna coverage often chose a group rather than a specific physician within the group, and;
- Patients with Cigna coverage who initially choose a specific physician frequently receive care by another physician within the practice or group.

Cigna Care Designation inclusion methodology

In 2019, physicians who meet our specific quality and cost-efficiency criteria, can receive Cigna Care Designation for a given specialty and will receive the symbol next to their name in our online provider directory tools. CCD may also be utilized as part of a tiered benefit plan option (e.g., Cigna Care Network). Additional information on Cigna products and benefit plans is available on the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Medical Resources > Medical Plans and Products).

How providers are evaluated for CCD

Cigna evaluates whether the physician or group has achieved certain quality and cost-efficiency results, which are detailed more fully below. If the physician or group achieves those results, then the physician or group may be assigned CCD.

Participating physicians may receive the designation if the physician or physician group:

- Is located in one of the 74 markets that currently participate in this program
- Practices in one of the 21 assessed specialties
- Meets Cigna group board certification criteria
- Has a minimum volume of 30 complete episode treatment group occurrences
- Group performance in the top 40% for quality OR have 50% of physicians in the practice achieve NCQA recognition **AND** meet the cost-efficiency criteria of being in the top 40% **with** the groups Adjusted Performance Index (API) less than or equal to 1.03.
- Group performance in the top 34% for quality OR have 50% of physicians in the practice achieve NCQA recognition **AND** have less than 30 ETG episodes (with no cost ranking).
- Group performs in the top 34% for cost **with** the groups Adjusted Performance Index (API) less than or equal to 1.03 **AND** are either between 2.5% and 66% for quality or have less than 30 EBM opportunities (with no quality ranking).

We inform our customers that a CCD for a physician or group should not be the sole basis for their decision-making because our review for cost-efficiency and quality reflects only a partial assessment of quality and cost-efficiency. There could be a risk of error in the data used to perform the review, and inclusion of a physician as CCD does not mean that the physician offers equal or greater quality and cost efficiency than other participating providers. We encourage our customers to consider all relevant factors when choosing a primary care physician or specialist for their care, and to speak with their treating physician when selecting a specialist.

THN-2018-338. © 2018 Cigna. Some content provided under license.

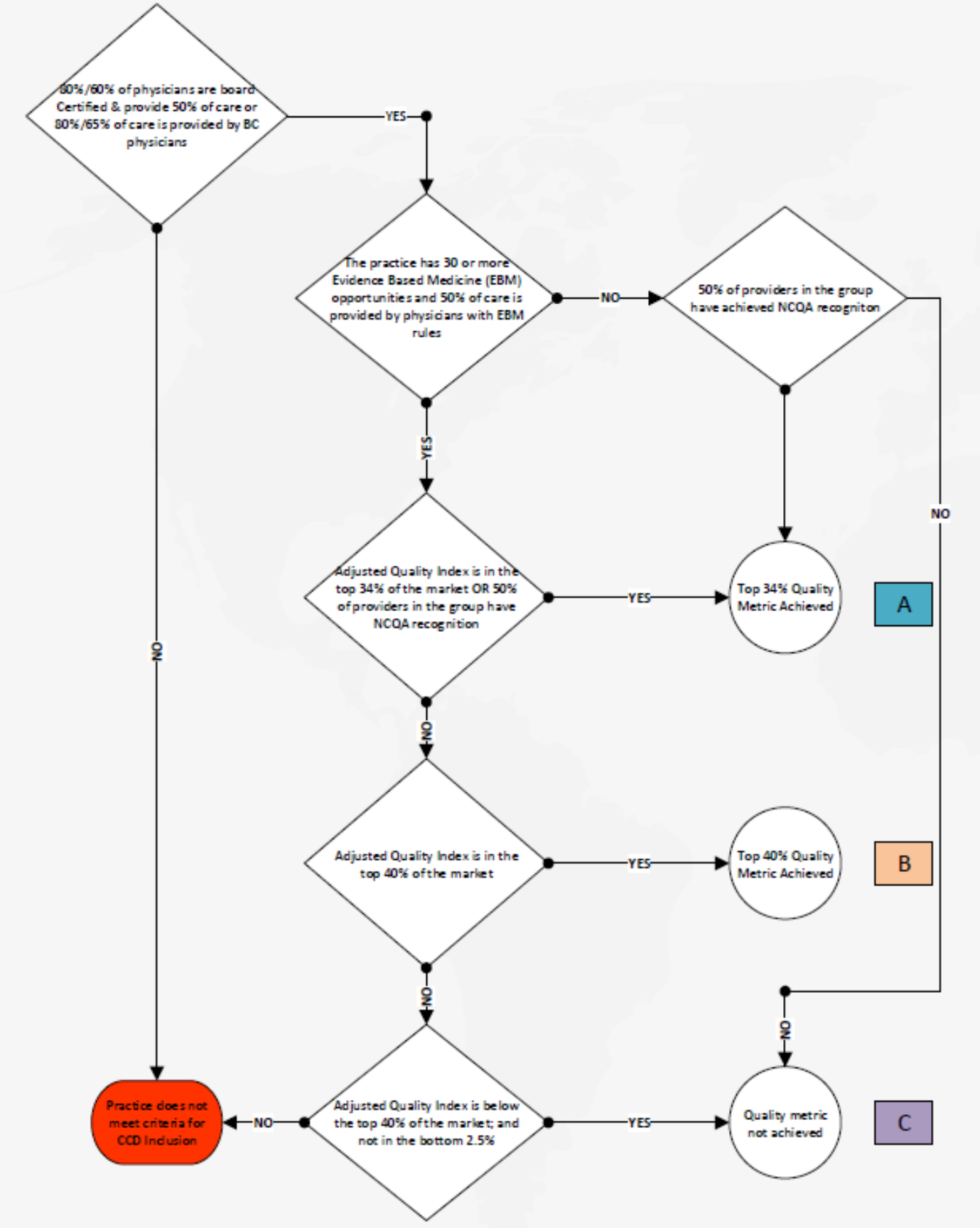
Buffer zone methodology

Variation in physician group or physician group performance (e.g., positive or negative, substantial, or minimal), is inevitable and expected in an annual review process due to various factors (e.g., changes to physician group makeup, external market factors, and practice pattern modifications). A “buffer zone” methodology addresses small-scale variation for physicians or physician groups whose CCD status changes from the previous review cycle. A practice may maintain its designation status if the group is within 3 percent of the current year's quality *and* cost criteria, *or* is within 3 percent of the cost index when the group does not meet cost and quality criteria.

The selected physician group must meet certain criteria to achieve the 2019 buffer zone designation. The standard criterion applied includes:

- meeting the physician group board certification criteria,
- the board-certified physicians must be responsible for at least 50 percent of the group episodes,
- the group must have at least 30 episodes, and
- the group must *not* be in the bottom 2.5 market percentile for EBM quality performance, in a market with greater than 20 groups within the specialty category in the market.

2019 Cigna Care Designation inclusion algorithm (Quality assessment)



2019 Cigna Care Designation inclusion algorithm (Cost assessment)

Cigna Collaborative Care pathway to achieve Cigna Care Designation

We collaborate with selected physician groups to help them achieve the triple aim of improving quality, cost efficiency, and the patient care experience. The Cigna Collaborative Care® (CCC), a value-based care approach, leverages the foundation of accountable care organizations (ACOs) and patient centered medical home (PCMH) models by recognizing physicians affiliated with a CCC that demonstrate improvement in medical delivery and clinical outcomes, and achieve improvement in reducing the cost of care.

Cigna's value-based care model is designed for collaboration with physician groups that may include PCPs only, a mix of PCPs and specialists, or specialists only. The groups enter into a contract with Cigna in which they agree to be evaluated based on quality and cost criteria that are unique to the CCC model.

Physicians and physician groups are first assessed by applying the standard CCD pathway to determine inclusion. If the physicians and physician groups are unable to achieve designation through the standard CCD pathway, but they are affiliated with a CCC group, then a CCC pathway inclusion criteria may be applied next to determine if they can be designated.

CCC primary care groups achieving a Total Medical Cost Performance Index of less than or equal to 1.03 *and* a CCC Quality Index of greater than or equal to 0.99, will be assigned CCD. Specialists that did not meet the standard CCD criteria, but are affiliated with a CCC primary care group that meets the alternate CCD pathway criteria for inclusion may be assigned CCD.

To be considered for CCD inclusion, CCC physicians must be MDs and/or DOs in one of three primary care specialties or one of 18 non-primary care specialties (see the Assessed specialty types table on page four).

Note: We perform evaluations at the group level. Some groups include geriatric physicians, nurse practitioners, and physician assistants who deliver primary care services as part of the group. In such cases, geriatric physicians, nurse practitioners, and physician assistants will be considered for CCD as part of the group.

Primary care quality assessment

The CCC group must have at least 20 evidence-based medicine (EBM) opportunities during the data collection period. A Quality Index is calculated for each CCC group based on adherence to EBM measures. If the CCC group’s Quality Index is 0.99 or better, the quality requirement is met. The Quality Index is calculated based on adherence to Evidence Based Medicine (EBM) standards. The EBM rules for CCC groups can vary from the core set utilized by CCD based on each individual CCC group agreement.

Primary care cost-efficiency assessment

Total medical cost (TMC) is used to evaluate cost-efficiency for primary care CCC group arrangements. To calculate the TMC index for CCC primary care groups, aligned patients and practitioners are identified. A per patient per month (PPPM) score is calculated and risk adjusted. The final risk adjusted PPPM score is divided by the market PPPM score to create the TMC cost index. The TMC cost index reflects all medical costs for Cigna customers who are aligned to PCPs in the CCC agreement, excluding pharmacy and non-PCP behavioral health costs. If the group's TMC Performance Index is 1.03 or less, the practice meets the pathway cost requirement.

Buffer zone methodology

Variation in CCC group performance (e.g., positive or negative, substantial, or minimal) is inevitable and expected in an annual review process due to various factors (e.g., changes to physician group makeup, external market factors, and practice pattern modifications). A “buffer zone” (grandfathering) methodology addresses variation for physician groups or physician groups whose CCD status changes from the previous review cycle. A CCC group may maintain its CCD status if the CCC group was “in” during the prior cycle**.**

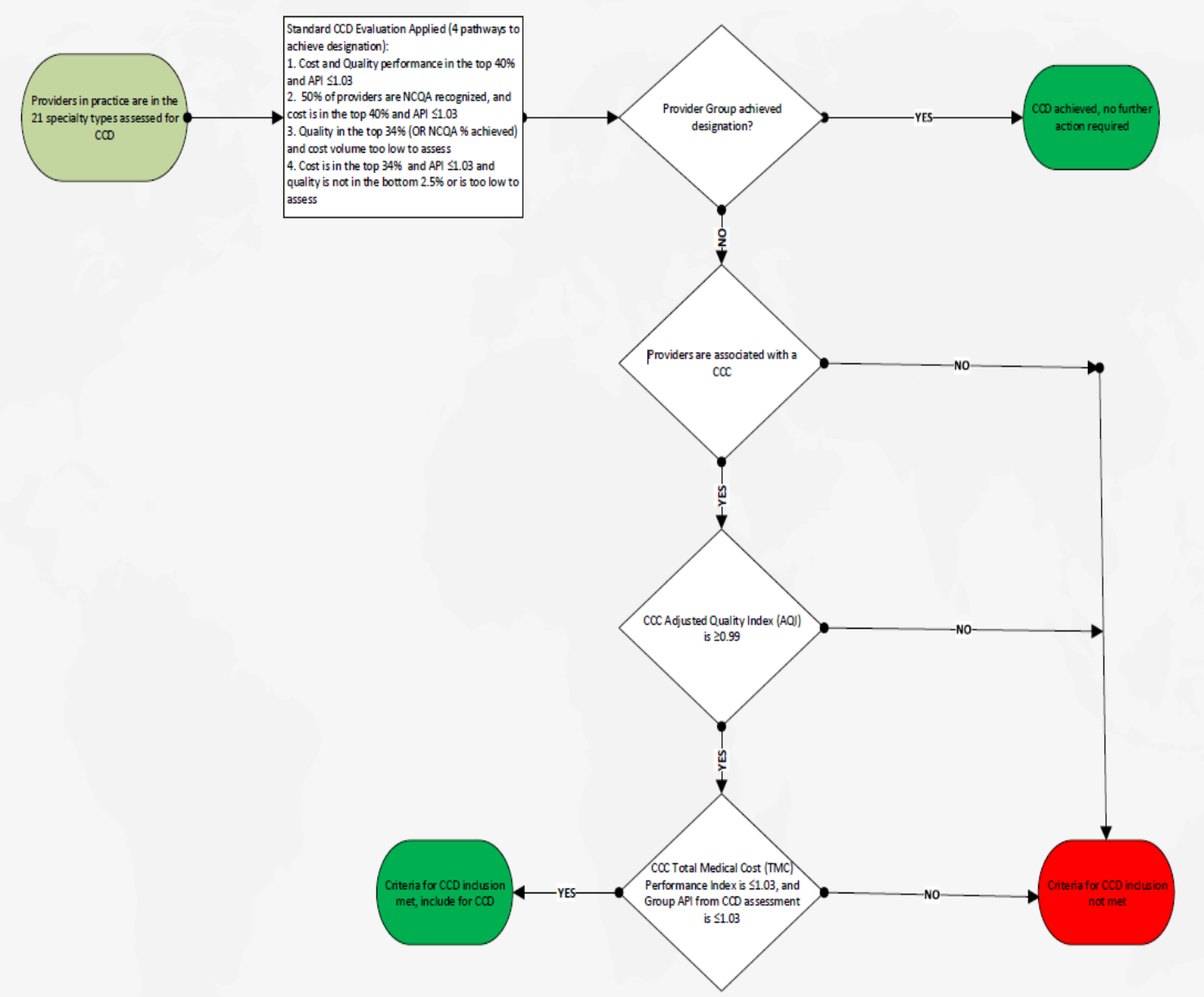
Note: Individual markets may adjust the grandfathering criteria for CCC groups at the market level, in order to exclude from grandfathering those CCC groups with large-scale variation in results from the prior year. Adjustments are made at the market level and are applied to all CCC groups in the market.

Cigna Collaborative Care review process

The evaluation methodology is applied annually (and quarterly as needed) to all existing and new CCC groups.

- CCC groups that do not meet criteria can be re-evaluated using quarterly data, through our reconsideration process. If the quality and performance indexes improve, and are meeting the market criteria for inclusion during two consecutive quarters, the CCC group will be given CCD status.
- Since CCC groups can earn CCD status on a quarterly basis, we reserve the right to remove the CCD status if the CCC group demonstrates significant decline in performance below the required criteria in four consecutive quarters, or if the CCC group discontinues its collaborative agreement with us and does not meet the standard CCD criteria.
- A re-evaluation occurs with each refresh where grandfathering may be applied. As noted previously, individual markets may adjust the grandfathering criteria at the market level. When adjustments are made at the market level, they are applied to all CCC groups in the market.

2019 Cigna Collaborative Care to Cigna Care Designation Algorithm



Data sources

The following table outlines the evaluation data sources, and how they are used:

Data source	How information is used
Cigna Physician Metrics (January 2016 – December 2017) Use combined Cigna managed care and PPO product data with episodes of care or EBM rules attributed to the responsible physician.	The data is used to produce ETG efficiency and EBM summary reports. Note: Data for Medicare-eligible individuals is removed.
Cigna Central Physician File (CPF) (as of April 2018)	File extracts to identify contracted physicians, TIN, groups, specialty, board certification status, network, and products contracted.
Physician Recognition Program File obtained from the National Committee for Quality Assurance (NCQA) (as of April 2018, and at least six times per year)	The status of physicians recognized for the diabetes, heart/stroke, physician practice connections, and patient-centered medical home, or patient-centered specialty practice recognition programs is updated based on information received from NCQA. Percent of physicians recognized in an NCQA program for a group is calculated based on the recognition and group alignment.
Cigna utilization and COE data	Specialty groups that admit to COE facilities (based on utilization data) will receive credit towards the quality component evaluation for CCD inclusion.

Additional information and data limitations

The quality and cost-efficiency displays are a partial assessment of quality and cost-efficiency, and are intended to provide information that can assist Cigna customers in health care decision-making. Cigna customers are encouraged to consider all relevant information and to consult with their treating physician in selecting a physician for care.

While we use the best available information to create an objective assessment methodology, there are some limitations:

- The EBM and cost-efficiency information is based on our claim data only. Aggregated claim data from multiple payers (e.g., insurance companies, self-insured plans, and government plans) may provide a more complete picture of physician performance. We support data aggregation initiatives, and will consider using it in evaluations when credible data are available.
- We can only use received claim data in evaluations. There may be health care services performed for which no information is provided to us.
- Specific service line item detail may not always be available due to the way claims may be submitted by physicians or processed by us.
- Pharmacy data inclusion is limited to customers covered by a Cigna-administered pharmacy benefit plan.
- We use ETGs), an industry standard grouper, to risk-adjust for patient severity. Although ETG

software is recognized as a leading risk adjustment model, perfect patient severity-risk adjustment does not exist.

- Many physicians or physician groups are unable to be displayed for quality and cost-efficiency due to small patient populations. We will not display results for those physicians or physician groups whose episodes or opportunities sample do not meet certain volume thresholds.

Process to display strategic alliances information

Health Alliance Plan (HAP)

Physicians or physician groups in the Eastern Michigan area (Genesee, Oakland, Lapeer, St. Clair, Livingston, Washtenaw, Macomb, Wayne, and Monroe counties) have been evaluated and designated through information received from Health Alliance Plan. In 2016, Cigna took on the role of evaluating these physicians using the same quality and cost methodology utilized in all other CCD markets, as described in this whitepaper. The assessment review period for 2019 CCD inclusion is January 1, 2016 through December 31, 2017. Physicians who meet our specific quality and cost-efficiency criteria will receive CCD status.

Specific market activities

California Integrated Healthcare Association assessment: Pay for performance

- Cigna HealthCare of California participates in a statewide initiative coordinated by the Integrated Healthcare Association (IHA) to measure and improve clinical quality, patient experience, use of information technology, and public reporting of physician performance results.
- We pay incentive payments to physician organizations based upon performance against standard quality measures.
- The common set of key measures used for assessment relies on national standards or EBM practices.
- The measure set, audit manual, and data-submission file layouts are released each year by IHA.
- More information about the program and the assessment results is available on the www.IHA.org website.

Feedback process

We welcome and encourage participating physicians, customers, and employers to provide feedback and suggestions for how we can improve the reports, as well as other suggested program improvements. Employees and patients with Cigna-administered plans should call the telephone number listed on the back of their Cigna ID card, or access the Feedback button available online at myCigna.com. Participating physicians can also provide feedback online by accessing the Feedback button on Cigna.com, or call Cigna Customer Service at 1.800.88Cigna (1.800.882.4462). Feedback and suggestions are reviewed, and changes to the physician evaluation methodology, reporting formats, and processes are implemented as appropriate. Methodology changes are generally reviewed and implemented on an annual basis.

THN-2018-338. © 2018 Cigna. Some content provided under license.

Physician process to correct errors or request reconsideration

Participating physicians or physician groups have a right to seek correction of errors, and request data review of their quality and cost-efficiency displays.

To do so, send an email to PhysicianEvaluationInformationRequest@Cigna.com, or fax to 1.866.448.5506 to request additional information, for detail reports, to request reconsideration of your quality and cost-efficiency displays, to correct inaccuracies, or to submit additional information. The request for reconsideration must include the reason and any documentation you wish to provide in support of the request. If the group meets the criteria for CCD inclusion upon reconsideration, the provider will be displayed with the  symbol next to their name in our online provider display tools.

The National Selection Review Committee process is initiated within five business days of our receipt of a reconsideration request. A Cigna Network Clinical Manager (NCM) or Network Clinical Specialist (NCS) will contact the physician practice or physician group to clarify information received for reconsideration and generate detail reports. The NCM or NCS may change the physician group designation if the obtained information meets inclusion criteria. These may include, but are not limited to a verification of board certification; a revision to the Evidence Based Medicine (EBM) adherence score; or a verification of completion of one or more NCQA physician recognition programs. The National Selection Review Committee will review the request if the obtained information does not meet inclusion criteria.

The National Selection Review Committee participants include Cigna physicians and Cigna network clinical performance staff. Voting committee participants include the National Medical Director and physician representatives from the three Cigna regions, their alternates, and ad hoc physicians. Non-voting participants include the Assistant Vice President of Provider Measurement and Performance, National Network Business Project Senior Analyst, Health Data Senior Specialist, Marketing Product Senior Specialist, Network Product Integration Leads, Network Clinical Managers and Network Clinical Specialists.

The National Selection Review Committee determination may include changing the designation, upholding the original designation, or pending the determination for additional information. Notification of the decision is sent to the physician group after the committee determination is made. The National Selection Review Committee process and final decision is complete within 45 days of receipt of a reconsideration request.

Colorado providers should refer to Appendix 4 on pages 38-39 for Colorado specific reconsiderations.

How to register complaints

At any time, Cigna customers may register a complaint with us about the quality, cost efficiency, and CCD displays by calling the telephone number located on the back of their Cigna ID card.

Registering a complaint for Cigna customers in New York

The NCQA is an independent not-for-profit organization that uses standards, clinical-performance measures, and member satisfaction to evaluate the quality of health plans. It serves as an independent ratings examiner for Cigna Life and Health Insurance Company, Connecticut General Life Insurance Company, and Cigna HealthCare of New York, Inc., reviewing how CCD, and quality and cost-efficiency displays meet criteria required by the State of New York.

Complaints about the quality, cost efficiency, and CCD displays in New York may be registered with NCQA, in addition to registering with Cigna, by submitting them in writing to customer support at www.ncqa.org or to NCQA Customer Support, 1100 13th Street, NW, Suite 1000, Washington, DC 20005.

2019 Physician evaluation methodology changes

Changes to our 2019 physician evaluation methodology are outlined below:

Methodology item	2019 change or enhancement	Details and rationale
Change in the number of diseases covered in the EBM rules	There are 91 rules covering 43 disease and preventive care conditions.	The EBM rule set was changed to align more closely with national standards.
NCQA Recognition Programs	The NCQA Physician Practice Connections Recognition Program (PPC) was removed.	NCQA retired the Physician Practice Connections Recognition Program (PPC)
Cigna Care Designation (CCD)	Appling a 1.03 cut point for API as a last step for cost inclusion	Normalizes inclusion criteria and helps to distribute the percentage of providers evenly in CCD markets
Cigna Care Designation (CCD)	Allow grandfathering at the default thresholds (40% and 34%) only	
Reconsideration requests for quality and cost-efficiency displays	Provider groups can request reconsideration for quality and or cost efficiency. If upon reconsideration the group meets the CCD criteria, they will be included as CCD.	

Appendices

Appendix 1: 2019 Cigna Care Designation market information

Market Name	Volume Reviewed	Percent Designated	Percent Not Designated
AR Arkansas	5618	10.73	89.27
AZ Maricopa	9141	39.22	60.78
AZ All Other	1877	12.47	87.53
AZ Pima	2601	30.41	69.59
CA North	2167	16.34	83.66
CA South	32069	21.03	78.97
CA Bay Area	13036	50.58	49.42
CA Sacramento	3310	36.37	63.63
CA Central Valley	3393	34.98	65.02
CO Front Range	10596	26.58	73.42
CT Connecticut	10076	52.86	47.14
DE Delaware	2509	10.96	89.04
FL Jacksonville	3085	18.02	81.98
FL All Other	5109	18.65	81.35
FL South Florida	10984	29.41	70.59
FL Orlando	6283	32.77	67.23
FL Tampa	10929	34.38	65.62
GA Atlanta	9374	55.78	44.22
GA All Other	4814	38.95	61.05
IL Chicago Metro	18040	58.36	41.64
IL Rockford	3127	14.23	85.77
IN Indianapolis	4764	31.76	68.24
KS KS/MO Kansas City	4947	21.22	78.78
LA All Other	2780	15.68	84.32
LA Baton Rouge	2997	19.92	80.08
LA New Orleans	3085	19.71	80.29
MA Western	4896	30.78	69.22
MA Boston	20287	32.98	67.02
MD Maryland	12209	51.22	48.78
MD Northern VA	5836	29.59	70.41
DC Metro North	6707	50.81	49.19
ME Maine	4070	38.48	61.52
MI Michigan	18358	17.62	82.38
MS Mississippi	5410	20.54	79.46
NC Charlotte	4573	30.81	69.19
NC East	4285	15.92	84.08
NC Raleigh	5232	31.94	68.06
NC Triad	3774	39.35	60.65
NC West	2825	18.76	81.24
NH New Hampshire	4343	33.46	66.54

Market Name	Volume Reviewed	Percent Designated	Percent Not Designated
NJ North Jersey	11423	32.05	67.95
NJ South Jersey	4837	17.43	82.57
NV Nevada	4285	24.95	75.05
NY Metro	30913	28.80	71.20
OH Northern	11755	22.01	77.99
OH Central	8127	72.76	27.24
OH Southern	7911	34.98	65.02
OH NW Ohio	3028	35.14	64.86
OR Oregon	10978	18.69	81.31
PA Philadelphia	11979	33.96	66.04
PA All Other	13259	21.38	78.62
PA Pittsburgh/Western	7583	64.76	35.24
RI Rhode Island	3379	22.67	77.33
SC Low Country	3241	20.98	79.02
SC Midlands	2592	26.16	73.84
SC Upstate	3590	14.68	85.32
TN West	3828	34.09	65.91
TN Central	6759	31.20	68.80
TN East	7088	26.27	73.73
TX Austin	4479	31.48	68.52
TX Dallas/Ft. Worth	10899	39.60	60.40
TX Houston	12431	26.04	73.96
TX San Antonio	3595	16.11	83.89
TX East Central Texas	2833	18.96	81.04
UT Wasatch Front	4611	24.46	75.54
VA Hampton Roads	3552	31.39	68.61
VA Richmond	3205	32.57	67.43
VA Western	3922	36.16	63.84
VT Vermont	2053	24.26	75.74
WA Seattle	11816	39.67	60.33
WA All Other	5653	16.24	83.76
WI Milwaukee/Green Bay	8503	41.49	58.51
WI All Other	4587	53.24	46.76
WV West Virginia	4687	18.75	81.25

THN-2018-338. © 2018 Cigna. Some content provided under license.

Appendix 2: 2019 Quality and cost-efficiency display markets

* *Indicates markets where physicians are assessed for quality and cost-efficiency display only*

Market name	Specialists reviewed
AL Alabama *	7224
AR Arkansas	5618
AZ Maricopa	9141
AZ All Other	1877
AZ Pima	2601
CA North	2167
CA South	32069
CA Bay Area	13036
CA Sacramento	3310
CA Central Valley	3393
CO All Other *	2214
CO Front Range	10596
CT Connecticut	10076
DE Delaware	2509
FL Jacksonville	3085
FL All Other	5109
FL South Florida	10984
FL Orlando	6283
FL Tampa	10929
GA Atlanta	9374
GA All Other	4814
IL Chicago Metro	18040
IL All Other *	6195
IL Rockford	3127
IN Indianapolis	4764
IN All Other *	6178
KS KS/MO All Other *	5302
KS KS/MO Kansas City	4947
KY Kentucky *	9548
LA All Other	2780
LA Baton Rouge	2997
LA New Orleans	3085
MA Western	4896
MA Boston	20287
MD Maryland	12209
MD Northern VA	5836
DC Metro North	6707
ME Maine	4070
MI Michigan	18358
MS Mississippi	5410
NC Charlotte	4573
NC East	4285

Market name	Specialists reviewed
NC Raleigh	5232
NC Triad	3774
NC West	2825
NH New Hampshire	4343
NJ North Jersey	11423
NJ South Jersey	4837
NV Nevada	4285
NY Metro	30913
NY All Other *	18303
OH Northern	11755
OH Central	8127
OH Southern	7911
OH NW Ohio	3028
OK Oklahoma *	5713
OR Oregon	10978
PA Philadelphia	11979
PA All Other	13259
PA Pittsburgh/Western	7583
RI Rhode Island	3379
SC Low Country	3241
SC Midlands	2592
SC Upstate	3590
TN West	3828
TN Central	6759
TN East	7088
TX Austin	4479
TX Dallas/Ft. Worth	10899
TX Houston	12431
TX San Antonio	3595
TX East Central Texas	2833
UT Wasatch Front	4611
VA Hampton Roads	3552
VA Richmond	3205
VA Western	3922
VT Vermont	2053
WA Seattle	11816
WA All Other	5653
WI Milwaukee/ Green Bay	8503
WI All Other	4587
WV West Virginia	4687

THN-2018-338. © 2018 Cigna. Some content provided under license.

Appendix 3: EBM rules used for the 2019 physician evaluation

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Attention-deficit/hyperactivity disorder (ADHD), follow-up care for children prescribed ADHD medication (National standard)	Patient(s) with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a prescribing provider during the 30 days after the initial ADHD prescription	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	NA	Family practice Pediatrics
ADHD, follow-up care for children prescribed ADHD medication (National standard)	Patient(s) with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a prescribing provider during the 30 days after the initial ADHD prescription, AND two follow-up visits during the 31 days through 300 days after the initial ADHD prescription	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	NA	Family practice Pediatrics
Adolescent well-care visits (National standard)*	Patient(s) 12-21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN in the last 12 reported months	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Adult access to preventive/ambulatory health services * (National standard)	Patient(s) 20-44 years of age that had a preventive or ambulatory care visit during the last 12 months of the report period	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Internal medicine
Adult access to preventive/ambulatory health services * (National standard)	Patient(s) 45-64 years of age that had a preventive or ambulatory care visit during the last 12 months of the report period	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Internal medicine
Alcohol and other drug dependence (National standard)	Patient(s) 13 years and older with an ED visit for alcohol and other drug dependence that had a follow-up visit within 30 days	National Committee for Quality Assurance (NCQA)	N/A	Family practice Internal medicine Pediatrics
Antidepressant medication management (National standard)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 weeks (effective acute phase treatment)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Obstetrics and gynecology	Family practice Internal medicine

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Antidepressant medication management (National standard)	Patient(s) with a major depression who start an antidepressant medication that remained on treatment for at least six months (effective continuation phase treatment)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Obstetrics and gynecology	Family practice Internal medicine
Atrial fibrillation	Patient(s) taking warfarin that had three or more prothrombin time tests in last six reported months	American College of Cardiology/ American Heart Association/Europe and Society of Cardiology(ACC/AHA/ESC)	Cardiology Cardiothoracic surgery Pulmonology	Family practice Internal medicine
Atrial fibrillation anticoagulation (National standard)	Patient(s) 18 years of age or older with atrial fibrillation or atrial flutter who had warfarin or another oral anticoagulant prescribed during the report period. (Performance measure)	Centers for Medicare and Medicaid Services (CMS) National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Cardiology Cardiothoracic surgery Pulmonology	Family practice Internal medicine
Beta-blocker treatment after a heart attack (National standard)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Cardiology Cardiothoracic surgery	Family practice Internal medicine
Breast cancer - part 1	Patient(s) that had an annual physician visit	National Committee for Quality Assurance (NCQA) Optum /American Cancer Society (ACS)/American Society of Clinical Oncology (ASCO)	Hematology and oncology Obstetrics and gynecology	Family practice Internal medicine
Breast cancer - part 2	Patient(s) newly diagnosed with breast cancer that received radiation, chemotherapy, or hormonal treatment or had medical oncology or radiation oncology consultation within 120 days of the diagnostic procedure	National Committee for Quality Assurance (NCQA) Optum/American Cancer Society (ACS)/American Society of Clinical Oncology (ASCO)	Hematology and oncology Obstetrics and gynecology	Family practice Internal medicine
Breast cancer screening (National standard*)	Patient(s) 52-74 years of age that had a screening mammogram in last 27 reported months	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Obstetrics and gynecology	Family practice Internal medicine
Bronchitis, acute, avoidance of antibiotic treatment*++	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Allergy and immunology Obstetrics and gynecology	Family practice Internal medicine

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
			Otolaryngology Pulmonology	
Cardiac surgery	Patient(s) 18 years of age and older hospitalized for an isolated CABG procedure taking a beta-blocker at admission or within seven days of discharge	American College of Cardiology/ American Heart Association (ACC-AHA) Optum	Cardiology Cardiothoracic surgery	Family practice Internal medicine
Cardiac surgery	Patient(s) 18 years of age and older hospitalized for an isolated CABG procedure taking a statin medication at admission or within seven days of discharge	American College of Cardiology/ American Heart Association (ACC-AHA) Optum	Cardiology Cardiothoracic surgery	Family practice Internal medicine
Cardiac surgery	Patient(s) 18 years of age and older hospitalized for an isolated CABG procedure that have no evidence of a CVA during the hospitalization or within seven days of discharge	American College of Cardiology/ American Heart Association (ACC-AHA) Optum	Cardiology Cardiothoracic surgery	Family practice Internal medicine
Cerebral vascular accident & Transient cerebral ischemia	Patient(s) taking warfarin that had three or more prothrombin time tests in last six reported months	American College of Cardiology/ American Heart Association (ACC-AHA) Optum	Cardiology Neurology	Family practice Internal medicine
Cerebral vascular accident & Transient cerebral ischemia	Patient(s) with a recent emergency room encounter for a transient cerebral ischemic event that had any physician visit within 14 days of the acute event	Optum /AMA-PCPI similar	Cardiology Neurology	Family practice Internal medicine
Cervical cancer screening (National standard)*	Women that had appropriate screening for cervical cancer (Commercial enrollment)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Obstetrics and gynecology	Family practice Internal medicine
Children and adolescent access to primary care* (National standard)	Patient(s) 12-19 years of age, that had a PCP visit during the 24-month report period	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Pediatrics
Children and adolescent access to primary care* (National standard)	Patient(s) seven to 11 years of age that had a PCP visit during the 24 month report period	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Pediatrics
Children and adolescent access to primary care* (National standard)	Patient(s) 12-24 months of age that had a PCP visit during the 12 months prior to the end of the report period	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Pediatrics

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Children and adolescent access to primary care* (National standard)	Patient(s) 25 months to six years of age that had a PCP visit during the 12 months prior to the end of the report period	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Pediatrics
Chlamydia screening (National standard)*	Patient(s) 16-20 years of age that had a chlamydia-screening test in last 12 reported months.	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Chlamydia screening (National standard)*	Patient(s) 21-24 years of age that had a chlamydia-screening test in last 12 reported months.	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Chronic kidney disease	Patient(s) with stage 5 or end stage renal disease that had a serum calcium in last 12 reported months	National Quality Forum (NQF) Similar Optum: Kidney Disease: Improving Global Outcomes (KDIGO) CKD-MBD Work Group	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
Chronic kidney disease	Patient(s) with stage 5 or end stage renal disease that had a serum phosphorus in last 12 reported months	National Quality Forum (NQF) Similar Optum: Kidney Disease: Improving Global Outcomes (KDIGO) CKD-MBD Work Group	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
Chronic kidney disease	Patient(s) with stage 5 or end stage renal disease that had a serum PTH test in last 12 reported months	National Quality Forum (NQF) Similar Optum: Kidney Disease: Improving Global Outcomes (KDIGO) CKD-MBD Work Group	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
Chronic kidney disease	Patient(s) with proteinuria currently taking an ACE-inhibitor or angiotensin II receptor antagonist	National Quality Forum (NQF) Similar Optum: Kidney Disease: Improving Global Outcomes (KDIGO) CKD-MBD Work Group	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
Congestive heart failure	Patient(s) currently taking a beta-blocker specifically recommended for CHF management	American College of Cardiology (ACC) American Heart Association (AHA) 2013	NA	Family practice Internal medicine
COPD exacerbation, pharmacotherapy management (National standard)	Patient(s) 40 years of age and older with COPD exacerbation that received a systemic corticosteroid within 14 days of the hospital or ED discharge	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Pulmonology	Family practice Internal medicine
COPD exacerbation, pharmacotherapy management (National standard)	Patient(s) 40 years of age and older with COPD exacerbation that received a bronchodilator within 30 days of the hospital or ED discharge	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Pulmonology	Family practice Internal medicine

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Coronary artery disease	Patient(s) currently taking an ACE-inhibitor or angiotensin receptor blocker (ARB)	American College of Cardiology Foundation (ACC) American Heart Association (AHA) National Quality Forum (NQF) Similar Optum	Cardiology Cardiothoracic surgery	Family practice Internal medicine
Coronary artery disease	Patient(s) currently taking a statin	American College of Cardiology Foundation (ACC) American Heart Association (AHA) Optum	Cardiology Cardiothoracic surgery	Family practice Internal medicine
Diabetes	Adult(s) that had a serum creatinine in last 12 reported months	American Diabetes Association (ADA) National Quality Forum (NQF) Similar Optum	Cardiology Endocrinology Nephrology Neurology Obstetrics and gynecology Cardiothoracic surgery	Family practice Internal medicine Pediatrics
Diabetes	Patient(s) that did not have a diabetes related hospitalization in last 12 reported months	Optum	Cardiology Endocrinology Nephrology Neurology Obstetrics and gynecology Cardiothoracic surgery	Family practice Internal medicine Pediatrics
Diabetes care (National standard)	Patient(s) 18-75 years of age that had a HbA1c test in last 12 reported months	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Endocrinology Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Diabetes care (National standard)	Patient(s) 18-75 years of age that had an annual screening test for diabetic retinopathy	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Endocrinology Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Diabetes care (National standard)	Patient(s) 18-75 years of age that had annual screening for nephropathy or evidence of nephropathy	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Endocrinology Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Diabetes care (National standard)	Patient(s) 18-75 years of age with lab results that have evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Endocrinology Obstetrics and gynecology	Family practice Internal medicine Pediatrics

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Diabetes care (National standard)	Patient(s) 18-75 years of age with lab results with most recent HbA1c result value less than 8.0%	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Endocrinology Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis (National standard)	Patient(s) who had a prescription dispensed for a disease modifying anti-rheumatic drug (DMARD) during the report period	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Rheumatology	Family practice Internal medicine
Epilepsy	Patient(s) with one or more hospitalizations or two or more emergency room encounters for epilepsy that had neurology consultation in last 3 reported months	Optum /The National Collaborating Centre for Primary Care Guidelines	Neurology	Family practice Internal medicine Pediatrics
Hypertension*	Patient(s) taking an ACE-inhibitor, angiotensin receptor blocker (ARB), diuretic, or aldosterone receptor antagonist-containing medication that had a serum potassium in last 12 reported months	Institute for Clinical Systems Improvement (ICSI) Optum	Cardiology Endocrinology Nephrology Neurology Obstetrics/ Gynecology	Family practice Internal medicine
Hypertension*	Patient(s) that had a serum creatinine in last 12 reported months	Joint National Committee on Prevention and Detection, Evaluation, and Treatment of High Blood Pressure: (The JNC 7) Institute for Clinical Systems Improvement (ICSI) National Quality Forum (NQF) Similar OPTUM	Cardiology Endocrinology Nephrology Neurology Obstetrics and gynecology	Family practice Internal medicine
Immunizations for adolescents (National standard)*	Patient(s) 13 years old at the end of the report period that had three HPV vaccinations between their ninth and 13th birthdays	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Pediatrics
Low back pain, use of imaging studies (National standard)++	Patient(s) with uncomplicated low back pain that did not have imaging studies	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Obstetrics and gynecology Rheumatology	Family practice Internal medicine
Medication management for people with asthma	Patient(s) between the ages of five and 64 with an asthma medication ratio >= 0.50 during the report period	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Allergy and immunology Obstetrics and gynecology Pulmonology	Family practice Internal medicine Pediatrics

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Medication management for people with asthma (National standard)	Patient(s) between the ages of five and 64 years of age compliant with prescribed asthma controller medication (minimum compliance 50%)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Allergy and immunology Obstetrics and gynecology Pulmonology	Family practice Internal medicine Pediatrics
Medication management for people with asthma (National standard)	Patient(s) between the ages of five and 64 years of age compliant with prescribed asthma controller medication (minimum compliance 75%)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Allergy and immunology Obstetrics and gynecology Pulmonology	Family practice Internal medicine Pediatrics
Migraine headache	Adult(s) with frequent use of acute medications that also received prophylactic medications	American Academy of Neurology (AAN) National Quality Forum (NQF) Similar Optum	Neurology Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Migraine headache	Patient(s) with frequent ER encounters or frequent acute medication use that had an ambulatory visit in last six reported months	American Academy of Neurology (AAN) Optum	Neurology Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Multiple sclerosis	Patient(s) that had neurology consultation in last 12 reported months	Optum /American Academy of Neurology (AAN) & the National Multiple Sclerosis Society (NMSS)	Neurology	Family practice Internal medicine
Non-recommended Cervical cancer screening in adolescents*	Patient(s) 16-20 years of age that had a cervical cancer screening (cervical cytology or HPV test) in the last 12 reported months	National Committee for Quality Assurance (NCQA)	Obstetrics and gynecology	Family practice Internal medicine Pediatrics
Osteoporosis management in women who had a fracture (National standard)	Women 67-85 years of age who were treated or tested for osteoporosis within six months of a fracture	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Endocrinology Obstetrics and gynecology Rheumatology	Family practice Internal medicine
Otitis externa, acute*++	Patient(s) two years of age and older with acute otitis externa who were NOT prescribed systemic antimicrobial therapy	American Academy of Otolaryngology-Head & Neck Surgery (AAO-HNS) Centers for Medicare and Medicaid Services (CMS) National Quality Forum (NQF) Similar Optum	Otolaryngology	Family practice Internal medicine Pediatrics
Otitis media, acute*	Patient(s) on antibiotic therapy with acute otitis media that received amoxicillin, a first line antibiotic	American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) Optum	Allergy and immunology Obstetrics and gynecology	Family practice Pediatrics

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
			Otolaryngology	
Pharyngitis (National standard)*	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Allergy and immunology Obstetrics and gynecology Otolaryngology	Family practice Pediatrics
Pneumonia, Community-acquired bacterial (CAP)	Adult(s) with community-acquired bacterial pneumonia who have a CXR	Infectious Disease Society of America (IDSA) / American Thoracic Society (ATS) Optum	Pulmonology	Family practice Internal medicine
Potentially harmful drug-disease interactions in the elderly	Elderly patients who had an accidental fall or hip fracture who took an anticonvulsant, nonbenzodiazepine hypnotic, SSRI, antipsychotic, benzodiazepine, or tricyclic antidepressant after the incident	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	N/A	Family practice Internal medicine
Potentially harmful drug-disease interactions in the elderly	Elderly patients with dementia who took an antipsychotic, benzodiazepine, tricyclic antidepressant, H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent after the earliest record of dementia	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	N/A	Family practice Internal medicine
Pregnancy management*	Pregnant women that had HIV testing	U.S. Preventive Services Task Force (USPSTF) Center for Disease Control (CDC) National Quality Forum (NQF) Similar Optum	Obstetrics and gynecology	Family practice
Pregnancy management*	Pregnant women less than 25 years of age that had chlamydia screening	U.S. Preventive Services Task Force (USPSTF) American College of Obstetricians and Gynecologists (ACOG) American Academy of Pediatrics (AAP) Optum	Obstetrics and gynecology	Family practice
Pregnancy management*	Pregnant women that had syphilis screening	U.S. Preventive Services Task Force (USPSTF) American College of Obstetricians and Gynecologists (ACOG) American Academy of	Obstetrics and gynecology	Family practice

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
		Pediatrics (AAP) National Quality Forum (NQF) Similar Optum		
Pregnancy management*	Pregnant women that had HBsAg testing	U.S. Preventive Services Task Force (USPSTF) American College of Obstetricians and Gynecologists (ACOG) National Quality Forum (NQF) Similar Optum	Obstetrics and gynecology	Family practice
Pregnancy management*	Pregnant women that received Group B Streptococcus testing	American College of Obstetricians and Gynecologists (ACOG) Centers for Disease Control and Prevention (CDC) Optum	Obstetrics and gynecology	Family practice
Prenatal and postpartum care	Women that received a prenatal visit in the first trimester or within 42 days of enrollment (including bundled prenatal services)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Obstetrics and gynecology	Family practice
Prenatal and postpartum care	Women that received postpartum care (including bundled postpartum services)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Obstetrics and gynecology	Family practice
Prenatal and postpartum care	Women with second deliveries that received a prenatal visit in the first trimester or within 42 days of enrollment (including bundled prenatal services)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Obstetrics and gynecology	Family practice
Prenatal and postpartum care	Women with second deliveries that received postpartum care (including bundled postpartum services)	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF) Similar	Obstetrics and gynecology	Family practice
Prostate cancer	Patient(s) that had a prostate specific antigen test in last 12 reported months	American Urological Association (AUA) National Comprehensive Cancer Network (NCCN) National Quality Forum (NQF) Similar Optum	Hematology and oncology Urology	Family practice Internal medicine
Prostate cancer	Patient(s) that had an annual physician visit or evidence of a digital rectal examination	American Urological Association (AUA) National Comprehensive Cancer Network (NCCN) Optum	Hematology and oncology Urology	Family practice Internal medicine

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Rheumatoid arthritis	Patient(s) taking methotrexate, sulfasalazine, gold, or leflunomide that had a CBC in the last three reported months	American College of Rheumatology (ACR) National Quality Forum (NQF) Similar Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking methotrexate that had a serum creatinine in last six reported months	Optum / Antirheumatic agents, Drug Facts and Comparisons, eFacts National Quality Forum (NQF) Similar	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking methotrexate, sulfasalazine, or leflunomide that had serum ALT or AST test in last three reported months	American College of Rheumatology (ACR) National Quality Forum (NQF) Similar Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking hydroxychloroquine that had an eye exam in last 12 reported months	American College of Rheumatology (ACR) The American Academy of Ophthalmology (AAO) National Quality Forum (NQF) Similar Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) with complex RA treatment regimens or complications that had rheumatology consultation in last six reported months	American College of Rheumatology (ACR) Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking chronic corticosteroids that had rheumatology consultation in last six reported months	American College of Rheumatology (ACR) Optum	Rheumatology	Family practice Internal medicine Pediatrics
Sickle cell anemia	Patient(s) that had a hemoglobin/hematocrit in last 12 reported months	American Academy of Pediatrics (AAP)/ similar National Heart, Lung, and Blood Institute (NHLBI) Optum	Hematology and oncology	Family practice Internal medicine Pediatrics
Sinusitis, acute*	Patient(s) treated with an antibiotic for acute sinusitis that received a first line antibiotic	Institute for Clinical Systems Improvement (ICSI)	Allergy and immunology Obstetrics and gynecology Otolaryngology Pulmonology	Family practice Internal medicine Pediatrics
Sinusitis, acute*++	Patient(s) that did not have a sinus computerized axial tomography (CT) or magnetic resonance imaging (MRI) test	Institute for Clinical Systems Improvement (ICSI) Centers for Medicare and Medicaid Services (CMS)	Allergy and immunology Obstetrics and gynecology	Family practice Internal medicine Pediatrics

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
			Otolaryngology Pulmonology	
Statin therapy diabetes	Patient(s) 40-75 years of age with diabetes that received a statin medication	National Committee for Quality Assurance (NCQA)	Cardiology Endocrinology Nephrology Neurology Obstetrics and gynecology Cardiothoracic surgery	Family practice Internal medicine
Statin therapy for cardiovascular disease (CD)	Patient(s) with CD that received a high or moderate-intensity statin medication	National Committee for Quality Assurance (NCQA)	Cardiology Endocrinology Obstetrics and gynecology Cardiothoracic surgery	Family practice Internal medicine Pediatrics
Statin therapy for CD	Men 21-75 years of age with CD that received a high or moderate-intensity statin medication	National Committee for Quality Assurance (NCQA)	Cardiology Endocrinology Obstetrics and gynecology Cardiothoracic surgery	Family practice Internal medicine Pediatrics
Statin therapy for CD	Women 40-75 years of age with CD that received a high or moderate-intensity statin medication	National Committee for Quality Assurance (NCQA)	Cardiology Endocrinology Obstetrics and gynecology Cardiothoracic surgery	Family practice Internal medicine Pediatrics
Tonsillectomy	Patient(s) one to 18 years of age that had a tonsillectomy and met clinical criteria for this procedure	American Academy of Otolaryngology-Head & Neck Surgery (AAO-HNS) Optum	Otolaryngology	N/A
Upper respiratory infection (URI), appropriate treatment* (National standard)	Patient(s) with a diagnosis of URI that did not have a prescription for an antibiotic on or three days after the initiating visit	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	Allergy and immunology Obstetrics and gynecology Otolaryngology	Family practice Pediatrics
Well-child visits in the first 15 months of life (National standard)*	Patient(s) that had six or more well-child visits with a PCP during the first 15 months of life	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	N/A	Family practice Pediatrics

Condition / treatment	Rule description	Source	Specialty types	Primary care specialty types
Well-child visits in the third, fourth, fifth and sixth years of life (National standard)*	Patient(s) three–six years of age that had one well-child visit with a PCP in the last 12 reported months	National Committee for Quality Assurance (NCQA) National Quality Forum (NQF)	N/A	Family practice Pediatrics

* Measures requiring one office visit in the most recent 12 months of the review period.
++ Atypical rule – measure indicates over-utilization of services. Compliance for the measure requires absence of the service. Compliance rates are inverted for reporting and comparison purposes.

Appendix 4: Colorado provider appeal process

Procedures to obtain additional information

To review additional quality and cost-efficiency information, obtain a full description of the methodology and data that our decisions were based on or declined, the physician should submit the request by email to PhysicianEvaluationInformationRequest@Cigna.com, or by faxing the request to 1.866.448.5506.

The NCM or NCS will contact the physician to provide additional details about the process and the results. If the request is regarding the methodology and data that the designation decisions were based on or declined, we will provide the physician or physician group with this information within 45 days of our receipt of the request. Where the law or our contractual obligation with a third party prevents disclosure of the data, we will provide sufficient information to allow the physician or physician group to determine how the withheld data affected the designation. After disclosure of the description of the methodology described above, the physician or physician group may request further information related to the designation decisions. If additional information exists that was not previously disclosed, we will provide it within 30 days of the request.

The 2019 Provider Quality, Cost Efficiency, and Cigna Care Designation Methodology is also available on the Cigna for Health Care Professionals website at CignaforHCP.com.

Request reconsideration for quality and cost-efficiency displays

To request an appeal for quality and cost-efficiency displays in Colorado (including the opportunity for a face-to-face meeting), have corrected data relevant to the designation decision considered, have the applicability of the methodology used in the designation decision considered, or to submit additional information, the physician should email Cigna at PhysicianEvaluationInformationRequest@Cigna.com, or fax the request to 1.866.448.5506. An NCM will contact the physician or physician group to provide additional details about the process and the results. If the provider meets the criteria for CCD upon reconsideration, the provider will be displayed as CCD.

The National Selection Review Committee reviews all appeal requests with Cigna participants in locations other than Colorado. The committee participants are listed below:

Voting Committee Participants

- National Medical Director for Network Clinical Performance and Improvement (Chair)
- Physician representatives from the four regions, their alternates, and ad hoc physicians

Non-voting Committee Participants

- Vice President, Clinical Measurement and Improvement
- Cigna Information Management & Analytics (CIMA) Representative
- Product Representative
- Network Clinical Managers
- Network Clinical Specialists

Non-voting and Ad Hoc Committee Participants

- Network Market Lead
- Market Medical Executive

Upon request, the physician will be provided with the name, title, qualifications, and relationship to Cigna of the persons participating on the National Selection Review Committee who are responsible for making a determination on the physician's appeal. If requested, a face-to-face meeting will be arranged at a location reasonably convenient to the physician; other participants can join the meeting using teleconference. The physician has the right to be assisted by a representative. The physician should provide the name and credentials of the representative to the NCM or NCS at least two weeks in advance of the scheduled Selection Review Committee meeting. If the physician requests an explanation of the designation decision, which is the subject of the appeal to be considered as part of the appeal, it will be included.

The physician or physician group will receive a written decision regarding the appeal that states the reasons for upholding, modifying, or rejecting the physician's appeal. The appeal process will be completed within 45 days from the date the data and methodology are disclosed unless otherwise agreed to by the parties to the appeal. No change or modification of a designation that is the subject of an appeal shall be implemented or used until the appeal is final. We will update any changes to designations previously disclosed publicly within 30 days after the appeal is final.

Together, all the way.™

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.