2024 QUALITY, COST EFFICIENCY, AND CIGNA CARE DESIGNATION METHODOLOGY

For Health Care Professionals

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cigna healthcare

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Introduction

Many of our customers want to know more about provider quality and cost efficiency. To help provide them 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 our 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.

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 and Information Set (HEDIS®),* 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, participating providers are independent practitioners; they are not employees or agents of Cigna Healthcare. 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. The patient population is derived from claims paid data with dates of services from January 1, 2021 through December 31, 2022 for the review period to assess for 2024 quality and cost-efficiency profiles and directory displays. This review includes claims data from our Managed Care and Preferred Provider Organization (PPO) plans, and excludes government and capitated plans.

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

External certification

Cigna Healthcare earned the NCQA Physician Quality (PQ) Certification for the eighth time in July 2023. The PQ 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 health care spending based on our claims data. A provider can only be evaluated under one specialty, Taxpayer Identification Number (TIN), and geographical market for quality and cost-efficiency displays. The provider's primary specialty, as determined by Cigna Healthcare, 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 (OB/GYN)
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

Geographic market definitions have been updated for 2024 to better align to the regions in which our customers evaluate their care alternatives (See 2024 Methodology Changes). The zip code of a provider's primary office address is used to align a provider with a given geographic 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.

A list of markets including the volume and percent of CCD providers in each market is available upon request by contacting PhysicanEvaluationInformation@CignaHealthCare.com. These providers will have CCD effective January 1, 2024.

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. Board Certified Care Standard

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 certification criteria help determine whether board-certified physicians in the group predominantly provide patient care to our 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 are 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 are 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 109 Evidence-Based Medicine (EBM) rules derived from measures endorsed by the NQF, HEDIS, or developed by provider organizations. These rules span 45 diseases and preventive care conditions (see Appendix 1), 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 2024 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 10.12 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, 0.37 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 2024 EBM assessment component review includes measuring compliance with 109 EBM rules obtained from Optum EBM Connect® software, version 11, 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:

EBM rule adherence

- In order for an EBM rule to be included for review 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) for the most recent two-year data review period. For 2024 displays, that period is January 1, 2021 through December 31, 2022.
- The nationwide average adherence rate for each EBM rule is calculated for the provider specialty category (primary care or non-primary care specialty types) to derive the expected adherence rate.

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 1). 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 Healthcare coverage during the claim review period, with at least one of the visits occurring in the most recent 12 months of the 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 nationwide EBM rule adherence 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®] 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 EBM 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 (Episode Treatment Groups [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.

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 Healthcare 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, 2024.

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 version 10 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 Healthcare 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 specialty type, episode severity and treatment level, comorbidity, complications, or the presence of pharmacy benefits) in order to determine the expected cost for that ETG® and include it in the analysis.

- 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.

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., laboratory, X-ray, hospital, ambulatory surgery, and physical therapy]) are used to characterize the total cost of the episode.

A provider group's **Performance Index (PI)** is the ratio of the average of actual costs to the average of expected costs for all qualifying episodes managed by the group. For each observed episode we calculate an expected episode cost by taking the national average episode cost for episodes with the same full digit ETG number, responsible provider specialty type, episode severity and treatment level, comorbidity, complications, and pharmacy benefit coverage of the observed episode.

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. Expected episode costs for ETG®1 and ETG®2 have been established .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 expected cost for the episodes.

	Actual Episode Cost	Expected Episode 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

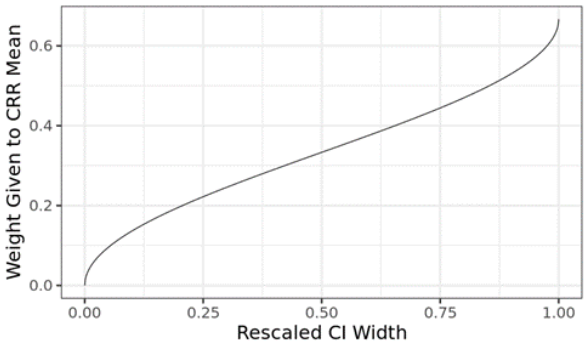
Dividing the average actual cost of all episodes of care attributable to the provider group by average expected episode cost for the ETG®s on which the provider group's cost-efficiency performance is being evaluated yields a Performance Index (PI) of 0.825.

- 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. To account for the uncertainty due to sample size, sample variability, and the delay between the observation period (2021-2022) and the published result (2024), an Adjusted Performance Index (API) is created. The API is a weighted average of a group's PI and the mean PI in the geographic market.. The weight given to the mean is determined by the relative size of the group's Confidence Interval (CI) in the geographic region. When we have more uncertainty about a group's performance (a wide 90 percent CI), we give more weight to the mean (up to 67 percent). In cases where we have little uncertainty about a group's performance (a narrow 90 percent CI), we give little to no weight to the mean. The calculation of API proceeds as follows:

  1. Rescale the CI Widths in the market to lie within the interval between 0 and 1:

$$\text{Rescaled CI Width} = \frac{\text{Group CI} - \text{Minimum CI in Market}}{\text{Maximum CI in Market} - \text{Minimum CI in Market}}$$

  2. Leverage the Cumulative Distribution Function (CDF) of the Beta Distribution under Alpha=0.5, Beta=0.5, to translate the rescaled CI width to a weight. Values for Alpha=0.5 and Beta=0.5 were selected following a grid search of potential alpha/beta combinations that optimized year-over-year disruption and prediction error, while equalizing the chances for small and large groups to earn designation:



3. Finally, calculate the API:

$$Adjusted\ PI = PI * (1 - weight) + CRR\ Mean\ PI * (weight)$$

As an example, consider a group with a PI=1.22 (90% CI: 0.95, 1.58; CI Width = 0.63). The mean PI in the group's CRR is 0.83. The minimum and maximum CI widths in the CRR are 0.14 and 1.68, respectively. The group's rescaled CI width is (0.63 – 0.14) / (1.68 – 0.14) = 0.32, which translates to a weight of 0.25. The group's API is 1.22*(1-.25) + 0.83*0.25 = 1.12. Finally, using a weighted percentile groups are then ranked by their API against their peers within their geographic market. They are not compared to groups outside their geographic market. Those groups ranking in the top 34 percent achieve three 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, and specialty level scoring will drive directory displays at the provider/specialty level. Three 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 one star for those in the bottom 34 percent.

2024 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 Healthcare coverage often chose a group rather than a specific provider within the group, and;
- Patients with Cigna Healthcare coverage who initially choose a specific provider frequently receive care by another provider within the practice or group.

Cigna Care Designation inclusion methodology

In 2024, 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 Healthcare 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 Healthcare 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 markets that currently participate in this program
- Practices in one of the 21 assessed specialties
- Meets Board Certified Care Standard
- 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, **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 **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 quality and cost efficiency 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 earned CCD last year and their API and AQI are within three percent of the lowest performing CCD group in their geographical market for 2024.

The selected provider group must meet certain criteria to achieve the 2024 buffer zone designation. The standard criterion applied includes:

- If a group is evaluated for Board Certified Care Standard
    - The group must meet the Board Certified Care Standard criteria
    - The board-certified physicians must be responsible for at least 50 percent of the group episodes
- A group must have at least 30 EBM opportunities to qualify for the AQI buffer zone
- A group must have at least 30 episodes to qualify for the API buffer zone

2024 Provider evaluation methodology changes

Changes to our 2024 provider evaluation methodology are outlined below:

Methodology	Change/Enhancement	Details/Rationale
Software update	EBM moving to version 11	
Data review period	Reporting years of 2021-2022	Utilizing the most recent data.
Market definition	Moving from 85 Legacy Markets to Cigna Referral Regions (CRRs)	CRRs are a better representation of our interconnectivity within a region compared to the Legacy Markets. CRRs were developed using predictive analytics and behavior technology, such as customer travel patterns, primary care provider/specialty access, and customer/provider interactions. They were developed similarly to Hospital Referral Regions (HRRs), but leverage our current data showing where our customers live and where they access common, provider-based care. CRRs are custom-built regions composed of Zip code areas grouped together to delineate health care markets based on our internal claims data.
Moving to a National Benchmark to calculate PI	National PI uses the average cost of episodes nationally as a benchmark for computing PIs. Groups are still ranked relative to peers in their own geography.	National PI decreases the CI width, implying increased certainty regarding group performance. National PI brings in more episodes for consideration that would be lost due to low volume in the market. National PI enables comparison across adjacent geographies.
Updated Adjusted PI	New version of the adjusted PI, which is a weighted average of the group's PI and the mean PI in the CRR.	Improves group level year-over-year disruption and customer-relationship disruption. Equalizes relative chance of large groups versus small groups to earn designation.
Removing the 1.03 PI cutoff	Reduces provider level disruption.	Increases the number of eligible groups that could earn designation.
Removing the CAC-to-CCD pathway	CAC-to-CCD pathway has been removed from the methodology	Due to the multiple types of collaborative care arrangement models a pathway to assign CCD based on the CAC performance is no longer considered plausible.

Data sources

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

Data source	How information is used
Cigna Healthcare provider metrics (January 2021 – December 2022) Use combined 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, TINs, provider group demographics, specialty, board certification status, networks, and products contracted.
Physician Recognition Program File obtained from the National Committee for Quality Assurance (NCQA) (as of April 2023 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.

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 Healthcare customers in health care decision-making. Our 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 claims data only. Aggregated claims 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 we receive, but are 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 Healthcare-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 Healthcare's tiered benefit

Cigna Healthcare'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 the 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 Healthcare-administered plans should call the telephone number listed on the back of their Cigna Healthcare 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, call Cigna Customer Healthcare Service at **800.88Cigna (882.4462)** or send an email to PhysicianEvaluationInformationRequest@CignaHealthCare.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 Healthcare 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@CignaHealthCare.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 Healthcare Quality Clinical Manager (QCM) will contact the provider practice or provider group to clarify information received for reconsideration and generate detail reports. The QCM 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 Healthcare physicians and quality clinical performance staff. Voting committee participants include the National Medical Director and physician representatives from each Cigna Healthcare 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 QCMs.

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 2 for state-specific notes about CCD reconsiderations.

How to register complaints

At any time, Cigna Healthcare 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 ID card.

Registering a complaint for Cigna Healthcare 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 Healthcare, 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: 2024 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 – Part 1	Patient(s) 18 years and older with at least one emergency department encounter 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 and oncology	N/A
Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy – Part 1	Patient(s) 18 years and older with at least one inpatient admission for complications of chemotherapy within 30 days of outpatient chemotherapy treatment.*	CMS NQF number 3490 Optum	Hematology and oncology	N/A
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Patient(s) 20 - 44 years that 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 (OB/GYN)
AAP	Patient(s) 45 - 64 years that had a preventive or ambulatory care visit during the last 12 months of the report period.	HEDIS NCQA	N/A	Family practice Internal medicine OB/GYN

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Antidepressant Medication Management (AMM)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 weeks (effective acute phase treatment).	HEDIS NCQA NQF number 0105	N/A	Family practice Internal medicine OB/GYN
AMM	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 6 months (effective continuation phase treatment).	HEDIS NCQA NQF number 0105	N/A	Family practice Internal medicine OB/GYN
Appropriate Testing for Pharyngitis (CWP)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	HEDIS NCQA	Allergy and immunology Ear, nose, and throat (ENT)	Family practice OB/GYN Pediatrics
Appropriate Treatment for Upper Respiratory Infection (URI)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or within three days after the initiating visit.	HEDIS NCQA NQF number 0069	Allergy and immunology Ear, nose, and throat (ENT)	Family practice OB/GYN Pediatrics
Asthma Medication Ratio (AMR)	Patient(s) between the ages of 5 and 64 with an asthma medication ratio >= 0.50 during the report period.	HEDIS NCQA NQF number 1800	Allergy and immunology Pulmonology	Family practice Internal medicine OB/GYN Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Atrial Fibrillation	Patient(s) taking warfarin that had 3 or more prothrombin time tests in last 6 reported months.	American College of Cardiology (ACC) American Heart Association (AHA) Optum	Cardiology Cardiothoracic surgery Pulmonology	Family practice Internal medicine
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB)	Patient(s) with a diagnosis of acute bronchitis/bronchiolitis that did not have a prescription for an antibiotic on or within three days after the initiating visit.	HEDIS NCQA NQF number 0058	Allergy and immunology ENT Pulmonology	Family practice Internal medicine OB/GYN
Breast Cancer - Part 1	Breast cancer patient(s) without evidence of metastases that had an annual mammogram.	American Cancer Society (ACS) American Society of Clinical Oncology (ASCO) NCQA Optum	Hematology and oncology	Family Practice Internal medicine OB/GYN
Breast Cancer - Part 1	Patient(s) compliant with prescribed anti-estrogen for chemotherapeutic use (minimum compliance 80%).	ACS ASCO NCQA Optum	Hematology and oncology	Family Practice Internal medicine OB/GYN
Breast Cancer - Part 1	Patient(s) compliant with prescribed aromatase inhibitor (minimum compliance 80%).	ACS ASCO NCQA Optum	Hematology and oncology	Family practice Internal medicine OB/GYN
Breast Cancer - Part 1	Patient(s) that had an annual provider visit.	ACS ASCO NCQA Optum	Hematology and oncology	Family practice Internal medicine OB/GYN

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
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 evaluation within 120 days of the diagnostic procedure.	ACS ASCO NCQA Optum	Hematology and oncology	Family practice Internal medicine OB/GYN
Breast Cancer Screening (BCS)	Patient(s) 52 - 74 years that had a screening mammogram in last 27 reported months.	HEDIS NCQA NQF number 2372	N/A	Family practice Internal medicine OB/GYN
Cerebral Vascular Accident & Transient Cerebral Ischemia - Part 1	Patient(s) taking warfarin that had 3 or more prothrombin time tests in last 6 reported months.	Optum	Cardiology Neurology	Family practice Internal medicine
Cerebral Vascular Accident & Transient Cerebral Ischemia - Part 3	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	Cardiology Neurology	Family practice Internal medicine
Cervical Cancer Screening (CCS)	Women that had appropriate screening for cervical cancer (Commercial enrollment).	HEDIS NCQA NQF number 0032	N/A	Family practice Internal medicine OB/GYN
Child and Adolescent Well-Care Visits (WCV)	Patient(s) 3 - 21 years that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner in the last 12 reported months.	HEDIS NCQA	N/A	Family practice Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Childhood Immunization Status (CIS)	Patient(s) 2 years old at the end of the report period that had a varicella immunization between their 1st and 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patient(s) 2 years old at the end of the report period that had an MMR immunization between their 1st and 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patient(s) 2 years old at the end of the report period that had four DTaP immunizations by their 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patient(s) 2 years old at the end of the report period that had four pneumococcal conjugate immunizations by their 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patient(s) 2 years old at the end of the report period that had one hepatitis A immunization between their 1st and 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patient(s) 2 years old at the end of the report period that had the required number of rotavirus immunizations by their 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
CIS	Patient(s) 2 years old at the end of the report period that had three hepatitis B immunizations by their 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patient(s) 2 years old at the end of the report period that had three HiB immunizations by their 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patient(s) 2 years old at the end of the report period that had three polio vaccinations by their 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
CIS	Patients 2 years old at the end of the report period that had two influenza immunizations by their 2nd birthday.	HEDIS NCQA NQF number 0038	N/A	Family practice Pediatrics
Chlamydia Screening in Women (CHL)	Patient(s) 16- 20 years that had a chlamydia screening test in last 12 reported months.	HEDIS NCQA NQF number 0033	N/A	Family practice Pediatrics OB/GYN
CHL	Patient(s) 21 - 24 years that had a chlamydia screening test in last 12 reported months.	HEDIS NCQA NQF number 0033	N/A	Family practice Pediatrics OB/GYN
Chronic Kidney Disease	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

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Chronic Kidney Disease	Patient(s) with stage 5 or end stage renal disease that had a serum calcium in last 12 reported months.	Intercontinental Medical Statistics (IMS) health Optum	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.	IMS health Optum	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.	IMS health Optum	Endocrinology Nephrology	Family practice Internal medicine Pediatrics
Colon Cancer - Part 1	Patient(s) newly diagnosed with colon cancer that did not have a PET scan.	Optum	Hematology and oncology	Family practice Internal medicine Pediatrics
Colon Cancer - Part 2	Patient(s) with newly diagnosed colon cancer that had CT staging prior to colon resection.	Optum	Hematology and oncology	N/A

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Colon Cancer Surveillance	Patient(s) newly diagnosed with non-obstructing colon cancer that had a surveillance colonoscopy approximately one year after diagnostic colonoscopy.	Health Benchmarks IMS health Optum	Hematology and oncology	Family practice Internal medicine
Comprehensive Diabetes Care (CDC)	Patient(s) 18 - 75 years of age that had a HbA1c test in last 12 reported months.	HEDIA NCQA	Endocrinology	Family practice Internal medicine OB/GYN Pediatrics
CDC	Patient(s) 18 - 75 years of age that had an annual screening test for diabetic retinopathy.	HEDIS NCQA NQF number 0055	Endocrinology	Family practice Internal medicine OB/GYN Pediatrics
CDC	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	HEDIS NCQA	Endocrinology	Family practice Internal medicine OB/GYN Pediatrics
Coronary Artery Disease	Patient(s) currently taking a statin.	American Diabetes Association (ADA) Optum	Cardiology Cardiothoracic surgery	Family practice Internal Medicine
Coronary Artery Disease	Patient(s) currently taking an ACE-inhibitor or angiotensin receptor blocker (ARB).	ACC AHA Optum	Cardiology Cardiothoracic surgery	Family practice Internal Medicine

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Depression	Patient(s) hospitalized for depression that had a mental health evaluation within 7 days after discharge.	Optum	N/A	Family practice Internal medicine OB/GYN Pediatrics
Depression	Patient(s) hospitalized for depression that had mental health evaluation or visit with a primary care provider for depression within 7 days after discharge.	Optum	N/A	Family practice Internal medicine OB/GYN Pediatrics
Depression	Patient(s) taking lithium that had a lithium level in last 6 reported months.	Optum	N/A	Family practice Internal medicine OB/GYN Pediatrics
Depression	Patient(s) who are currently taking lithium or an antipsychotic-containing medication that had a psychiatric evaluation in last 6 reported months.	Optum	N/A	Family practice Internal medicine OB/GYN Pediatrics
Developmental Screening in the First Three Years of Life (National Standard)	Children 1 year of age at the end of the report period that were screened for risk of developmental, behavioral, and social delays using a standardized tool.	CMS NCQA	Neurology	Family Practice Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Developmental Screening in the First Three Years of Life (National Standard)	Children 2 years of age at the end of the report period that were screened for risk of developmental, behavioral, and social delays using a standardized tool.	CMS NCQA	Neurology	Family practice Pediatrics
Developmental Screening in the First Three Years of Life (National Standard)	Children 3 years of age at the end of the report period that were screened for risk of developmental, behavioral, and social delays using a standardized tool.	CMS NCQA	Neurology	Family practice Pediatrics
Diabetes Mellitus	Adult(s) 18-75 years of age that had a serum creatinine or estimated glomerular filtration rate in last 12 reported months.	HEDIS NCQA	Cardiology Cardiothoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine OB/GYN Pediatrics
Diabetes Mellitus	Patient(s) compliant with prescribed statin-containing medication (minimum compliance 80%).	CMS	Cardiology Cardiothoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine OB/GYN Pediatrics
Diabetes Mellitus	Patient(s) that did not have a diabetes related hospitalization in last 12 reported months.	HEDIS NCQA	Cardiology Cardiothoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine OB/GYN Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Diabetes Mellitus	Patient(s) with most recent HbA1c result 8.0% or lower.	NCQA Optum NQF number 0575	Cardiology Cardiothoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine OB/GYN Pediatrics
Epilepsy	Patient(s) with one or more hospitalizations or two or more emergency room encounters for epilepsy that had neurology evaluation in last 3 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 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 3488	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, 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

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
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
Heart Failure - Part 1	Patient(s) currently taking a beta-blocker specifically recommended for heart failure management.	ACC AHA Europe and 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 that a serum potassium in the last 12 reported months.	Institute for Clinical Systems Improvement (ICSI) Optum	Cardiology Endocrinology Nephrology Neurology	Family practice Internal medicine OB/GYN
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 ICSI Optum	Cardiology Endocrinology Nephrology Neurology	Family practice Internal medicine OB/GYN

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Immunizations for Adolescents (IMA)	Patient(s) 13 years old at the end of the report period that had the meningococcal vaccine by their 13th birthday.	HEDIS NCQA NQF number 1407	N/A	Family practice OB/GYN Pediatrics
IMA	Patient(s) 13 years old at the end of the report period that had the Tdap vaccine by their 13th birthday.	HEDIS NCQA NQF number 1407	N/A	Family practice OB/GYN Pediatrics
IMA	Patient(s) 13 years old at the end of the report period that had three HPV vaccinations at least 14 days apart, or two HPV vaccinations at least 146 days apart between their 9th and 13th birthdays.	HEDIS NCQA NQF number 1407	N/A	Family practice OB/GYN Pediatrics
Migraine Headache	Adult(s) with frequent use of acute medications that also received prophylactic medications.	American Academy of Neurology (AAN) Optum	Neurology	Family practice Internal medicine OB/GYN Pediatrics
Migraine Headache	Patient(s) with frequent ER encounters or frequent acute medication use that had an ambulatory visit in last 6 reported months.	AAN Optum	Neurology	Family practice Internal medicine OB/GYN Pediatrics
Multiple Sclerosis	Patient(s) that had neurology evaluation in last 12 reported months.	AAM National Multiple Sclerosis Society (NMSS) Optum	Neurology	Family practice Internal medicine

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	Patient(s) 16-20 years of age that had a cervical cancer screening (cervical cytology or HPV test) in the last 12 reported months.*	HEDIS NCQA	N/A	Family practice Internal medicine OB/GYN Pediatrics
Oncology – Appropriate Use of Antiemetics	Patient(s) receiving parenteral highly emetogenic single agent chemotherapy who received appropriate antiemetic prophylaxis.	Optum	Hematology and oncology	N/A
Osteoporosis Management in Women Who Had a Fracture (OMW) – Part 2	Women 67 - 85 years who were treated or tested for osteoporosis within six months of a fracture.	HEDIS NCQA NQF number 0053	Endocrinology Rheumatology	Family practice Internal medicine OB/GYN
Osteoporosis Screening in Older Women (OSW)	Women 65 - 75 years that had appropriate screening for osteoporosis.	HEDIS NCQA	Endocrinology Rheumatology	Family practice Internal medicine OB/GYN
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	ENT	Family practice Internal medicine Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care 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) The Children's Hospital of Philadelphia Optum NQF number 2811e	Allergy and immunology ENT	Family practice OB/GYN 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 Cardiothoracic surgery	Family practice Internal medicine
Pharmacotherapy Management of COPD Exacerbation (PCE)	Patient(s) 40 years of age and older with COPD exacerbation that received a bronchodilator within 30 days of the hospital or ED discharge.	HEDIS NCQA	Pulmonology	Family practice Internal medicine
PCE	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.	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 (ATS) Infectious Disease Society of America (IDSA) Optum	Pulmonology	Family practice Internal medicine

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)	Older adult patients who had an accidental fall or hip fracture who used an antiepileptic, nonbenzodiazepine hypnotic, SSRI, SNRI, antipsychotic, benzodiazepine, or tricyclic antidepressant after the incident.*++	HEDIS NCQA	N/A	Family practice Internal medicine
DDE	Older adult patients with dementia who used an antipsychotic, benzodiazepine, tricyclic antidepressant, nonbenzodiazepine hypnotic or anticholinergic agent after the earliest record of dementia.*++	HEDIS NCQA	N/A	Family practice Internal medicine
Pregnancy Management	Pregnant women less than 25 years of age that had chlamydia screening.	American College of Obstetricians and Gynecologists (ACOG) AAP U.S. Preventive Services Task Force (USPSTF) Optum	N/A	Family practice OB/GYN
Pregnancy Management	Pregnant women that had HBsAg testing.	ACOG AAP USPSTF Optum	N/A	Family practice OB/GYN
Pregnancy Management	Pregnant women that had HIV testing.	ACOG AAP USPSTF Optum	N/A	Family practice OB/GYN

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Pregnancy Management	Pregnant women that had syphilis screening.	ACOG AAP USPSTF Optum	N/A	Family practice OB/GYN
Pregnancy Management	Pregnant women that received Group B Streptococcus testing.	COG AAP USPSTF Optum	N/A	Family practice OB/GYN
Prenatal and Postpartum Care (PPC)	Women that received a prenatal visit in the appropriate time period.	HEDIS NCQA	N/A	Family practice OB/GYN
PPC	Women that received postpartum care (excluding bundled postpartum services).	HEDIS NCQA	N/A	Family practice OB/GYN
Prostate Cancer – Part 1	Patient(s) that had a prostate specific antigen test in last 12 reported months.	Optum	Hematology and oncology Urology	Family practice Internal medicine
Prostate Cancer – Part 1	Patient(s) that had an annual provider visit or evidence of a digital rectal examination.	Optum	Hematology and oncology Urology	Family practice Internal medicine
Rheumatoid Arthritis	Patient(s) taking chronic oral corticosteroids that had rheumatology evaluation in last 6 reported months.	American College of Rheumatology (ACR) Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid Arthritis	Patient(s) taking hydroxychloroquine that had an eye exam in last 12 reported months.	ACR Optum	Rheumatology	Family practice Internal medicine Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Rheumatoid Arthritis	Patient(s) taking methotrexate that had a serum creatinine in last 6 reported months.	ACR Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid Arthritis	Patient(s) taking methotrexate, sulfasalazine, or leflunomide that had a CBC in last 3 reported months.	ACR Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid Arthritis	Patient(s) taking methotrexate, sulfasalazine, or leflunomide that had serum ALT or AST test in last 3 reported months.	ACR Optum	Rheumatology	Family practice Internal medicine Pediatrics
Rheumatoid Arthritis	Patient(s) with complex RA treatment regimens or complications that had rheumatology evaluation in last 6 reported months.	ACR Optum	Rheumatology	Family practice Internal medicine Pediatrics
Sickle Cell Anemia	Patient(s) that had a hemoglobin/ hematocrit in last 12 reported months.	Optum	Hematology and oncology	Family practice Internal medicine Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Sinusitis, Acute	Patient(s) that did not have a sinus computerized axial tomography (CT) or magnetic resonance imaging (MRI) test.	Optum	Allergy and immunology ENT Pulmonology	Family practice Internal medicine OB/GYN Pediatrics
Sinusitis, Acute	Patient(s) treated with an antibiotic for acute sinusitis that received a first line antibiotic.	Optum	Allergy and immunology ENT Pulmonology	Family practice Internal medicine OB/GYN Pediatrics
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Men 21-75 years with cardiovascular disease that received a high-intensity or moderate-intensity statin medication.	HEDIS	Cardiology Cardiothoracic surgery Endocrinology	Family practice Internal medicine OB/GYN Pediatrics
SPC	Patient(s) with cardiovascular disease that received a high-intensity or moderate-intensity statin medication.	HEDIS	Cardiology Cardiothoracic surgery Endocrinology	Family practice Internal medicine OB/GYN Pediatrics
SPC	Women 40-75 years with cardiovascular disease that received a high-intensity or moderate-intensity statin medication.	HEDIS	Cardiology Cardiothoracic surgery Endocrinology	Family practice Internal medicine OB/GYN Pediatrics
Statin Therapy for Patients with Diabetes (SPD)	Patient(s) 40-75 years with diabetes that received a statin medication.	HEDIS	Cardiology Cardiothoracic surgery Endocrinology Nephrology Neurology	Family practice Internal medicine OB/GYN
Tonsillectomy	Patient(s) 1 - 18 years of age that had a tonsillectomy and met clinical criteria for this procedure.	Optum	ENT	Family practice Internal medicine Pediatrics

Condition/ Treatment	Rule Description	Source	Specialty Types	Primary Care Types
Use of Imaging Studies for Low Back Pain (LBP)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	HEDIS	Rheumatology	Family practice Internal medicine OB/GYN
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	Patient(s) that had appropriate spirometry testing to confirm COPD diagnosis.	HEDIS NCQA	Pulmonology	Family practice Internal medicine
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Patient(s) 3 - 17 years of age that had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile documentation during the report period.	HEDIS NCQA	N/A	Family practice Internal medicine OB/GYN Pediatrics
Well-Child Visits in the First 30 Months of Life – Part 1 (W30)	Patient(s) that had six or more well- child visits with a PCP during the first 15 months of life.	HEDIS NCQA NQF number 1392	N/A	Family practice Pediatrics
Well-Child Visits in the First 30 Months of Life – Part 2 (W30)	Patient(s) age 30 months that had two well-child visits with a PCP between ages 15 months and 30 months.	HEDIS NCQA	N/A	Family practice Pediatrics

* 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.
++ Measure does not require a visit in the past 12 months

Appendix 2: 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@CignaHealthCare.com or fax to **866.448.5506**.

The QCM 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 2024 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 Healthcare at PhysicianEvaluationInformationRequest@CignaHealthCare.com or fax the request to **866.448.5506**. A QCM 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 committee 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 Healthcare region, their alternates, and ad hoc physicians

Non-voting Committee Participants

- Vice President, Clinical Measurement and Improvement
- Cigna Healthcare Global Data & Analytics (GD&A) Representative
- Product Representative
- QCMs

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 Healthcare 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 QCM 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.