

CIGNA Care Network measured against AMA's Principles for Pay for Performance programs

The CIGNA Care Designation program (CCD) is a tiered network that rates physicians in 21 specialties on quality, cost and other factors and ranks them into one of two tiers. Primary care physicians are not included in the CCD program; however, these physicians will have a quality and cost efficiency profile displayed on the CIGNA members-only Web site. In order to be assessed for the CIGNA Care Designation, all physicians in the 21 specialties must pass an initial quality standard. Physicians who meet the highest initial quality criteria automatically receive CIGNA's "Care Designation." Physicians who do not reach the highest quality rating, but pass minimum quality standards, are further assessed for additional quality criterion and also for cost-efficiency. Also, those physicians who score highest for quality and cost are given the "Care Designation" moniker.

The following chart contains an AMA staff description and analysis of CCD. In this chart, CCD is broken horizontally into five sections that correspond to the AMA's five Principles for Pay-for-Performance Programs. There are also four vertical columns, the first of which contains each of the five AMA Principles. The second column contains descriptions of aspects of the program, as derived from CIGNA's Web site or other CIGNA-generated documents, that pertain to each particular AMA Principle. The third column contains some of the strategies that CIGNA officials envisioned when they designed these particular aspects of this program and information from discussions with participating physicians and practice managers. The last column is an AMA analysis of the program when compared to the AMA Principles.

It is apparent that CCD is not a pay-for-performance program as evidenced by the absence of physician incentives noted opposite the fifth AMA Principle. Rather, CCD is a physician-profiling program that confers the CCD on some physicians depending on how highly they are rated on CIGNA's "quality" and "cost efficiency" measures and places physicians in tiers within CIGNA's physician network. Unlike narrow network programs, the CCD program does not exclude physicians from CIGNA's network. Although all of these physicians, regardless of their ratings/rankings, remain in-network, patients may pay differential copayments/coinsurances based on their benefit plans and CIGNA's ratings and tier placements of their physicians. The CCD benefit plan option is available in 58 markets.

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The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.

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<p>1. Ensure quality of care</p> <p>Fair and ethical PFP programs are committed to improved patient care as their most important mission.</p>	<p>The CIGNA Care Designation (CCD) distinguishes physicians within CIGNA's physician network based upon performance under specific quality and cost efficiency measures for 21 specialties: Allergy/Immunology, Cardiology, Cardio-Thoracic Surgery, Dermatology, Endocrinology, Gastroenterology, General Surgery, Hematology/Oncology, Infectious Disease, Nephrology, Colon and Rectal Surgery, Neurology, Neurosurgery, Obstetrics/ Gynecology, Otolaryngology, Ophthalmology, Orthopaedics and Surgery, Pulmonology, Rheumatology, Urology and Vascular Surgery.</p>	<p>In April 2008, CIGNA made some changes to its physician-profiling program. Formerly called CIGNA Care Network, the CCD program uses "Physician Quality and Cost-efficiency Profiles," which are available on CIGNA's member-only Web site to assess physicians in 21 specialties when sufficient information exists. Starting in April 2008, information about primary care physicians (PCPs) in the specialties of Internal Medicine, Family Practice and Pediatrics are included in the profile display for transparency purposes only.</p> <p>For quality rating, CIGNA uses a symbol system representing:</p> <ul style="list-style-type: none"> • NCQA recognition for diabetes, heart-stroke, back care or physician practice connections; • Top-tier profile rank according to nationally-recognized evidence based medicine (EBM) measures; • Specialty board certification of 	<p>CIGNA uses a three-tier system to rate physicians on quality of care. Top-tier quality designations are dependent upon physicians meeting Board certification criteria (may also have ABIM-PIM if applicable) and top-third rating on evidence-based medicine measures and/or recognition by NCQA or meets Bariatric surgeon criteria. For physicians who rank in the middle tier on quality, cost becomes the factor that determines CCD eligibility. CIGNA disqualifies physicians from CCD if their profiles fall in the lowest quality tier.</p> <p>AMA applauds CIGNA for its group board certification standard. This standard is met if either 80% of the physicians in a group are board certified and provide 50% of the care, or at least 80% of the care provided by the group is provided by board certified physicians.</p>

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Ensure quality of care (cont.)		<p>80% of the physicians who practice in a group; and/or</p> <ul style="list-style-type: none"> • Completion of the American Board of Internal Medicine Practice Improvement Module (ABIM-PIM). <p>Physicians who achieve NCQA recognition or perform in the top-third for quality measurement (compared to their peers in their market) are included in the CCD regardless of their cost-efficiency status. For cost-efficiency rating, CIGNA uses a three-star display based on Episode Treatment Groups (ETGs) results. However, CIGNA does not display “one star” efficiency ratings. “CIGNA prefers to only report positive results and work with ‘one star’ physicians on opportunities for improvement.”</p>	<p>CIGNA displays only quality symbols for physicians who achieve top- or middle-tier quality ratings but one-star cost-efficiency ratings. Only efficiency ratings are displayed for physicians who rate in the lowest quality tier but achieve two- or three-star efficiency ratings.</p>
Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs.	CCD quality measures include measures endorsed by or derived from independent third parties such as NCQA, AQA, NQF and HEDIS. If a physician or group falls in the lower 5% of EBM compliance, CIGNA performs an	The CCD program has been modified as a result of input over several years from the Physician Advisory Committee established as part of the Kaiser settlement. Also, community physicians serve on the Quality Committees as well	NCQA recognition programs use chart data provided by eligible physicians to evaluate quality and may be successful in identifying physicians who are effective in treating these conditions. However, the majority of the

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<p>Ensure quality of care (cont.)</p>	<p>outreach to the physician or group to obtain additional information to support the evidence-based quality of care measures.</p> <p>Cost efficiency is measured using an industry standard cost efficiency methodology (ETGs) and CIGNA HealthCare claims data.</p>	<p>as Physician Advisory Panels.</p> <p>CIGNA's approach, in which quality trumps cost, insures that physicians who achieve superior quality receive CCD independent of their cost profile.</p>	<p>measures in this program are HEDIS measures, some of which may not be evidence-based. To the extent that measures are not truly evidence-based, resulting physician ratings may not judge true quality of care.</p> <p>Few medical societies and their practicing physicians appear to have been involved in the overall design and evaluation of the methodology used in this program. Instead, physician input is largely sought after the program is designed rather than up-front.</p> <p>CCD is more quality-based than similar programs; however, second-tier physicians could be excluded from designation simply based on costs of care.</p>

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<p>Ensure quality of care (cont.)</p> <p>Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.</p>	<p>CIGNA has implemented a "grandfathering" methodology that allows physicians who have been included in the CCD in the previous year and whose quality or cost-efficiency results have not significantly changes, but do not meet the thresholds for the current year, to maintain their designation.</p>	<p>CCD does not make allowances for individual patient care regimens based on physicians' sound clinical judgment. CIGNA expects physicians to adjust their adherence to guidelines based on individual patient characteristics and local medical practice circumstances.</p>	<p>Physicians could be penalized for providing appropriate, quality care that differs from recommended quality protocols or patient preference. CIGNA has an appeal process for physicians who feel an outlier case may be driving their CCD results.</p>
<p>2. Foster the patient/physician relationship</p> <p>Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.</p>	<p>CIGNA members are able to compare participating specialists in 21 specialists based on their performance under select quality and cost efficiency measures. CIGNA's <i>Physician Quality and Cost Efficiency</i> tool gives quality symbols for specialists in the network based on performance on select quality criterion and a three star rating display for cost efficiency measurement. Symbol and star designations are viewable only by CIGNA members via the online provider directory on the</p>	<p>Patients are incentivized, typically with a reduction of the co-pay or co-insurance, when they receive care from CCD-designated specialists. Members enrolled in the CCD benefit plan option must see designated specialists for physician services to be covered at the enhanced benefit level.</p>	<p>The use of tiered networks limits patients' choice of physicians and may result in severing long-standing patient/physician relationships, which may threaten continuity and quality of care. The CCD does not offer a narrow network, which is far more restrictive than tiering.</p>

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<p>Foster the patient/physician relationship (cont.)</p>	<p>insurer's secure member Web site.</p> <p>The ETG methodology is used to determine cost efficiency scores and includes case-mix adjustment.</p>	<p>CIGNA believes that appropriate use of quality and cost information at this stage of development is:</p> <p>A) To provide information that members may wish to consider in choosing a new doctor, or may wish to discuss with their current doctor. "We strongly emphasize that members should discuss this information with a physician before using the information in their decision making."</p> <p>B) To provide "a minimal financial incentive designed to encourage a member's considering this information but not to disrupt existing satisfactory patient/physician relationships."</p>	<p>Case mix and risk adjustment should control for differences among patients in severity, comorbidities and demographics. Demographic differences often correlate to patient compliance with therapeutic regimens. If indicators are not properly adjusted to control for such differences, the CCD program could create perverse incentives for physicians to stop treating certain types of patients. While the CCD program allows patients to choose physicians from the CIGNA network, some patients will opt to receive care from select physicians simply based on lower copays or co-insurance.</p>

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<p>3. Offer voluntary physician participation</p> <p>Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices.</p>	<p>Currently, CCD has been assigned to physicians practicing in the 21 specialties and who perform in approximately the top 25 percent of CIGNA's market.</p>	<p>Participation in CCD is not voluntary for physicians who practice in the 21 specialties. However, if a physician notifies CIGNA that they do not want the CCD, even though they qualify for it, CIGNA removes the physician from the program.</p>	<p>Physicians are rarely given the opportunity to voluntarily participate in a tiered network. One of the primary concerns physicians have with tiered networks is that these schemes may place profits ahead of patients by lessening patient access to physicians who are not included in the networks and possibly resulting in irrevocable damage to patient/physician relationships.</p>
<p>These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.</p>	<p>In 2008, CIGNA added primary care physicians to its physician-profiling process only (not the CCD). CIGNA will display quality symbols and cost ratings for PCPs in its members-only directory.</p>	<p>CCD applies only to physicians within the 21 specialties. Physicians who practice in other specialties are not eligible for designation status. The physician evaluation criterion does not require any additional financial or technological requirements.</p>	<p>Except for participation in NCQA's Physician Practice Connections program, health information technology (HIT) is not required for CCD participation. However, HIT will go a long way to help physicians qualify for CCD and CIGNA does not compensate physicians who invest in HIT.</p>

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<p>4. Use accurate data and fair reporting</p> <p>Fair and ethical PFP programs use accurate data and scientifically valid analytical methods.</p>	<p>To be considered for CCD designation, a participating specialist or medical group must have managed episodes of care for a minimum of 20 unique CIGNA HealthCare members over a two-year period. This helps to ensure statistical validity.</p> <p>For 2008 profiles, the claim review period used is October 2004 to September 2006. A physician is considered responsible for adherence to the EBM standard if s/he had two office visit encounters with the member in the claim review period and one is in the last 12 months of the review period.</p> <p>CIGNA reviews the previous two years of data for inpatient, outpatient, diagnostic, laboratory and pharmacy claims for patients of eligible specialists.</p> <p>Cost efficiency scores reflect a specialist's cost-efficiency relative to peers in the same geographic area using the ETG methodology</p>	<p>For the quality ratings, CIGNA compares physicians to their peer average (specialist or primary care in the same market), not to an absolute 100% adherence standard, which it agrees would be inappropriate. For efficiency ratings, CIGNA compares the resources used to treat the patients of profiled physicians to those of other physicians in the same specialty and general location.</p> <p>CIGNA will be moving to a 30-episode minimum in 2009.</p> <p>CIGNA received the NCQA Quality Plus Distinction for Physician Hospital Quality. The NCQA review is a review of methodology, statistical soundness, and implementation of both physician and hospital quality and cost efficiency evaluations. CIGNA was the first national health plan to receive the distinction award across all of its accredited health plans. CIGNA's appeal process allows any</p>	<p>Claims data do not capture all information associated with a patient encounter; therefore, errors and omissions are inevitable. There will inevitably be information that is not captured in claims data (the hysterectomy that was performed ten years ago under a different insurer). Two-year old data does not reflect the current quality or efficiency of a physician practice. One unusual result can drastically affect a rating based on small sample sizes. According to Bill Thomas (an efficiency measurement expert and a consultant for both CIGNA and the AMA), the potential accuracy of efficiency rating improves dramatically when higher numbers of episodes are used as the basis for a rating. Thomas' modeling of cost efficiency ratings would suggest that rating inaccuracy is likely to be 20-30% when 20 episodes are used to determine so-called</p>

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<p>Use accurate data and fair reporting (cont.)</p>	<p>that looks at medical costs (inpatient, outpatient, laboratory, radiology, pharmacy, etc.) for an episode of care and includes case-mix adjustment to help account for differences in the severity of patients' illnesses. ETGs provide a way to measure and compare costs. The episode is attributed to the physician who is paid the most management and surgery fees within the episode. The efficiency scores for all groups or TIN's within a market are arrayed into three categories as in the quality evaluation. For cost-efficiency: the top tier is the top 33%, the middle tier falls between 2 ½ % to 67 ½% and the lowest tier falls in the bottom 2 ½%. The percentile used for CCD is set on a market specific basis, and ranges from approximately 30% to 70%. In 2007, physicians practicing in a CCD-impacted specialty service area received notice of their CCD designation status. In future years, physicians should consult the online provider directory to find their designation status.</p>	<p>physician who feels their practice pattern has changed significantly in recent years or who feels their results were inappropriately affected by a few high-risk patients to request a re-evaluation. CIGNA selected only those quality measures that have higher percentages of compliance through administrative (claims) data. CIGNA also incorporates data from its laboratory vendors and pharmacy information. For rules that require pharmacy data, patients who do not have CIGNA Pharmacy benefits are removed from both the numerator and denominator.</p>	<p>efficiency. According to Thomas, an episode of care can encompass multiple diagnostics and treatments provided by a number of physicians working together to treat the patient. Determining which physicians are responsible for which costs can be problematic, and the underlying claims data can be inaccurate and incomplete. None of the three methodologies (ETGs, MEGs, and the Cave grouper) consider socio-economic factors that may negatively impact patient health statuses. Studies have failed to verify the accuracy of any of these methodologies. In other words, using the same data, a physician may be rated efficient by one system and inefficient by another. Inaccurate physician profiling can seriously impact the financial viability of practices as well as damage some patient/physician relationships.</p>

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<p>Use accurate data and fair reporting (cont.)</p> <p>Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.</p>		<p>Prior to the publication of results, CIGNA notifies physicians (through newsletters, CIGNA's Provider Portal, letters and facsimiles) that their assessments are complete and that their results are available. CIGNA has a formalized Selection Review (appeal) process. CIGNA provides physicians with lower quality scores the opportunity to review their patient data and submit additional information. If the physician accepts the offer to provide additional chart information and it improves their status, CIGNA revises the physician's results. Because Cigna recognizes the variability and potential inaccuracies in these rating results, once designated, CCD physicians will not lose their designation unless they fail to meet the CCD criteria two years in a row</p>	<p>CIGNA is in accordance with the AMA Principles in affording physicians the opportunity to review and comment on or appeal their results prior to the use of the results for reporting or tiering. AMA is unaware of how satisfied/dissatisfied physicians are with CIGNA's appeal process. AMA is still concerned about the inaccuracies that undoubtedly exist in Cigna's physician-profiling system; however, the review and appeal processes and the reluctance to remove the CCD status from a previously designated physician, based on one year's experience, demonstrate that Cigna is trying to minimize the effects of the flaws in the program for patients and physicians.</p>

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<p>5. Provide fair and equitable program incentives</p> <p>Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program.</p>		<p>Patients are incentivized through lower copays or co-insurance to seek health care services from “top-tier” physicians.</p>	<p>CCD is not a physician PFP program — there are no direct physician bonuses for participants in CCD; instead, the program is a tiered network.</p>
<p>The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.</p>	<p>CIGNA offers physicians and physician groups an opportunity to meet with CIGNA clinical staff either face-to-face or via telephone to reach an understanding of the methodology utilized and their results.</p>		<p>Although a good portion of the CCD program is based on quality, middle-tier physicians are selected primarily on “efficiency.” The CCD program does not offer physicians rewards, but may steer more patients to a high-rated practice. The AMA opposes the use of physician networks that deny patient access to or attempt to steer patients towards certain physicians primarily based on cost of care factors. The CCD program is very complex and probably is not well understood by physicians or the public.</p>