

2020 QUALITY, COST EFFICIENCY, AND CIGNA CARE DESIGNATION METHODOLOGY

For Health Care Providers
June 2019

Together, all the way.™



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Introduction

Many of our customers want to know more about provider quality and cost-efficiency. To help provide Cigna customers with relevant information to make their own health care decisions, we evaluate provider quality and cost-efficiency information at the specialty level by using a methodology consistent with national standards and incorporating provider feedback on contracted providers in 21 specialty types. In addition, groups who meet Cigna's specific quality and cost-efficiency criteria can receive the Cigna Care Designation (CCD), which 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 providers at the specialty level and how the criteria are met for a group to achieve CCD, as well as provide details regarding the profile 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 providers:

- 1. Standardized performance measures using the most comprehensive data set available.** We use nationally recognized measures 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 provider organizations.
- 2. Responsible use of the information.** The profiles 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 their treating provider 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 provider and their patient. We provide our customers with helpful information to allow them to make informed decisions. The quality and cost-efficiency markers used in evaluating providers for Cigna Care Designation are intended for that purpose only. We do not guarantee the quality or cost efficiency of the actual services provided by contracted providers, 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 providers and provider groups. We also continue to have ongoing discussions with key provider organizations, ranging from national associations to large provider groups, which provide input for future design changes.

The methodology for determining the quality and cost-efficiency displays is subject to change as tools and industry standards evolve, and provider feedback is obtained and periodically updated. We used claims paid data with dates of services from January 1, 2017 through December 31, 2018 for the review period to assess for 2020 quality and cost-efficiency profiles and directory displays. This review includes claims data from Cigna Managed Care and PPO plans, and excludes government and capitated plans.

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

External certification

Cigna earned the NCQA Physician and Hospital Quality (PHQ) Certification for the sixth time in July 2019. The 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

Listed below are the 21 provider specialty types that are reviewed. These specialty types account for more than 85 percent of primary and specialty healthcare spending based on Cigna claims data. A provider can only be assigned one specialty, tax identification number (TIN), and geographical market for quality and cost-efficiency displays. The provider's primary specialty, as determined by Cigna, is used to establish the specialty to evaluate providers 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*	Internal medicine	Nephrology
Neurology	Neurosurgery	Obstetrics and gynecology
Ophthalmology	Orthopedic surgery	Pediatrics
Pulmonary	Rheumatology	Urology

*Does not include oncology

Note: While Cigna Care Designation is determined at the aggregated group level, we determine cost and quality performance metrics by reviewable specialty type for groups comprised of more than one specialty type.

Market availability

Our Network Contracting and Market Medical Executive teams defined the 2020 geographical markets in which CCD is recognized. The zip code of a provider's primary office address is used to align a provider with a given market. The provider's primary specialty and geographic market is then used to determine the provider peer group for comparison of quality and cost-efficiency results.

Please see Appendix 1 for a list of markets, and the volume and percent of providers reviewed in each market, which are CCD providers effective January 1, 2020.

Sample: Online Health Care Professional Directory display (myCigna.com)

Robert Smith, MD 0.7 mi |

Doctors Group Health Partners | 123 Main Street, Anytown, CT 12345 | (555) 123-1111

Specialties (2): Family Practice, Geriatric Medicine | **Hospitals (3):** Christ Hospital...see all

Years in Practice: Not Available

Cigna Care Designation

Cost Efficiency Rating: ★★ ★

Quality Ratings: [see all](#)

New Patient Office Visit

\$164 ESTIMATED OUT-OF-POCKET COST

[Show Math](#)

- Tier 1 Provider
- In-Network
- Accepting new patients

[Select PCP](#)

Quality evaluation and displays

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

1. Group board certification

Group board certification is measured based on certification data obtained from the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA), 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 episodes of care, or at least 80 percent of the episodes of care is provided by board-certified physicians, *or*
- For practices (groups) with four or fewer physicians, either 65 percent of physicians within a group are board certified and provide 50 percent of the episodes of care, or at least 65 percent of the episodes of care is provided by board-certified physicians

2. Adherence to evidence-based medicine rules

The quality of provider care is evaluated using a claims-based assessment for 95 Evidence Based Medicine (EBM) rules derived from measures endorsed by the National Quality Forum (NQF), Healthcare Effectiveness Data Information Set (HEDIS), or developed by provider organizations. These rules span 43 diseases and preventive cares conditions (see Appendix 3), and are potentially applicable to the care provided by providers 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 seventeen.

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).

4. Bridges to Excellence (BTE) Provider Recognition

Bridges to Excellence programs measure the quality of care delivered in provider practices. BTE emphasizes managing patients with chronic conditions, who may be at risk for potentially avoidable complications. We identify providers in our online provider directory who have received recognition in any of these BTE programs. BTE is currently available for these health concerns:

- Asthma care
- Cardiac care
- Chronic obstructive pulmonary disease (COPD) care
- Depression care
- Diabetes care
- Heart failure care
- Hypertension care
- Inflammatory bowel disease (IBD) care
- Maternity care

Additional information about these programs is available on the Bridges to Excellence website (<http://www.bridgestoexcellence.org>). Refer to page 19 for the 2020 Data Sources table, and page 24 for the 2020 Provider Evaluation Methodology Changes table.

Evidence-based medicine (EBM) assessment process

The EBM rules used in the 2020 evaluation apply to 15 primary care and non-primary care specialty types. 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 13.7 percent of providers 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, 10,472 or 1.73 percent of providers 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
Internal medicine	Nephrology	Neurology
Obstetrics and gynecology (OB/GYN)	Otolaryngology (ENT)	Pediatrics
Pulmonary	Rheumatology	Urology

The 2020 EBM assessment component review includes measuring compliance with 95 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	Childhood immunization	Persistence of beta-blocker treatment after a heart attack
Adult access to preventive/ambulatory health	Chronic kidney disease	Pharyngitis, appropriate testing for children
Alcohol and other drug dependence	Chronic obstructive pulmonary disease (COPD) exacerbation, pharmacotherapy management	Potentially harmful drug-disease interactions in the elderly
Antidepressant medication management	Congestive heart failure	Pregnancy management
Asthma (includes use of appropriate medications)	Coronary artery disease (including statin therapy)	Prenatal and postpartum care
Atrial fibrillation (includes use of Anticoagulation Medications)	Diabetes (including statin therapy)	Prostate cancer
Attention deficit hyperactivity disorder (ADHD)	Epilepsy	Rheumatoid arthritis
Breast cancer	Human papillomavirus vaccine (HPV) for adolescents	Sickle Cell Anemia
Breast cancer screening	Hypertension	Sinusitis (acute)
Bronchitis (acute)	Low back pain	Tonsillectomy
Cardiac surgery	Migraine headache	Upper respiratory infection
Cerebral vascular accident and transient cerebral ischemia	Multiple sclerosis	Well-child visits in the first 15 months of life
Cervical cancer screening	Osteoporosis	Well-child visits in the third, fourth, fifth, and sixth years of life
Chlamydia screening	Otitis externa (acute)	
Child and adolescent access to primary care	Otitis media (acute)	

Definitions used in the following methodology description:

1. **Provider 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 providers 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 provider 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 provider or provider group, there must be at least 20 opportunities for the rule within the specialty category (primary care or non-primary care specialty types) and market for the most recent two-year data review period. For 2020 displays, that period is January 1, 2017 through December 31, 2018.
- The average adherence rate for each EBM rule is calculated for the provider specialty category (primary care or non-primary care specialty types) for each geographic market to derive the peer market-average result.

Individual provider or group practice EBM rule adherence

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

Visit requirements: A provider is considered responsible for adherence to the EBM rule if the following conditions are met:

- The EBM rule is relevant to the provider'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 specialty types.
- 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: 32 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 providers are aligned to medical groups (practices), and EBM rule opportunities, successes, and expected successes are then summed to obtain totals. Provider performance is aggregated to the specialty level within a group for quality displays and at the group level to achieve CCD.

- A **Quality Index** for the medical group is calculated by dividing the provider's or provider 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 provider group's particular mix of rule 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 provider or provider group is defined as the **Adjusted Quality Index** for that provider group.
- Provider groups must have 30 or more total EBM rule- adherence opportunities. In addition, at least 50 percent of their treatment episodes of care (used in the provider's or group's cost-efficiency (ETG[®]) analysis) are attributed to the provider specialty types that are assessed for EBM rule adherence, and are ranked using the Adjusted Quality Index score.
- Provider 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. This score is utilized at the group level in achieving the quality component of CCD. Provider 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; there will be no cost-efficiency display for these individuals. The remainder is in the middle category.
- Specialties within each group are assessed in a similar manner to determine the Evidence Based Medicine score at the specialty level. Specialty level scoring will drive directory displays at the provider/specialty level, i.e. "Evidence Based Medicine Standards" language will display on the directory for those providers in the top 34% for their specialty.

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 and provider groups are evaluated for their cost efficiency using an industry-standard methodology (Episode Treatment Groups[®] or ETG[®]) 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 providers and provider 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 providers or provider groups when compared to other providers and provider groups of like specialty type within the geographic market. Two stars represent providers or provider groups in the middle 33 percent for cost efficiency. Provider groups that are in the bottom 33 percent for cost efficiency receive one star.

Providers that 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. Rankings are based on weighted percentile of total medical spend by market to account for variation in group size.

Cost-efficiency symbols

- ★★★ Results in the top 34 percent for cost efficiency
- ★★ Results in the 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 providers reviewed for quality and cost- efficiency displays beginning January 1, 2020.

We use ETG[®] methodology, an industry standard available through Optum, to evaluate the cost efficiency of individual providers 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 ETG[®]s, is available at etg.optum.com/etg-links/episode-treatment-groups/.

Using the ETG[®] methodology, we can determine how a provider's cost-efficiency compares to other providers in the same geographic market. The provider's cost-efficiency performance is compared to the performance of same-specialty providers in the same market. A provider or provider group's aggregated performance is a result of its fee schedule, utilization patterns and referral patterns (e.g., use of hospitals and other facilities).

ETG[®] assessment requirements

- Cigna uses ETG[®] 'full number' descriptions, inclusive of treatment approach and/or presence of comorbid conditions or complications where they apply, to accurately compare like clinical scenarios. 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 provider 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 provider specialty type. Provider performance is aggregated to the specialty level within a group for cost displays and at the group level to achieve CCD.
- To reduce variation within cost-efficiency results, several ETG[®]s are excluded from the assessment process, including routine immunizations and other inoculations, transplants, and ETG[®]s 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 identification 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 provider 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 provider groups must have at least 30 total episodes of care in aggregate and at the individual specialty level during the review period in order to be assessed for cost efficiency. In order for an episode to be attributed to a provider group, two criteria must be met:
 1. The practice must be responsible for more costs for medical or surgical management services than any other provider group providing care for the episode, and
 2. The medical or surgical management costs for the practice 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 practices' provision of management services are used to attribute the episode to a particular provider, total costs (provider 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 provider group and for the providers within that group is compared to the market average cost of an episode of care, which is derived using their unique mix of ETG®s and the peer averages.
- The sum of all actual ETG® costs for a medical group divided by the sum of all corresponding ETG® market-average costs is the provider group's **Performance Index**.

Example: The ABC Provider Group consisting of three family physicians in the Nashville market has five episodes of care belonging to two unique ETG®s (ETG®1 and ETG®2) that are attributable to the group. For simplicity, disregard the requirement that the provider or provider group must have a minimum of 30 attributable episodes in order to be reviewed for cost efficiency. Average episode costs for ETG®1 and ETG®2 have been established for all other primary care providers practicing in the Nashville market. Three episodes of ETG®1 are attributable to the ABC Provider Group and two episodes of ETG®2 are attributable to the ABC Provider Group.

In the table below, the provider group’s cost per episode is displayed for each of the three occurrences of ETG[®]1 and for each of the two occurrences of ETG[®]2, along with the market average cost for an episode for ETG[®]1 and ETG[®]2 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 provider group by the average of all market-average episode costs for the ETG[®]s on which the provider group’s cost-efficiency performance is being evaluated yields a Performance Index (PI) of 0.825. The PI for the provider 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 provider medical groups. The upper bound of the 90 percent confidence interval is used to ensure that the provider group’s performance is at least as good as, or better than the upper bound threshold.
- Using a weighted percentile groups are then ranked by their Adjusted Performance Index within their geographic area. Those groups ranking in the top 34% achieve 3 stars for efficiency and this score is utilized at the group level in achieving the cost component of CCD evaluation.
- Specialties within each group are assessed in a similar manner to determine the Cost Efficiency score at the specialty level, specialty level scoring will drive directory displays at the provider/specialty level, i.e. 3 cost stars will display on the directory for those providers in the top 34% for their specialty, two stars for those falling between 34% and 66% and 1 star for those in the bottom 34%.

2020 Outlier methodology


In order to portray providers’ 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 (ETG[®]s) are identified by interquartile (IQ) variances by market and specialty averages; outlier episode costs are reduced to the IQ value used to calculate cost-efficiency before peer comparison is performed. Similarly, low cost outlier episodes are determined by the Optum software, or are episodes of less than \$25 and are excluded from the evaluation.

Level of evaluation (unit of analysis)

While we review participating providers at the individual level, the Cigna Care Designation is provided at the provider group or practice, or group TIN, level. Individual providers 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 provider within the group, and;
- Patients with Cigna coverage who initially choose a specific provider frequently receive care by another provider within the practice or group.

Cigna Care Designation inclusion methodology

In 2020, providers who meet our specific quality and cost-efficiency criteria, can receive the Cigna Care Designation 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., Tier 1 Provider). 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 Cigna Care Designation

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

Participating providers may receive Cigna Care Designation if the provider or provider 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 **AND**
- Group performance in the top 34 percent for quality **OR** have 50 percent of providers in the practice achieve NCQA or BTE recognition **AND** meet the cost-efficiency criteria of being in the top 34 percent **with** the groups Adjusted Performance Index (API) less than or equal to 1.03 **OR**
- Group performance in the top 25 percent for quality **OR** have 50 percent of providers in the practice achieve NCQA or BTE recognition **AND** have less than 30 ETG[®] episodes (with no cost ranking) **OR**
- Group performance in the top 25 percent for cost **with** the groups Adjusted Performance Index (API) less than or equal to 1.03 **AND** are either between 2.5 and 66 percent for quality or have less than 30 EBM opportunities (with no quality ranking).

We inform our customers that a CCD for a provider 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 provider as CCD does not mean that the provider 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 provider or specialist for their care, and to speak with their treating provider when selecting a specialist.

Buffer zone methodology

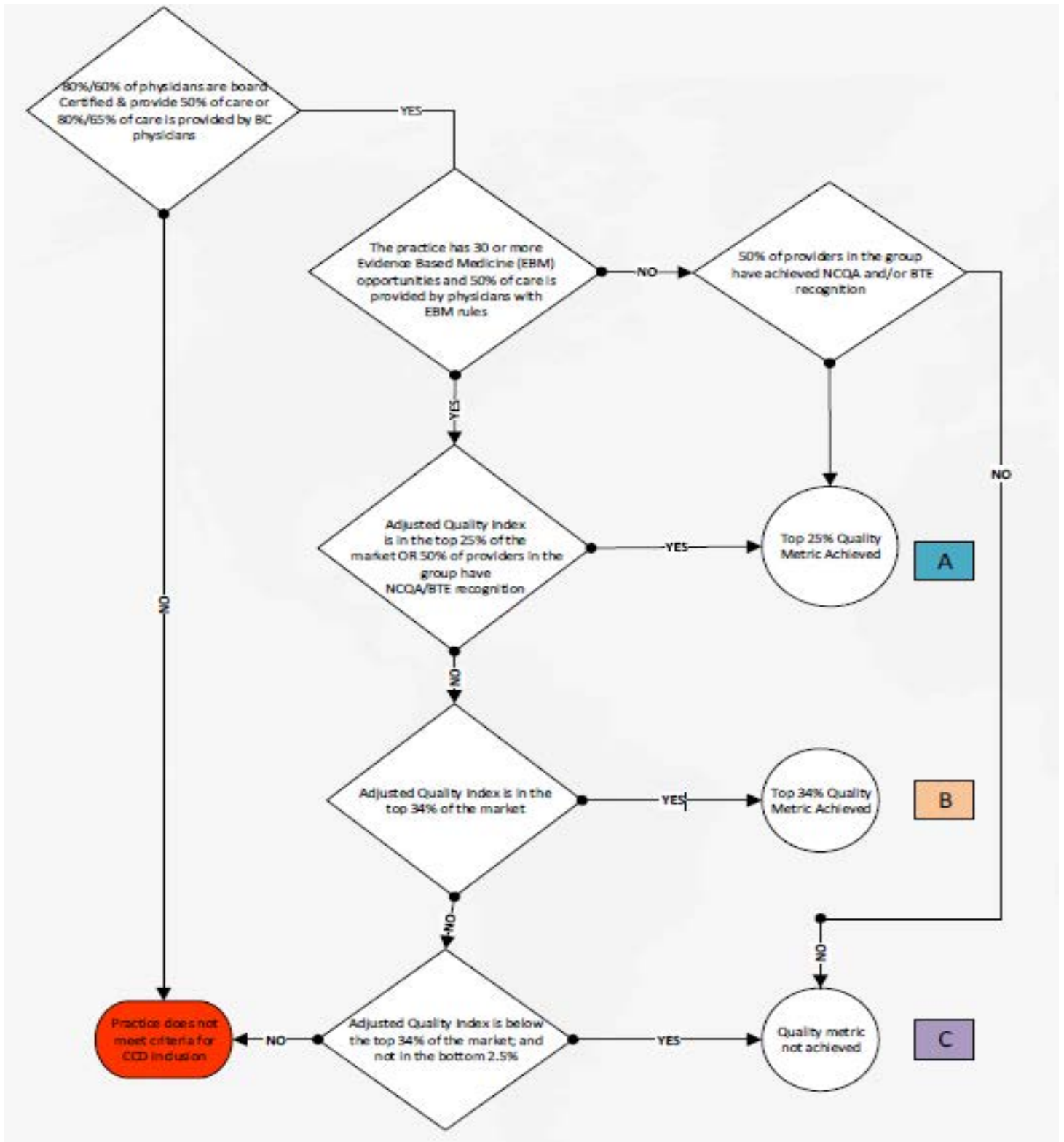
Variation in provider group or provider group performance (e.g., positive or negative, substantial or minimal), is inevitable and expected in an annual review process due to various factors (e.g., changes to provider group makeup, external market factors, and practice pattern modifications). A “buffer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

The selected provider group must meet certain criteria to achieve the 2020 buffer zone designation.

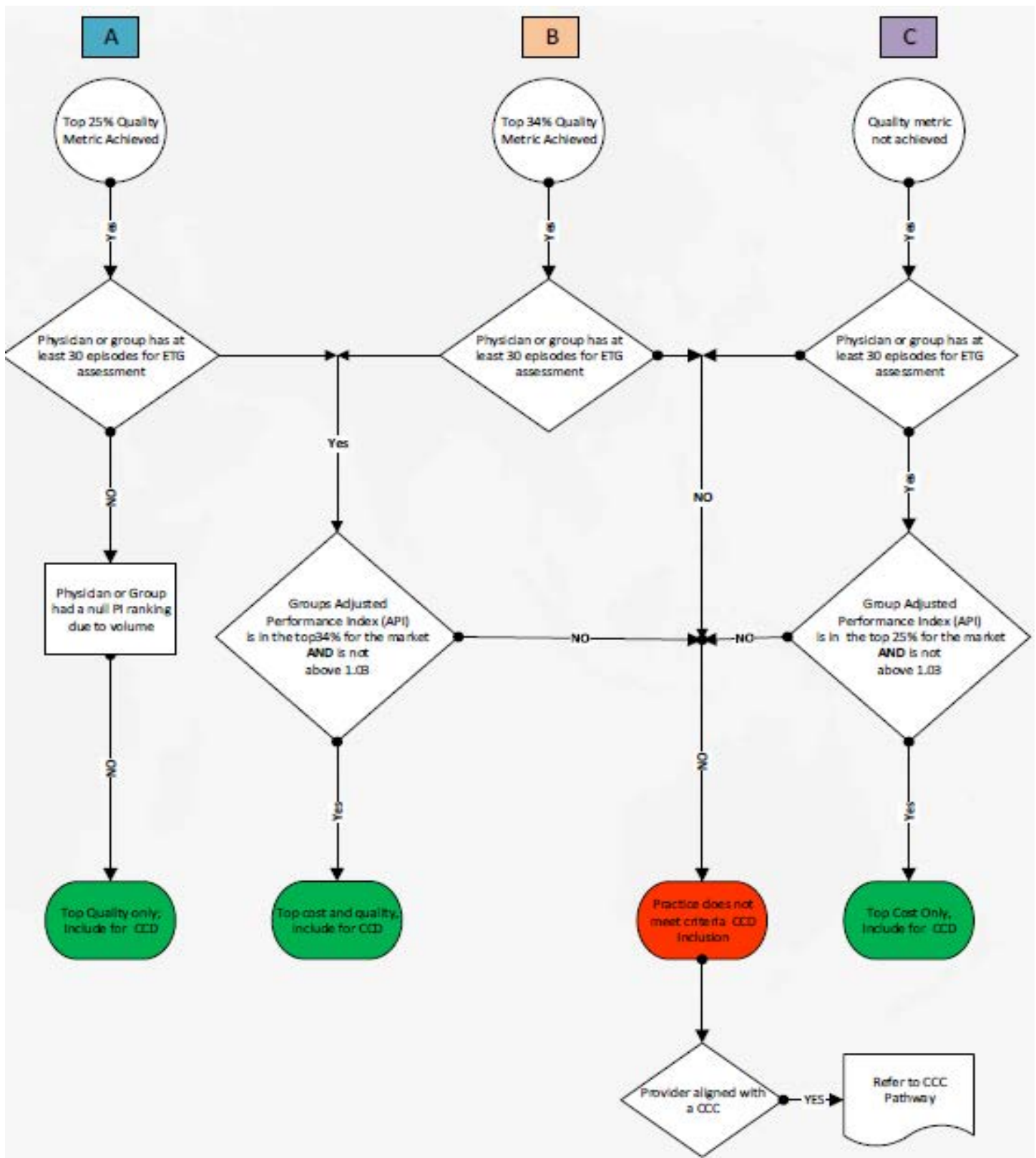
The standard criterion applied includes:

- meeting the physician group board certification criteria,
- the board-certified physicians must be responsible for at least 50 percent of the group episodes, **and**
- 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.

2020 Cigna Care Designation inclusion algorithm (Quality assessment)



2020 Cigna Care Designation inclusion algorithm (Cost assessment)



Alternative pathways to achieve Cigna Care Designation

Cigna Collaborative Care pathway to achieve Cigna Care Designation

We collaborate with selected provider groups in order to help them achieve the triple aim of improving quality, cost efficiency, and the patient care experience. The Cigna Collaborative Care (CCC[®]) approach, which leverages the foundation of accountable care organizations (ACOs) and patient centered medical home (PCMH) models by recognizing providers affiliated with CCCs that demonstrate improvement in medical delivery and clinical outcomes, and reduced total cost of care.

Cigna's collaborative care model is designed for collaboration with provider 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.

Providers and provider groups are first assessed by applying the standard CCD pathway to determine inclusion. If the providers and provider 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.

To be considered for Cigna Care Designation, CCC providers 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) with attributed Cigna customers in their patient panels.

Primary care quality assessment

The CCC must have at least 20 evidence-based medicine (EBM) opportunities per rule during the data collection period. A Quality Index is calculated for each CCC based on adherence to Evidence Based Medicine (EBM) measures. CCCs with agreements effective after December 31, 2016, must have a Quality Index of 0.99 or better to meet the quality requirement. Established CCCs with an agreement effective prior to December 31, 2016, must have a Quality Index of 1.00 or better to meet the quality requirement. The Quality Index is calculated based on adherence to Evidence Based Medicine (EBM) standards. The EBM rules for CCCs can vary from the core set utilized by CCD based on each individual CCC agreement.

Primary care cost-efficiency assessment

Total medical cost (TMC) is used to evaluate cost-efficiency for primary care CCC arrangements. To calculate the TMC index for primary care CCCs, aligned patients and practitioners are identified. A CCC per patient per month (PPPM) score is calculated and risk adjusted. The final risk adjusted CCC 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, excluding pharmacy and non-PCP behavioral health costs. CCCs with agreements effective after December 31, 2016, must have a TMC Performance Index of 1.03 or less to meet the pathway cost requirement. Established CCC's with a CCC agreement effective prior to December 31, 2016, must have a TMC Performance Index of 1.00 or less to meet the pathway cost requirement.

Specialty care cost-efficiency assessment

For CCCs with reviewable specialty type providers who comprise $\geq 20\%$ of the roster, the ETG Performance Index must be 1.03 or less to meet the pathway cost requirement for the specialists to meet the inclusion criteria.

NOTE: The alternate CCD pathway criteria may not be available in certain markets.

Buffer zone methodology

Variation in CCC 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 provider group makeup, external market factors, and practice pattern modifications). A “buffer zone” (grandfathering) methodology addresses variation for provider groups or provider groups whose Cigna Care Designation changes from the previous review cycle. A CCC may maintain its CCD status if the CCC was “in” during the prior cycle.

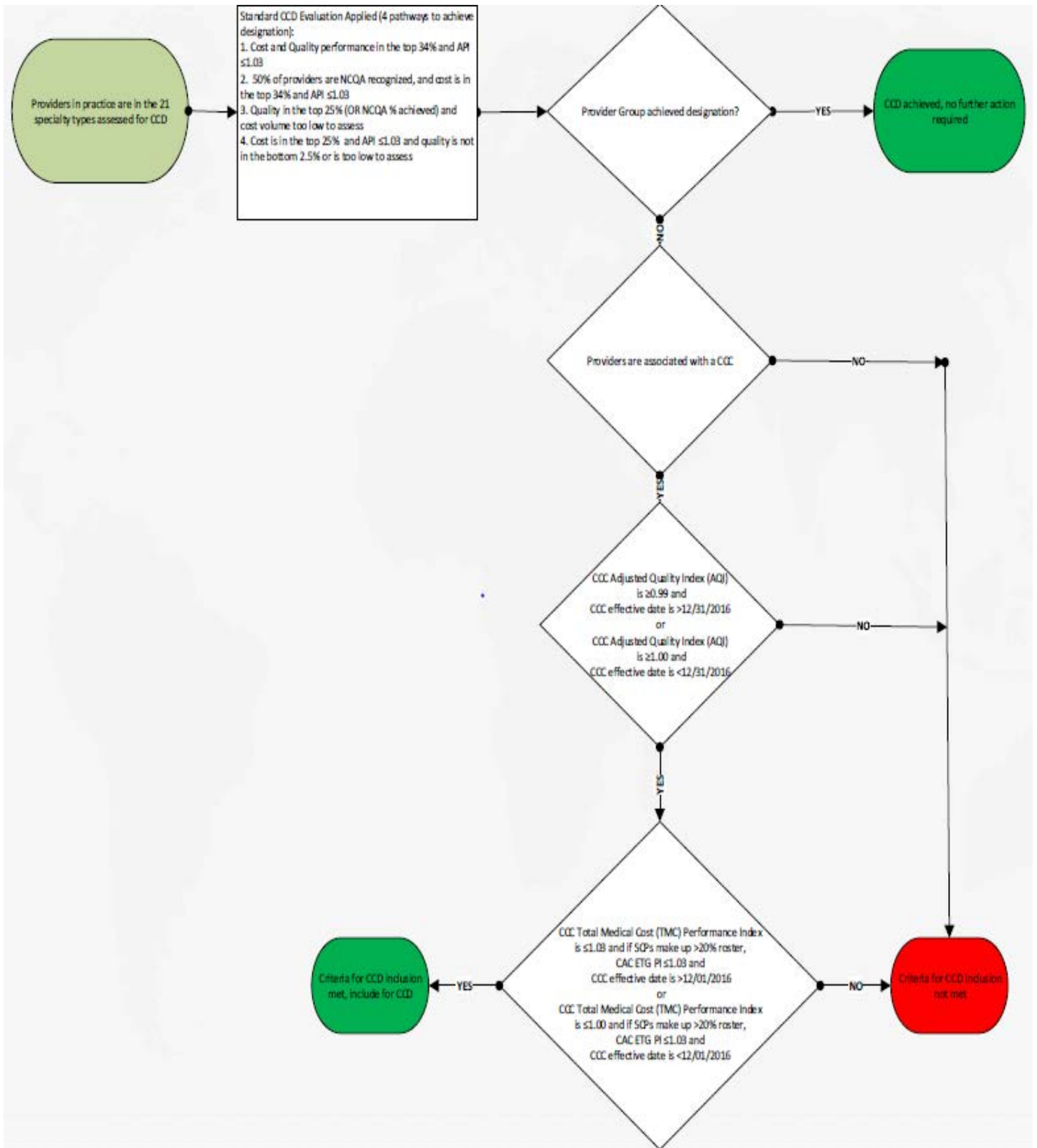
Note: Individual markets may adjust the grandfathering criteria for CCCs at the market level, in order to exclude from grandfathering those CCCs with large-scale variation in results from the prior year. Adjustments are made at the market level and are applied to all CCCs in the market.

Cigna Collaborative Care review process

The evaluation methodology is applied annually (and quarterly as needed) to all existing CCC arrangements and to new CCCs that become effective.

- CCCs 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 will be given CCD status.
- Since CCCs can earn CCD status on a quarterly basis, we reserve the right to remove the CCD status if the CCC demonstrates significant decline in performance below the required criteria in four consecutive quarters, or if the CCC discontinues its collaborative agreement with us and does not meet the standard CCD criteria.
- A re-evaluation occurs with each CCD 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 CCCs in the market.

2020 Cigna Collaborative Care to Cigna Care Designation Algorithm



Cigna Centers of Excellence pathway to achieve CCD

We evaluate hospital-stay outcomes and cost-efficiency information for Cigna customers through the Cigna Centers of Excellence (COE) program; groups that do not qualify for any Quality and/or Cost-efficiency inclusions are evaluated for COE to CCD inclusion pathway. The pathway provides a 10 percent bump to the quality score and a 10 percent reduction to the cost score. Group criteria for this inclusion pathway are:

- At least one admission to COE hospital for the diagnostic-related groups (DRGs) in the latest COE evaluation program
- Group achieves a minimum Quality ranking of 70 percent
- At least 25 percent of the providers in the group are affiliated with a COE

2020 Provider evaluation methodology changes

Changes to our 2020 provider evaluation methodology are outlined below:

Methodology	2020 Change/Enhancement	Details/Rationale
Inclusion criteria	2020 CCD inclusion criteria have returned to values used in prior years	Top 34 percent for both quality and cost-efficiency by specialty and market achieve designation. Where either quality or cost-efficiency only is measured, top 25 percent for metric compared to market peers meets inclusion criteria. Realigns inclusion criteria with top quality and cost thresholds.
Collaborations pathway to Cigna Care Designation	2020 pathway criteria will be narrowed ONLY for those collaborations that have been under contract prior to December 31, 2016.	Quality scores and total medical cost (TMC) trend are expected to be better than average, and continue to improve compared to market peers for mature collaborations; Quality Index \geq 1.00 and TMC Performance Index \leq 1.00.
Quality and cost-efficiency designation	Give CCD status at the group level, but evaluate quality and cost at the specialty level within the group; applies to multispecialty groups only.	More accurately and appropriately assigns quality and cost-efficiency results to providers.

Methodology	2020 Change/Enhancement	Details/Rationale
Specialists reviewed	Oncology will not be evaluated for 2020 Cigna Care Designation.	Current methodology does not drill down into treatment to appropriately compare practices.
Quality proxy	2020 CCD will include Bridges to Excellence (BTE) certification information as a component of provider quality evaluation.	BTE will be 'scored' in the way NCQA physician certification is and as a proxy for EBM compliance. To achieve this quality marker, 50 percent of providers in the practice must have recognition from either BTE or NCQA.
Cost-efficiency evaluation	Exclusion of non-routine inoculation treatment episodes in the cost-efficiency calculations.	The non-routine inoculations ETG [®] includes routine inoculations; routine inoculations are not intended to be measured for cost.
Weighted percentiles	Use a weighted percentile to determine top 34 percent rather than current methodology, which does not account for group composition.	Improved accuracy to evaluate the performance of providers, accounting for the group size in a given market.
Outlier methodology	Utilization of interquartile range for outlier identification rather than 150 percent of mean.	Provides for a more even application of low and high outliers, better accounts for distribution; no longer advantages large groups with high volume of high-cost outliers
Episode attribution logic	Attribute episodes at the group level rather than at the provider level.	Improves attributable volume for groups where numerous providers might see the same member.
ETG[®] confidence interval calculation	Utilize provider/group level variance rather than market level variance to calculate confidence interval value.	Improved methodology for 90-percentile confidence interval calculation, and more fairly assesses small groups.

Data sources

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

Data source	How information is used
<p>Cigna Provider Metrics (January 2017 – December 2018)</p> <p>Use combined Cigna managed care and PPO product data with episodes of care or EBM rules attributed to the responsible provider.</p>	<p>The data is used to produce ETG® efficiency and EBM summary reports.</p> <p>Note: Data for Medicare-eligible individuals and capitated business is removed.</p>
<p>Cigna Central Provider File (CPF) (as of April 2019)</p>	<p>File extracts to identify contracted providers, TIN, Group demographics, specialty, board certification status, network, and products contracted.</p>
<p>Physician Recognition Program File obtained from the National Committee for Quality Assurance (NCQA) (as of April 2019, and at least six times per year)</p>	<p>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.</p> <p>Percent of physicians recognized in an NCQA program for a group is calculated based on the recognition and group alignment.</p>
<p>Physician Recognition Program File obtained from Bridges to Excellence (BTE) (as of April 2019, and at least six times per year)</p>	<p>The status of providers recognized for BTE for asthma care, cardiac care, chronic obstructive pulmonary disease (COPD) care, depression care, diabetes care, heart failure care, hypertension care, inflammatory bowel disease (IBD) care, and maternity care.</p> <p>Physician Office Systems and Physician Office Systems Specialty certifications, recently retired by BTE, will persist until individual two-year certifications expire.</p> <p>Percent of providers recognized in a BTE program for a group is calculated based on the recognition and group alignment.</p>
<p>Cigna utilization and COE data</p>	<p>Specialty groups that admit to COE facilities (based on utilization data) will receive credit towards the quality component evaluation for Cigna Care Designation inclusion.</p>

Additional information and data limitations

The quality and cost-efficiency profiles 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 provider in selecting a provider 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 provider 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 providers or processed by us.
- Pharmacy data inclusion is limited to customers covered by a Cigna-administered pharmacy benefit plan.
- We use ETG[®] 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 providers or provider groups are unable to be displayed for quality and cost-efficiency due to small patient populations. We will not display results for those providers or provider groups whose episodes or opportunities sample do not meet minimum volume thresholds.

Process to display strategic alliances information

Health Alliance Plan (HAP)

Providers or provider 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 providers using the same quality and cost methodology utilized in all other Cigna Care Designation markets, as described in this whitepaper. The 2020 assessment review period for Cigna Care Designation for 2020 is January 1, 2017 through December 31, 2018. HAP providers who meet our specific quality and cost-efficiency criteria will receive Cigna Care Designation.

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 provider performance results.
- We pay incentive payments to provider 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 providers, 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 providers 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 provider evaluation methodology, reporting formats, and processes are implemented as appropriate. Methodology changes are generally reviewed and implemented on an annual basis.

Provider process to request reconsideration

Participating providers or provider 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 provider practice or provider group to clarify information received for reconsideration and generate detail reports. The NCM or NCS may change the provider group designation if the obtained information meets CCD 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 or BTE provider recognition programs. The National Selection Review Committee will review the request if the obtained information does not meet CCD 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 each Cigna region, 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 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 provider 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 42-43 for state-specific notes about CCD reconsiderations.

How to register complaints

At any time, Cigna customers may register a complaint with us about the Cigna Care Designation, and quality and cost-efficiency 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 Health and Life 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 Cigna Care Designation, quality, and cost-efficiency 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.

Appendices

Appendix 1: 2020 Cigna Care Designation market information

Market name	Volume reviewed	Percent designated	Percent not designated
AR Arkansas	5,880	14.37	85.63
AZ Maricopa	9,515	34.61	65.39
AZ All Other	1,922	20.55	79.45
AZ Pima	2,580	22.02	77.98
CA North	2,077	12.13	87.87
CA South	32,411	19.32	80.68
CA Bay Area	12,621	41.26	58.74
CA Sacramento	3,348	34.14	65.86
CA Central Valley	3,455	34.73	65.27
CO Front Range	10,740	29.82	70.18
CT Connecticut	10,460	39.03	60.97
DE Delaware	2,567	9.93	90.07
FL Jacksonville	3,159	20.39	79.61
FL All Other	5,164	18.55	81.45
FL South Florida	11,115	30.97	69.03
FL Orlando	6,690	26.53	73.47
FL Tampa	10,950	25.71	74.29
GA Atlanta	9,829	37.16	62.84
GA All Other	4,688	30.06	69.94
IL Chicago Metro	18,659	46.59	53.41
IL Rockford	4,136	13.39	86.61
IN Indianapolis	4,550	34.44	65.56
KS KS/MO Kansas City	5,091	21.43	78.57
LA All Other	2,825	14.62	85.38
LA Baton Rouge	3,136	21.97	78.03
LA New Orleans	3,130	13.93	86.07
MA Western	4,700	35.30	64.70
MA Boston	19,793	27.74	72.26
MD Maryland	11,883	35.03	64.97
MD Northern VA	6,087	27.01	72.99
DC Metro North	6,749	26.24	73.76
ME Maine	4,183	19.75	80.25
MI Michigan	19,245	12.78	87.22
MS Mississippi	5,588	16.14	83.86
NC Charlotte	4,705	28.71	71.29
NC East	4,400	27.02	72.98
NC Raleigh	5,567	31.00	69.00
NC Triad	3,927	33.56	66.44
NC West	2,849	19.52	80.48

Market name	Volume reviewed	Percent designated	Percent not designated
NH New Hampshire	4,411	37.70	62.30
NJ North Jersey	11,746	35.66	64.34
NJ South Jersey	4,950	20.73	79.27
NV Nevada	4,467	22.10	77.90
NY Metro	31,484	31.33	68.67
OH Northern	12,029	14.26	85.74
OH Central	8,497	48.92	51.08
OH Southern	7,992	32.63	67.37
OH NW Ohio	3,129	23.07	76.93
OR Oregon	11,358	22.45	77.55
PA Philadelphia	11,745	30.18	69.82
PA All Other	13,493	23.55	76.45
PA Pittsburgh/Western	7,463	55.85	44.15
RI Rhode Island	3,281	18.26	81.74
SC Low Country	3,363	16.44	83.56
SC Midlands	2,742	13.79	86.21
SC Upstate	3,875	33.21	66.79
TN West	4,095	30.13	69.87
TN Central	6,905	27.04	72.96
TN East	7,136	32.17	67.83
TX Austin	4,648	29.67	70.33
TX Dallas/Ft. Worth	11,477	34.76	65.24
TX Houston	13,370	25.99	74.01
TX San Antonio	3,622	16.92	83.08
TX East Central Texas	2,768	21.97	78.03
UT Wasatch Front	4,811	25.57	74.43
VA Hampton Roads	3,711	21.21	78.79
VA Richmond	3,321	28.94	71.06
VA Western	3,932	32.53	67.47
VT Vermont	2,071	19.70	80.30
WA Seattle	11,821	23.37	76.63
WA All Other	5,557	13.19	86.81
WI Milwaukee/Green Bay	8,987	51.13	48.87
WI All Other	5,081	23.34	76.66
WV West Virginia	4,733	12.34	87.66

Appendix 2: 2020 Quality and cost-efficiency display markets

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

Market name	Specialist reviewed
AL Alabama **	7,357
AR Arkansas	5,880
AZ Maricopa	9,515
AZ All Other	1,922
AZ Pima	2,580
CA North	2,077
CA South	32,411
CA Bay Area	12,621
CA Sacramento	3,348
CA Central Valley	3,455
CO All Other **	2,272
CO Front Range	10,740
CT Connecticut	10,460
DE Delaware	2,567
FL Jacksonville	3,159
FL All Other	5,164
FL South Florida	11,115
FL Orlando	6,690
FL Tampa	10,950
GA Atlanta	9,829
GA All Other	4,688
IL Chicago Metro	18,659
IL All Other **	6,532
IL Rockford	4,136
IN Indianapolis	4,550
IN All Other **	6,308
KS KS/MO All Other **	6,036
KS KS/MO Kansas City	5,091
KY Kentucky **	9,797
LA All Other	2,825
LA Baton Rouge	3,136
LA New Orleans	3,130
MA Western	4,700
MA Boston	19,793
MD Maryland	11,883
MD Northern VA	6,087
DC Metro North	6,749
ME Maine	4,183
MI Michigan	19,245
MS Mississippi	5,588
NC Charlotte	4,705

Market name	Specialist reviewed
NC East	4,400
NC Raleigh	5,567
NC Triad	3,927
NC West	2,849
NH New Hampshire	4,411
NJ North Jersey	11,746
NJ South Jersey	4,950
NV Nevada	4,467
NY Metro	31,484
NY All Other **	18,301
OH Northern	12,029
OH Central	8,497
OH Southern	7,992
OH NW Ohio	3,129
OK Oklahoma **	5,741
OR Oregon	11,358
PA Philadelphia	11,745
PA All Other	13,493
PA Pittsburgh/Western	7,463
RI Rhode Island	3,281
SC Low Country	3,363
SC Midlands	2,742
SC Upstate	3,875
TN West	4,095
TN Central	6,905
TN East	7,136
TX Austin	4,648
TX Dallas/Ft. Worth	11,477
TX Houston	13,370
TX San Antonio	3,622
TX East Central Texas	2,768
UT Wasatch Front	4,811
VA Hampton Roads	3,711
VA Richmond	3,321
VA Western	3,932
VT Vermont	2,071
WA Seattle	11,821
WA All Other	5,557
WI Milwaukee/Green Bay	8,987
WI All Other	5,081
WV West Virginia	4,733

Appendix 3: EBM rules used for the 2020 provider 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)	N/A	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)	N/A	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 provider 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

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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 Otolaryngology Pulmonology	Family practice Internal medicine
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 and 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 and Transient cerebral ischemia	Patient(s) with a recent emergency room encounter for a transient cerebral ischemic event that had any provider 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

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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
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
Childhood immunization (National standard)*	Patient(s) 2 years old at the end of the report period that had an MMR by their 2nd birthday.	National Committee for Quality Assurance (NCQA)	N/A	Family practice Pediatrics
Childhood immunization (National standard)*	Patient(s) 2 years old at the end of the report period that had a varicella immunization by their 2nd birthday.	National Committee for Quality Assurance (NCQA)	N/A	Family practice Pediatrics
Childhood immunization (National standard)*	Patient(s) 2 years old at the end of the report period that had one hepatitis A immunization by their 2nd birthday.	National Committee for Quality Assurance (NCQA)	N/A	Family practice Pediatrics
Childhood immunization (National standard)*	Patient(s) 2 years old at the end of the report period that had two influenza immunizations by their 2nd birthday.	National Committee for Quality Assurance (NCQA)	N/A	Family practice Pediatrics

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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	N/A	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
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	Cardiology Cardiothoracic surgery	Family practice Internal medicine

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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	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	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, 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
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

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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 and 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)	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	Otolaryngology	Family practice Internal medicine Pediatrics

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
Otitis media, acute*	Patient(s) on antibiotic therapy with acute otitis media that received amoxicillin, a first line antibiotic	American Academy of Pediatrics (AAP) American Academy of Family Physicians (AAFP) Optum	Allergy and immunology Obstetrics and gynecology Otolaryngology	Family practice Pediatrics
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 Internal medicine
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	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	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)	Obstetrics and gynecology	Family practice

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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 Pediatrics (AAP)	Obstetrics and gynecology	Family practice
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	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

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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 provider 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
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

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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 Otolaryngology Pulmonology	Family practice Internal medicine Pediatrics
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

Condition/treatment	Rule description	Source	Specialty types	Primary care specialty types
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
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 provider 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 provider 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 provider or provider 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 provider or provider group to determine how the withheld data affected the designation. After disclosure of the description of the methodology described above, the provider or provider 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 2020 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 provider should email Cigna at PhysicianEvaluationInformationRequest@Cigna.com, or fax the request to 1.866.448.5506. An NCM will contact the provider or provider group to provide additional details about the process and the results. If the provider meets the criteria for Cigna Care Designation 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 each Cigna region, their alternates, and ad hoc physicians

Non-voting Committee Participants

- Vice President, Clinical Measurement and Improvement
- Cigna Global Data & Analytics (GD&A) 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 provider 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 provider's appeal. If requested, a face-to-face meeting will be arranged at a location reasonably convenient to the provider; other participants can join the meeting using teleconference. The provider has the right to be assisted by a representative. The provider 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 provider 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 provider or provider group will receive a written decision regarding the appeal that states the reasons for upholding, modifying, or rejecting the provider'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.

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