2023 QUALITY, COST EFFICIENCY, AND CIGNA CARE DESIGNATION METHODOLOGY

For Health Care Providers
July 2022

Together, all the way.™

Cigna®

Table of contents

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 addition, groups who meet Cigna's specific quality and cost-efficiency criteria can receive the Cigna Care Designation (CCD), which denotes a higher performing provider, based on the criteria outlined in this document.

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 CCD 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, 2020 through December 31, 2021 for the review period to assess for 2023 quality and cost-efficiency profiles and directory displays. This review includes claims data from Cigna-administered Managed Care and PPO plans, and excludes government and capitated plans.

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[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 seventh time in June 2021. 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 and oncology	Internal medicine	Nephrology
Neurology	Neurosurgery	Obstetrics and gynecology
Ophthalmology	Orthopedic surgery	Pediatrics
Pulmonary	Rheumatology	Urology

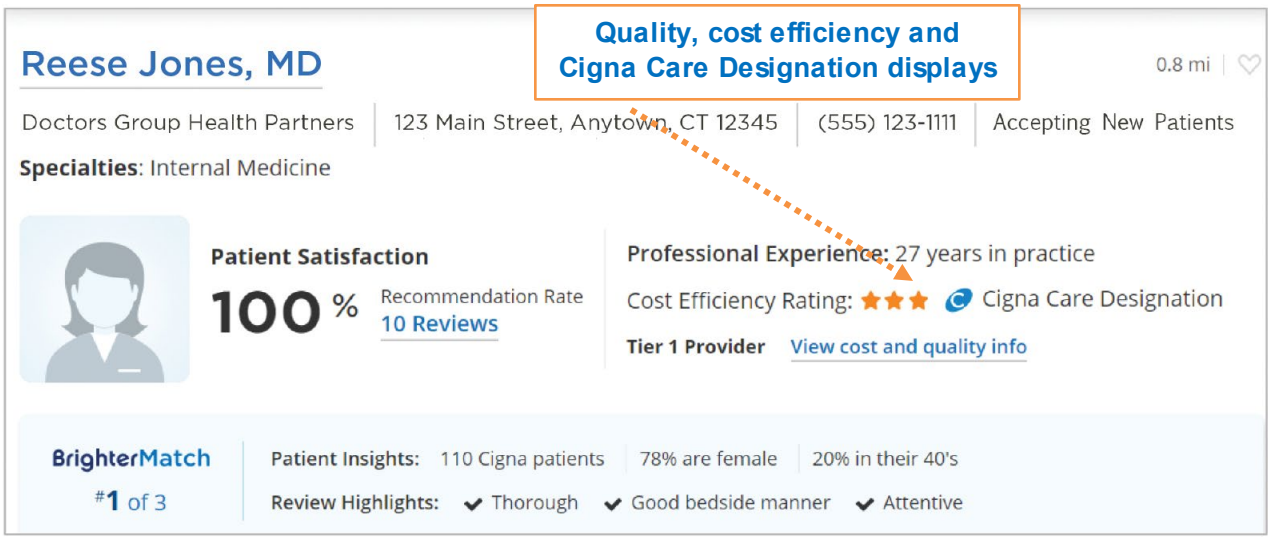
Note: While CCD is determined at the aggregated group level, we determine cost and quality performance metrics by reviewable specialty type for groups comprised of more than one specialty type.

Market availability

Our Network Contracting and Market Medical Executive teams defined the 2023 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, 2023.

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 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 to Cigna customers. 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 82 Evidence Based Medicine (EBM) rules derived from measures endorsed by the NQF, Healthcare Effectiveness Data Information Set (HEDIS), or developed by provider organizations. These rules span 45 diseases and preventive cares conditions (see Appendix 2), 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 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 five NCQA physician recognition programs:

   NCQA Diabetes Recognition Program (DRP)
   NCQA Heart/Stroke Recognition Program (HSRP)
   NCQA Patient-Centered Medical Home Recognition (PCMH – two versions)
   NCQA Patient-Centered Specialty Practice Recognition (PCSP)
   NCQA Patient-Centered Connected Care (PCCC)

   Additional information about these programs is available on the NCQA website (NCQA.org > Our Programs).

4. **Quality Oncology Practice Initiative Certification Program**
   The Quality Oncology Practice Initiative (QOPI®) Certification Program provides a three-year certification recognizing high-quality care for outpatient hematology-oncology practices within the United States (ASCO Practice Central, 2021). The QOPI Certification Program builds upon the success of the American Society of Clinical Oncology's (ASCO) Quality Oncology Practice Initiative. We identify physicians in our online provider directory who have received this certification.

   Additional information about this program is available on the ASCO Practice Central website at QOPI Certification Program.

Evidence-based medicine (EBM) assessment process

The EBM rules used in the 2023 evaluation apply to 15 primary care and non-primary care specialty types. Currently, there are no EBM rules that apply to dermatology, and limited EBM rules for gastroenterology, general surgery, neurosurgery, ophthalmology, and orthopedic surgery. Therefore, those specialties are not evaluated for EBM quality.

Overall, approximately 14.25 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, 15,442 or 2.16 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 and oncology
Internal medicine	Nephrology	Neurology
Obstetrics and gynecology (OB/GYN)	Otolaryngology (ENT)	Pediatrics
Pulmonary	Rheumatology	Urology

The 2023 EBM assessment component review includes measuring compliance with 82 EBM rules obtained from Optum EBM Connect® software, version 10.2, where applicable, for the medical conditions displayed in Appendix 2.

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 2023 displays, that period is January 1, 2020 through December 31, 2021.
- 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 2). 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.
- 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 determine 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 (clinical 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 (Episode Treatment Groups® or 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 percent for their specialty.

Cost-efficiency evaluation and displays

Participating providers and provider groups are evaluated for their cost efficiency using an industry-standard methodology (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.

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 Cigna 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 1 for the geographical markets and volume of providers reviewed for quality and cost- efficiency displays beginning January 1, 2023.

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® is available in the Symmetry® Episode Treatment Groups® whitepaper on the Optum website (www.optum.com). Optum ETG® software version10 is used for the assessment.

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 for the same ETG. A provider or provider group's aggregated performance is influenced by 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® meeting the minimum tally above 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.
  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 and surgical 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 percent 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, an, 3 cost stars will display on the directory for those providers in the top 34 percent for their specialty, two stars for those falling between 34% and 66 percent and 1 star for those in the bottom 34 percent.

2023 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 CCD is conferred 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 2023, providers who meet our specific quality and cost-efficiency criteria, can receive the CCD and will receive the CCD ( ) 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 CCD

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

Participating providers may receive CCD if the provider or provider group:

- Is located in one of the 85 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 QOPI certification **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 QOPI certification 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 CCD 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 provider group must meet certain criteria to achieve the 2023 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
- 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

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, recognizes 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 provider is 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 CCD, CCC providers must be 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 opportunities per rule during the data collection period. A Quality Index is calculated for each CCC based on adherence to EBM measures. CCCs must have a Quality Index greater than or equal to 1.00 to meet the quality requirement. The Quality Index is calculated based on adherence to 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., must have a TMC Performance Index of less than or equal to 0.97 to meet the pathway cost requirement.

Specialty care cost-efficiency assessment

For CCCs with reviewable specialty type providers who comprise >=20 percent of the roster, the ETG Performance Index must be 1.00 or less to meet the pathway cost requirement for the specialists to meet the inclusion criteria.

Note: Quality and cost-efficiency criteria for CCCs may be adjusted locally to address market specific needs.

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.

Cigna Centers of Excellence pathway to achieve Cigna Care Designation

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 10 admissions to COE hospital for the diagnostic-related groups (DRGs) in the latest COE evaluation program
- At least 25 percent of the providers in the group are affiliated with a COE

2023 Provider evaluation methodology changes

Changes to our 2023 provider evaluation methodology are outlined below:

Methodology	Change/Enhancement	Details/Rationale
Software Update	EBM moving to version 10.2	Added additional Oncology rules bringing the total to 12
Software Update	ETG moving to version 10.0	
Data review period	Reporting years of 2020-2021	Utilizing the most recent data
California 2 Market Updates	Break out of CA2 market into 4 separate markets: CA6, CA7, CA8, CA9.	CCD Geo Access is limited due to the large size of one market; division into 4 markets addresses this issue

Data sources

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

Data source	How information is used
Cigna provider metrics (January 2020 – December 2021) Use combined Cigna-administered managed care and PPO product data with episodes of care or EBM rules attributed to the responsible provider.	The data is used to produce ETG® efficiency and EBM summary reports. **Note:** Data for Medicare-eligible individuals and capitated business is removed.
Health Care Provider Manager (HPCM)	File extracts to identify contracted providers, TIN, provider group demographics, specialty, board certification status, network, and products contracted.
Physician Recognition Program File obtained from the National Committee for Quality Assurance (NCQA) (as of April 2022 and at least six times per year)	The status of physicians recognized for the diabetes, heart/stroke, patient-centered medical home, patient-centered specialty practice recognition programs, and patient-centered connected care 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.
American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI) certification	Percent of physicians recognized with ASCO QOPI for a group is calculated based on the recognition and group alignment.
Cigna utilization and COE data	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 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. Claims received by Cigna, but processed by a delegate are excluded. 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.

About Cigna's tiered benefit

Cigna's tiered benefit is offered in various markets through employer-sponsored health plans. This benefit has copayment and coinsurance levels for covered services provided by Tier 1 providers that differ from those of other participating providers. CCD can be one of the considerations for inclusion in Tier 1 for Cigna's tiered benefit plan design in the markets where this benefit is available, however, it does not ensure inclusion. Tier 1 providers are determined through multiple criteria, including but not limited to, contractual requirements, business needs, access, and quality and cost efficiency performance. The benefit is intended to encourage individuals with this plan to consider using a Tier 1 provider.

While a provider's overall reimbursement is unchanged as a result of their status as a Tier 1 provider, customers may experience a lower coinsurance or copayment when selecting a Tier 1 provider. Inclusion of a provider as a Tier 1 provider does not indicate that the provider offers services of equal or greater quality and cost efficiency than any other participating provider.

Feedback process

We welcome and encourage participating providers, customers, and employers to provide feedback and suggestions for how we can improve the evaluation or 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 **800.88Cigna (882.4462)** or send an email to PhysicianEvaluationInformationRequest@Cigna.com. 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.

Removal of Cigna Care Designation

Cigna reserves the right to remove a provider's CCD if the provider no longer meets our specific criteria for designation, or for reasons that include, but are not limited to:

- Fraud
- Federal or state sanctions
- Complaints about quality or service
- Failure to meet the quality standards or metrics

Provider reconsideration request process

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 **866.448.5506** for detail reports, to request or submit additional information, to request reconsideration of your quality and cost-efficiency displays, or to correct inaccuracies. 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) will contact the provider practice or provider group to clarify information received for reconsideration and generate detail reports. The NCM 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 EBM adherence score; or a verification of completion of one or more NCQA physician or QOPI 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, and Network Clinical Managers

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 3 on pages 34-35 for state-specific notes about CCD reconsiderations.

How to register complaints

At any time, Cigna customers may register a complaint with us about the CCD, 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 CCD, 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: 2023 Quality, Cost and Cigna Care Designation market information

* Indicates markets where the tiered-benefit option is not available.

Market name	Number of providers reviewed	Percent of CCD providers designated	Percent of CCD providers *not* designated
AL ALABAMA*	10,424	13.37	86.63
AR ARKANSAS	7,026	6.70	93.30
AZ MARICOPA	12,266	21.21	78.80
AZ ALL OTHER	2,435	15.73	84.27
AZ PIMA	3,061	18.95	81.05
CA NORTH	2,477	11.10	88.90
CA LOS ANGELES	14,945	17.29	82.71
CA BAY AREA	13,475	27.88	72.12
CA SACRAMENTO	3,671	10.87	89.13
CA CENTRAL VALLEY	3,860	21.45	78.55
CA KERN/SAN BERNADINO/RIVERSIDE/IMPERIAL	5,778	14.87	85.13
CA SAN DIEGO/ORANGE	11,861	24.21	75.79
CA SAN LUIS OBISPO/SANTA BARBARA/VENTURA	2,640	20.80	79.20
CO ALL OTHER*	2,649	20.39	79.61
CO FRONT RANGE	13,073	25.98	74.02
CT CONNECTICUT	12,725	22.42	77.58
DC METRO NORTH	7,313	17.54	82.46
DE DELAWARE	3,221	5.96	94.04
FL JACKSONVILLE	4,155	23.61	76.39
FL ALL OTHER	6,581	18.81	81.19
FL SOUTH FLORIDA	13,588	21.97	78.03
FL ORLANDO	8,353	27.43	72.57
FL TAMPA	13,857	31.09	68.91
GA ATLANTA	11,814	21.09	78.91
GA ALL OTHER	5,718	14.90	85.10
IL CHICAGO METRO	22,067	35.27	64.73
IL ALL OTHER*	7,262	19.69	80.31
IL ROCKFORD	4,465	12.63	87.37
IN INDIANAPOLIS	5,209	20.62	79.38
IN ALL OTHER*	7,193	8.45	91.55
KS KS/MO ALL OTHER*	6,930	18.21	81.79
KS KS/MO KANSAS CITY	5,571	17.39	82.61
KY KENTUCKY*	11,414	15.67	84.33
LA ALL OTHER	3,574	7.47	92.53
LA BATON ROUGE	3,844	16.60	83.40
LA NEW ORLEANS	3,664	12.83	87.17
MA WESTERN	4,978	10.55	89.45

Market name	Number of providers reviewed	Percent of CCD providers designated	Percent of CCD providers *not* designated
MA BOSTON	22,522	20.98	79.02
MD MARYLAND	13,328	20.87	79.13
MD NORTHERN VA	7,341	17.83	82.17
ME MAINE	4,899	15.53	84.47
MI MICHIGAN	23,409	13.85	86.15
MS MISSISSIPPI	6,485	7.62	92.38
NC CHARLOTTE	6,693	24.53	75.47
NC EAST	5,212	14.85	85.15
NC RALEIGH	7,949	29.26	70.74
NC TRIAD	4,501	17.22	82.78
NC WEST	3,554	20.96	79.04
NH NEW HAMPSHIRE	4,748	14.53	85.47
NJ NORTH JERSEY	14,856	21.61	78.39
NJ SOUTH JERSEY	5,877	11.42	88.58
NV NEVADA	5,498	18.84	81.16
NY METRO	37,777	27.79	72.21
NY ALL OTHER*	18,557	23.99	76.01
OH NORTHERN	13,618	14.37	85.63
OH CENTRAL	9,787	15.15	84.85
OH SOUTHERN	9,268	15.25	84.75
OH NW OHIO	3,273	4.61	95.39
OK OKLAHOMA*	6,828	4.77	95.23
OR OREGON	12,822	14.21	85.79
PA PHILADELPHIA	14,167	28.55	71.45
PA ALL OTHER	15,929	23.55	76.45
PA PITTSBURGH/WESTERN	9,573	15.02	84.98
RI RHODE ISLAND	3,722	13.65	86.35
SC LOW COUNTRY	4,140	14.54	85.46
SC MIDLANDS	3,696	12.88	87.12
SC UPSTATE	4,499	6.13	93.87
TN WEST	4,651	24.30	75.70
TN CENTRAL	8,118	24.67	75.33
TN EAST	8,039	19.24	80.76
TX AUSTIN	5,743	24.97	75.03
TX DALLAS/FT. WORTH	14,796	28.72	71.28
TX HOUSTON	15,689	22.56	77.44
TX SAN ANTONIO	3,830	11.62	88.38
TX EAST CENTRAL TEXAS	3,456	13.37	86.63
UT WASATCH FRONT	5,766	26.08	73.92
VA HAMPTON ROADS	4,541	10.20	89.80
VA RICHMOND	3,868	23.14	76.86
VA WESTERN	4,761	17.18	82.82
VT VERMONT	2,377	17.16	82.84

Market name	Number of providers reviewed	Percent of CCD providers designated	Percent of CCD providers *not* designated
WA SEATTLE	13,232	17.13	82.87
WA ALL OTHER	6,289	7.51	92.49
WI MILWAUKEE/GREEN BAY	9,941	20.77	79.23
WI ALL OTHER	5,609	11.54	88.47
WV WEST VIRGINIA	5,729	9.71	90.30

Appendix 2: 2023 EBM rules used for provider evaluation

Condition/treatment	Rule description	Source	Specialty types	Primary care types
Admissions and emergency department (ED) visits for patients receiving outpatient chemotherapy	Patient(s) 18 years of age and older with at least one inpatient admission for complications of chemotherapy within 30 days of outpatient chemotherapy treatment	Centers for Medicare & Medicaid Services (CMS) National Quality Forum (NQF) number 3490 Optum	Hematology/ oncology	N/A
Admissions and ED visits for patients receiving outpatient chemotherapy	Patient(s) 18 years of age and older with at least one ED encounter for complications of chemotherapy within 30 days of outpatient chemotherapy treatment	CMS NQF number 3490 Optum	Hematology/ oncology	N/A
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Patient(s) 20-44 years of age who had a preventive or ambulatory care visit during the last 12 months of the report period	Healthcare Effectiveness Data Information Set (HEDIS®) National Committee for Quality Assurance (NCQA)	N/A	Family practice Internal medicine Obstetrics and gynecology
AAP	Patient(s) 45-64 years of age who had a preventive or ambulatory care visit during the last 12 months of the report period	HEDIS NCQA	N/A	Family practice Internal medicine Obstetrics and gynecology
Antidepressant Medication Management (AMM)	Patient(s) with major depression who start an antidepressant medication and remained on treatment for at least 12 weeks (effective acute phase treatment)	HEDIS NCQA NQF number 0105	N/A	Family practice Internal medicine Obstetrics and gynecology

AMM	Patient(s) with major depression who start an antidepressant medication and remained on treatment for at least six months (effective continuation phase treatment)	HEDIS NCQA NQF number 0105	N/A	Family practice Internal medicine Obstetrics and gynecology
Appropriate Testing for Pharyngitis (CWP)	Patient(s) treated with an antibiotic for pharyngitis who had a group A streptococcus test	HEDIS NCQA NQF number 0002	Allergy and /immunology Ear, nose, and throat	Family practice Obstetrics and gynecology pediatrics
Appropriate Treatment for Upper Respiratory Infection (URI)	Patient(s) with a diagnosis of upper respiratory infection (URI) who did not have a prescription for an antibiotic on or within three days after the initiating visit	HEDISNCQANQF number 0069 (similar)	Allergy and immunology Ear, nose, and throat	Family practice Obstetrics and gynecology Pediatrics
Asthma Medication Ratio (AMR)	Patient(s) between 5-64 years of age with an asthma medication ratio >= 0.50 during the report period	HEDIS NCQA NQF number 1800	Allergy and immunology Pulmonology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Atrial fibrillation	Patient(s) taking warfarin that had three or more prothrombin time tests in last six reported months	American College of Cardiology (ACC) American Heart Association (AHA) Optum	Cardiology Cardio-thoracic surgery Pulmonology	Family practice Internal medicine
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Patient(s) with a diagnosis of acute bronchitis/bronchiolitis who did not have a prescription for an antibiotic on or within three days after the initiating visit	HEDIS NCQA NQF number 0058 similar	Allergy and immunology Ear, nose, and throat Pulmonology	Family practice Internal medicine Obstetrics and gynecology
Breast cancer – part 1	Patient(s) compliant with prescribed anti-estrogen for chemotherapeutic use (minimum compliance 80%)	American Cancer Society (ACS) American Society of Clinical Oncology (ASCO) NCQA NQF number 0387e (similar) Optum	Hematology/ oncology	Family practice Internal medicine Obstetrics and gynecology

Breast cancer – part 1	Patient(s) compliant with prescribed aromatase inhibitor (minimum compliance 80%)	ACS ASCO NCQA NQF number 0387e (similar) Optum	Hematology/ oncology	Family practice Internal medicine Obstetrics and gynecology
Breast cancer – part 1	Patient(s) who had an annual physician visit	ACS ASCO NCQA Optum	Hematology/ oncology	Family practice Internal medicine Obstetrics and gynecology
Breast cancer – part 1	Patient(s) who had an annual mammogram	ACS ASCO NCQA Optum	Hematology/ oncology	Family practice Internal medicine Obstetrics and gynecology
Breast cancer – part 2	Patient(s) newly diagnosed with breast cancer who received radiation, chemotherapy, or hormonal treatment or had medical oncology or radiation oncology consultation within 120 days of the diagnostic procedure	ACS ASCO Optum	Hematology/ oncology	Family practice Internal medicine Obstetrics and gynecology
Breast cancer screening (BCS)	Patient(s) 52-74 years of age who had a screening mammogram in last 27 reported months	HEDIS NCQA NQF number 2372	N/A	Family practice Internal medicine Obstetrics and gynecology
Cerebral vascular accident and transient cerebral ischemia – part 1	Patient(s) taking warfarin who had three or more prothrombin time tests in last six reported months	ACC AHA Optum	Cardiology Neurology	Family practice Internal medicine
Cerebral vascular accident and transient cerebral ischemia – part 3	Patient(s) with a recent ED encounter for a transient cerebral ischemic event who had a provider visit within 14 days of the acute event	Optum	Cardiology Neurology	Family practice Internal medicine
Cervical cancer screening (CCS)	Women who had appropriate screening for cervical cancer (commercial enrollment)	HEDIS NCQA NQF number 0032 endorsed	N/A	Family practice Internal medicine Obstetrics and gynecology

Chlamydia screening in women (CHL)	Patient(s) 16-20 years of age who had a chlamydia screening test in last 12 reported months	HEDIS NCQA NQF number 0033	N/A	Family practice Internal medicine Obstetrics and gynecology Pediatrics
CHL	Patient(s) 21-24 years of age who had a chlamydia screening test in last 12 reported months	HEDIS NCQA NQF number 0033	N/A	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Chronic kidney disease (CKD)	Patient(s) with stage 5 or end stage renal disease who had a serum calcium in last 12 reported months	IMS health (Intercontinental Medical Statistics) NQF number 0574 Optum	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
CKD	Patient(s) with stage 5 or end stage renal disease who had a serum phosphorus in last 12 reported months	IMS health NQF number 0570 Optum	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
CKD	Patient(s) with stage 5 or end stage renal disease who had a serum PTH test in last 12 reported months	IMS health NQF number 0571 Optum	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
CKD	Patient(s) with proteinuria currently taking an ACE-inhibitor or angiotensin II receptor antagonist	NQF number 1662 Optum Renal Physicians Association	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
Colon cancer – part 2	Patient(s) newly diagnosed with colon cancer who did not have a PET scan	Optum	Hematology/ oncology	Family practice Internal medicine
Colon cancer surveillance	Patient(s) newly diagnosed with nonobstructing colon cancer who had a surveillance colonoscopy approximately one year after diagnostic colonoscopy	Health Benchmarks-IMS Health Optum	Hematology/ oncology	Family practice Internal medicine
Comprehensive Diabetes Care (CDC)	Patient(s) 18-75 years of age who had a HbA1c test in last 12 reported months	HEDIS NCQA NQF number 0057	Endocrinology	Family practice Internal medicine

				Obstetrics and gynecology Pediatrics
CDC	Patient(s) 18-75 years of age who had an annual screening test for diabetic retinopathy	HEDIS NCQA NQF number 0055	Endocrinology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
CDC	Patient(s) 18-75 years of age who had annual screening for nephropathy or evidence of nephropathy	HEDIS NCQA NQF number 0062	Endocrinology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Coronary artery disease	Patient(s) currently taking an ACE-inhibitor or angiotensin receptor blocker (ARB)	ACC AHA Optum	Cardiology Cardio-thoracic surgery	Family practice Internal medicine
Coronary artery disease	Patient(s) currently taking a statin	American Diabetes Association (ADA) Optum	Cardiology Cardio-thoracic surgery	Family practice Internal medicine
Depression	Patient(s) taking lithium who had a lithium level in last six reported months.	Optum	N/A	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Diabetes mellitus	Patient(s) compliant with prescribed statin-containing medication (minimum compliance 80%).	CMS NQF number 0545	Cardiology Cardio-thoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Diabetes mellitus	Adult(s) 18-75 years of age who had a serum creatinine or estimated glomerular filtration rate in last 12 reported months.	ADA NQF number 0604 Optum	Cardiology Cardio-thoracic surgery Endocrinology	Family practice Internal medicine Obstetrics and gynecology

			Nephrology Neurology	Pediatrics
Diabetes mellitus	Patient(s) who did not have a diabetes-related hospitalization in last 12 reported months	NCQA Optum	Cardiology Cardio-thoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Diabetes mellitus	Patient(s) with most recent HbA1c result 8.0% or lower	NCQA NQF number 0575 (endorsed)	Cardiology Cardio-thoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Patient(s) with rheumatoid arthritis who had a prescription dispensed for a disease modifying anti-rheumatic drug (DMARD) during the report period	HEDIS NCQA NQF number 0054	Rheumatology	Family practice Internal medicine
Epilepsy	Patient(s) with one or more hospitalizations or two or more ED encounters for epilepsy who had neurology evaluation in last three reported months	Optum The National Collaborating Centre for Primary Care Guidelines	Neurology	Family practice Internal medicine Pediatrics
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Patient(s) 13 years of age and older with an ED visit for alcohol and other drug abuse or dependence that had a follow-up visit within 30 days	HEDIS NCQA NQF number 2605	N/A	Family practice Internal medicine Pediatrics
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	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	HEDIS NCQA NQF number 0108	N/A	Family practice Pediatrics

Follow-Up Care for Children Prescribed ADHD Medication (ADD)	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.	HEDIS NCQA) NQF number 0108	N/A	Family practice Pediatrics
Heart failure – part 1	Patient(s) currently taking a beta-blocker specifically recommended for heart failure management	ACC AHA European Society of Cardiology (ESC) Optum	Cardiology	Family practice Internal medicine
Hypertension	Patient(s) taking an ACE-inhibitor, angiotensin receptor blocker (ARB), diuretic, or aldosterone receptor antagonist-containing medication who had a serum potassium in last 12 reported months	Institute for Clinical Systems Improvement (ICSI) Optum	Cardiology Endocrinology Nephrology Neurology	Family practice Internal medicine Obstetrics and gynecology
Hypertension	Patient(s) who 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) ICSI	Cardiology Endocrinology Nephrology Neurology	Family practice Internal medicine Obstetrics and gynecology
Migraine headache	Adult(s) with frequent use of acute medications who also received prophylactic medications	American Academy of Neurology (AAN) Optum NQF number 0607 Ingenix	Neurology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Migraine headache	Patient(s) with frequent ED encounters or frequent acute medication use who had an ambulatory visit in last six reported months	AAN Optum	Neurology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Multiple sclerosis	Patient(s) who had a neurology evaluation in last 12 reported months	AAN National Multiple Sclerosis Society Optum	Neurology	Family practice Internal medicine

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	Patient(s) 16-20 years of age who had a cervical cancer screening (cervical cytology or HPV test) in the last 12 reported months	HEDIS NCQA	N/A	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Oncology – Appropriate use of antiemetics	Patient(s) receiving parenteral highly emetogenic single agent chemotherapy who received appropriate antiemetic prophylaxis.	Optum	Hematology/ oncology	N/A
Osteoporosis Management in Women Who Had a Fracture (OMW) – part 2	Women 67-85 years of age who were treated or tested for osteoporosis within six months of a fracture	HEDIS NCQA NQF number 0053	Endocrinology Rheumatology	Family practice Internal medicine Obstetrics and gynecology
Otitis externa, acute	Patient(s) 2 years of age and older with acute otitis externa who were *not* prescribed systemic antimicrobial therapy	American Academy of Otolaryngology - Head and Neck Surgery NQF number 0654 Optum	Ear, nose, and throat	Family practice Internal medicine Pediatrics
Otitis media, acute	Patient(s) on antibiotic therapy with acute otitis media that received amoxicillin, a first line antibiotic	AAP American Academy of Family Physicians Optum	Allergy and immunology Ear, nose, and throat	Family practice Obstetrics and gynecology Pediatrics
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge	HEDIS NCQA NQF number 0071	Cardiology Cardio-thoracic surgery	Family practice Internal medicine
Pharmacotherapy Management of COPD Exacerbation (PCE)	Patient(s) 40 years of age and older with COPD exacerbation who received a systemic corticosteroid within 14 days of the hospital or ED discharge	HEDIS NCQA	Pulmonology	Family practice Internal medicine
Pharmacotherapy Management of COPD Exacerbation (PCE)	Patient(s) 40 years of age and older with COPD exacerbation who received a bronchodilator within 30 days of the hospital or ED discharge	HEDIS NCQA	Pulmonology	Family practice Internal medicine
Pneumonia, community-acquired bacterial (CAP)	Adult(s) with community-acquired bacterial pneumonia who have a CXR	American Thoracic Society Infectious Disease Society of America Optum	Pulmonology	Family practice Internal medicine

Pregnancy management	Pregnant women who were tested for HIV	AAP HEDIS American College of Obstetricians and Gynecologists (ACOG) NQF number 0606 U.S. Preventive Services Task Force (USPSTF)	N/A	Family practice Obstetrics and gynecology
Pregnancy management	Pregnant women less than 25 years of age who were screened for chlamydia	ACOG AAP USPSTF	N/A	Family practice Obstetrics and gynecology
Pregnancy management	Pregnant women who were screened for syphilis	AAP HEDIS ACOG NQF number 0607 USPSTF	N/A	Family practice Obstetrics and gynecology
Pregnancy management	Pregnant women that had HBsAg testing.	AAP HEDIS ACOG NQF number 0608 USPSTF	N/A	Family practice Obstetrics and gynecology
Pregnancy management	Pregnant women who received group B streptococcus testing	ACOG AAP USPSTF	N/A	Family practice Obstetrics and gynecology
Prenatal and postpartum care (PPC)	Women who received a prenatal visit within the appropriate time period	HEDIS NCQA NQF number 1517	N/A	Family practice Obstetrics and gynecology
PPC	Women who received postpartum care (excluding bundled postpartum services)	HEDIS NCQA NQF number 1517	N/A	Family practice Obstetrics and gynecology
Prostate cancer	Patient(s) who had a prostate-specific antigen test in last 12 reported months	Optum	Hematology/ oncology Urology	Family practice Internal medicine
Prostate cancer	Patient(s) who had an annual physician visit or evidence of a digital rectal	Optum	Hematology/ oncology	Family practice Internal

	examination		Urology	medicine
Rheumatoid arthritis	Patient(s) taking methotrexate, sulfasalazine, gold, or leflunomide who had a CBC in last three reported months	American College of Rheumatology (ACR) NQF number 0598 (similar) Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking methotrexate who had a serum creatinine in last six reported months	ACR NQF number 0589 (similar) NQF number 0599 (similar) Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking methotrexate, sulfasalazine, or leflunomide who had serum ALT or AST test in last three reported months	ACR) NQF number 0590 (similar) Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking hydroxychloroquine who had an eye exam in last 12 reported months	ACR NQF number 0585 (similar) Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) with complex RA treatment regimens or complications who had rheumatology consultation in last six reported months	ACR Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid arthritis	Patient(s) taking chronic oral corticosteroids who had rheumatology consultation in last six reported months	ACR Optum	Rheumatology	Family practice Internal medicine Pediatrics
Sickle cell anemia	Patient(s) who had a hemoglobin/hematocrit in the last 12 reported months	Optum	Hematology/ oncology	Family practice Internal medicine Pediatrics
Sinusitis, acute	Patient(s) treated with an antibiotic for acute sinusitis who received a first line antibiotic	Optum	Allergy and immunology Ear, nose, and throat Pulmonology	Family practice Internal medicine Obstetrics and gynecology Pediatrics

Sinusitis, acute	Patient(s) who did not have a sinus computerized axial tomography (CT) or magnetic resonance imaging (MRI) test	Optum	Allergy and immunology Ear, nose, and throat Pulmonology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Patient(s) with cardiovascular disease who received a high-intensity or moderate-intensity statin medication	HEDIS	Cardiology Cardio-thoracic surgery Endocrinology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
SPC	Men 21-75 years of age with cardiovascular disease who received a high-intensity or moderate-intensity statin medication	HEDIS	Cardiology Cardio-thoracic surgery Endocrinology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
SPC	Women 40-75 years of age with cardiovascular disease who received a high-intensity or moderate-intensity statin medication	HEDIS	Cardiology Cardio-thoracic surgery Endocrinology	Family practice Internal medicine Obstetrics and gynecology Pediatrics
Statin Therapy for Patients with Diabetes (SPD)	Patient(s) 40-75 years of age with diabetes who received a statin medication	HEDIS	Cardiology Cardio-thoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine Obstetrics and gynecology
Tonsillectomy	Patient(s) 1-18 years of age who had a tonsillectomy and met the clinical criteria for this procedure	Optum	Ear, nose, and throat	Family Practice Internal Medicine Pediatrics
Use of Imaging Studies for Low Back Pain (LBP)	Patient(s) with uncomplicated low back pain who did not have imaging studies	HEDIS	Rheumatology	Family practice Internal medicine

				Obstetrics and gynecology

* 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 3: 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 **866.448.5506**.

The NCM 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 2023 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 **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 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 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

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 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.