PRACTICE MANAGEMENT CENTER

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A comparison of three physician profiling programs

The following chart provides a side-by-side comparison of the major components of three programs focused on the measurement of physicians on quality and cost of care. The first example is Aetna's Aexcel program. The second is the CIGNA Care Network (CCN) and the Physician Quality and Cost Efficiency Designations (PQCED) programs, and the third is UnitedHealthcare's Premium Designation (UHPD) program. The health insurers reviewed and provided input on the description of their respective program. The American Medical Association (AMA) created this chart to make the similarities and differences of the programs transparent for physicians, their practice staff, and staff of medical societies and associations. Additionally, the chart offers some concerns and issues related to each key element of these physician profiling programs.

Key elements	Aetna's Aexcel program	CIGNA Care Network and Physician Quality and Cost Efficiency Designations programs	UnitedHealthcare's Premium Designation program	Concerns and issues
Brief description of the profiling program	Aexcel is a designation for physicians in 12 specialties, who are part of Aetna's broader network of physicians and who have met certain clinical performance and efficiency (cost-of-care) standards. As a result of Aetna's evaluations, it creates either a narrow physician network, which excludes eligible specialists who do not satisfy the Aexcel standards or the standards of a tiered physician network from the network.	CIGNA sponsors two physician designation programs, the CIGNA Care Designation (CCD) program and the Physician Quality and Cost Efficiency Designations (PQCED) program, which distinguish eligible specialists who are part of CIGNA's physician network and who have met certain quality and efficiency (cost-of-care) standards. As a result of CIGNA's evaluations, it creates a three-	In UnitedHealthcare's Premium Designation (UHPD) program, eligible physicians who are part of UnitedHealthcare's (UHC) network of physicians and who have met certain quality or quality and efficiency (cost-of-care) benchmarks are designated. Some employers may offer health benefit programs that provide benefit incentives for members to use UHPD specialists.	Frequently, the physicians targeted by these programs represent those specialties that generate the highest spending for health insurers and employers. Although eligible physicians are rated on quality measures in these programs, health care costs can also become the determining factor for program inclusion.

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Readers are encouraged to check with the insurer to ascertain if program changes made by the insurer subsequent to the date this chart was prepared impact its currency or completeness.

Key elements	Aetna's Aexcel program	CIGNA Care Network and Physician Quality and Cost Efficiency Designations programs	UnitedHealthcare's Premium Designation program	Concerns and issues
Brief description of the profiling program (cont.)	Members receive incentives through lower co-payments when they obtain their health care services from Aexcel-designated specialists.	tiered network of specialists.	Internal medicine, family practice, pediatrics and OB/GYN specialists are not included in benefit tiering.	
Physician specialties targeted by the program	The Aexcel network applies to physicians in 12 designated specialties: Cardiology, Cardiothoracic Surgery, Gastroenterology, General Surgery, Obstetrics/Gynecology (Ob/Gyn), Orthopaedics, Otolaryngology, Neurology, Neurosurgery, Plastic Surgery, Urology and Vascular Surgery. Aetna maintains that it chose to address physician specialty care in developing the Aexcel program for several reasons: specialty care is more episodic than primary care; specialty care drives most of the advances in treatment, procedures, pharmaceuticals, and diagnostic imaging and the costs that accompany these advances. According to Aetna, the specialty categories chosen for Aexcel represent approximately 70 percent of its specialty costs and control approximately 50 percent of its members' total medical costs. The number of specialists affected by this program is approximately 77,000. Aetna offers the Aexcel program in 36 markets.	CIGNA targets specialists in two physician profiling programs: 1. The CCD program distinguishes physicians for 21 specialties: Allergy/Immunology, Cardiology, Cardiothoracic Surgery, Dermatology, Endocrinology, Gastroenterology, General Surgery, Hematology/Oncology, Infectious Disease, Nephrology, Colon and Rectal Surgery, Neurology, Neurosurgery, Ob/Gyn, Otolaryngology, Ophthalmology, Orthopaedics and Surgery, Pulmonology, Rheumatology, Urology and Vascular Surgery. Effective 2010, the CCD program is available in 64 markets and impacts approximately 158,700 physicians. According to CIGNA, the specialists CCD targets account for more than 70 percent of its specialty care and 54 percent of its total medical and pharmaceutical spending. The PQCED program applies to physicians in 24 specialties (the 21 specialties in the CCD program and three primary care specialties: Family Practice, Internal Medicine and Pediatrics). According to CIGNA, this program is available in 75 markets, which include the 64 CCD markets and affects approximately 366,200 physicians.	The UHPD program evaluates the care delivery of physicians across 20 medical specialties, including several internal medicine disciplines: Cardiothoracic Surgery, Interventional Cardiology, Electrophysiology, Neurosurgery, Orthopaedic Surgery, Spine Surgery, Total Joint Replacement, Sports Medicine, Allergy, Nephrology, Neurology, Pulmonology, Rheumatology, Cardiology (non-interventional), Endocrinology, Infectious Disease, Family Medicine, Internal Medicine, Ob/Gyn and Pediatrics. UHC included 212,000 physicians in the UHPD evaluation across 138 markets.	Health insurers must be careful to avoid providing ratings and/or patient and physician incentives that might result in reduced patient access to specialists who may be in short supply in certain geographic areas. Primary care specialists are already under-represented in most areas of the country.

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Quality metrics	Aetna begins the Aexcel evaluation by identifying physicians and groups within their network in the 12 specialty areas. Physicians must have a minimum volume of episodes of care and pass clinical performance criteria to be considered for Aexcel designation. All physicians are included in the clinical performance evaluation, which uses five categories of measures. One of these categories is claim-based measures. A physician must have at least 10 Aetna cases for each applicable measure to be evaluated. Effective in 2010, physicians who meet one of the following proxy performance criteria are further evaluated for Aexcel designation: (1) recognition by either Bridges to Excellence (BTE) or NCQA in the areas of diabetes, cardiac/stroke or low back/spine; (2) BTE or National Committee for Quality Assurance (NCQA) recognition in the Physician Office Link program; (3) application of National Quality Forum-(NQF) endorsed measures on using health information technology; (4) board certification in the physician's Aexcel specialty; and (5) physician practices at an Aetna Institute of Quality facility.	Participating CIGNA physicians in 24 surgical, non-surgical and primary care specialties are evaluated for their quality of care. Individual physicians and physician groups must have at least 30 eligible patient interactions in the past 24 months to be rated. Physicians and physician groups are first evaluated on board certification (physician groups must have at least 80 percent of their work performed by board-certified physicians, or have 80 percent of their physicians board-certified and performing at least 50 percent of the work). If they pass this criterion, they are assessed on their adherence to the 41 evidence-based medicine (EBM) rules established by the program. Physicians are then compared by EBM rules to other physicians in their specialty category and market to derive the peer-expected quality results.	For quality measurement, the UHPD program uses national measures and criteria from NQF, Ambulatory Care Quality Alliance (AQA), NCQA and physician organizations, such as the Physician Consortium for Performance Improvement (PCPI), which define evidence-based and consensus-based standards for treating medical conditions. The following aspects of care are measured: patient safety (duplication, complications and monitoring); sequencing of care (diagnostic, treatments and monitoring); procedural effectiveness (failed therapy and monitoring); and compliance with guidelines. UHC has separate quality measurement processes for procedural and non-procedural specialists. For non-procedural specialists, UHC uses Symmetry EBM Connect software to assess quality measure compliance. This software uses paid claims data and selected laboratory data to evaluate the sequence and content of care at the individual patient level and then compares it with evidence-based guidelines. Each application of a criterion to a patient is called an EBM measure. To meet the EBM scoring criteria for quality designation, the physician must have a minimum of 30 clinical observations among five unique patients. An EBM measure that relates to pharmacy is only included in the quality analysis when the patient has a pharmacy benefit, and UHC has access to their pharmacy claims for the period specified in the measure. Primary	Quality measurement programs that are designed simply to identify and exclude physicians and other health care professionals whose results appear to fall below the top level of performance will not yield the system-wide improvements that are necessary to ensure access to high-quality health care for all patients. The AMA encourages and supports efforts to expand and accelerate the development of meaningful quality measures and reliable data sources that are necessary to build an evidence base for high-quality care. Additionally, efforts by medical specialty societies to develop new quality improvement tools and educate physicians about best practices should be supported. The AMA supports policies to designate all physicians in a group practice when the group meets quality standards. The most important use of quality data is to provide it to physicians in an understandable and usable format to promote quality improvement activities.

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Quality metrics (cont.)			care physicians and endocrinologists may receive quality recognition if they have individual recognition through the NCQA Diabetes Recognition program. Primary care physicians may also receive quality recognition through the NCQA Heart/Stroke program. The quality measurement of proceduralists is measured on the basis of comparative procedural outcomes (e.g., re-study and re-operative rates) with other surgical specialists in the market. Interventional cardiologists are also evaluated on lipid testing and statin and beta-blocker utilization according to EBM Connect measures. The rates are blended into specialists' comparative procedural outcome scores, which are based on the summary of the physician's risk-adjusted practice and an expected norm performance interval that is established by national expert scientific advisory boards that UHC convenes.	
Efficiency measurement process	For evaluation of efficiency (cost-of-care), Aetna identifies specialists and physician groups currently participating in Aetna's network who have managed at least 20 episodes of care for Aetna members over the past three years. Aetna applies the Symmetry Episode Treatment Groups (ETG) methodology to three years of its claims data to measure a physician's efficiency. The ETG methodology is based on episodes of care, and focuses on all costs (inpatient, outpatient, professional, office, laboratory, pharmacy and ancillary) required to care for a patient's underlying	For efficiency (cost-of-care) measurement in the CCD and the PQCED programs, CIGNA evaluates two years of its claims data (inpatient, outpatient, laboratory, radiology and pharmacy) using the ETG methodology. The cost efficiency evaluation includes a methodology to account for episodes that are outliers (i.e., those episodes that are substantially different from the market-expected amounts). High-cost episodes that are greater than 1.5 times the market-specialty average are capped at 150 percent of the market-specialty average. For 2010,	The unit of analysis of the efficiency (cost-of-care) of proceduralists is the cost of an episode of care as constructed by the Anchor Target Procedure Grouper (ATPG) software. ATPG episodes include the costs of the major procedure (anchor), related diagnostic and therapeutic procedures (targets), and facilities. The ATPG software constructs an episode by connecting the anchor procedure to targets. Pharmacy costs are not included in ATPG episodes. The unit of analysis of the cost efficiency for non-proceduralists is the cost of an episode of care as constructed	Focusing on costs may promote an inappropriate under-use of health care services, which could have a profound impact on patients' health outcomes. Furthermore, patients who require a large number of health care services or are otherwise disadvantaged may have difficulty accessing necessary care. Generally, designations are based on several years of retrospective data in order to gather enough data for profiling physicians. Therefore, the data do not necessarily reflect the current status

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Efficiency measurement process (cont.)	medical condition. An index rating is created based on actual costs for the physician practice's episodes compared with the expected costs of the episode. The expected cost is the average adjusted cost of an episode managed by like specialists in the physician's locality. If a physician practices in a group, the group's efficiency is measured as a whole, and the group rating is assigned to each of the group's members.	approximately 15 percent of physicians' episodes were reduced by this cap. Low-cost outlier episodes are determined by the ETG software, which excludes episodes with costs of less than $25.00 from the evaluation.	by ETGs. The ETGs are split into two versions, those for patients with a pharmacy benefit and those for patients without a pharmacy benefit. Outlier logic is applied so that episodes under the 5th percentile in cost are dropped and those above the 95th percentile are capped at the 95th percentile amount (a statistical technique known as "modified Winsorization"). Cost efficiency is measured as an index relative to peers. The cost efficiency measure is constructed by summing each physician's actual (observed) costs among their episodes in each of the episodes and dividing by the sum of the expected costs for each of those episodes. The resulting ratio of the observed-to-expected costs (O: E ratio) measures the physician's cost efficiency relative to his or her specialty peers in their market. An efficiency index score of 1.00 indicates average cost-efficiency, and lower scores indicate more cost-efficient care relative to peers.	of physicians' practice patterns. Overall, the AMA's biggest concern with the use and reporting of efficiency measurement ratings is the propensity of all efficiency measurement systems to be extremely inaccurate and subjective in their design.
Designation process of the program	Aexcel designation is given to Aetna participating physicians in 12 specialties if they meet Aexcel's clinical performance measures, adhere to clinical guidelines and pass the efficiency evaluation. Only those physicians who have treated Aetna members with at least 20 measurable conditions over the past three years are eligible for this designation. Aetna uses statistical significance when reviewing efficiency evaluation results to increase the confidence of the evaluation decisions.	The CCD status is given to physicians who satisfy CIGNA's quality and efficiency measurement standards. Physicians who are ranked in the top third of their specialty physician ratings satisfy the quality standards as detailed in the quality section of this report and are automatically given CCD status. For physicians who are not ranked in the top 33 percent, there are additional ways to achieve the CCD status. Individual physicians and groups that are ranked in the bottom 2.5 percent of	Physicians may achieve two levels of distinction in UHPD. Physicians who meet the quality designation criteria are awarded one star, while physicians who satisfy both quality and cost efficiency designation criteria achieve a two-star rating. Physicians who are board-certified in their primary specialty and whose performance meets or exceeds UHC's aforementioned quality threshold receive a star in the UHC consumer directory. Only quality-designated physicians are eligible	The methodologies used to determine physician quality-of-care and physician efficiency scores often produce inaccurate results, which are used to produce physician rankings and ratings. These ratings are then frequently used by health insurers and employers to publicly designate and/or reward physicians who are deemed to practice high-quality and low-cost medicine. The designation process is different for each health

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Designation process of the program (cont.)	Physicians do not pass the efficiency standard if their results either did not meet the minimum 20-episode threshold or did not meet the minimum standard at the statistically significant level. All other physicians pass the efficiency standard. The statistical significance is performed at the 90 percent confidence level. In 2010, on average, 64 percent of the evaluated specialists across Aexcel's markets achieved this designation.	physicians are placed in the bottom category. The remaining physicians are placed in the middle category and are subjected to CIGNA's efficiency measurement. Beginning with the most efficiently ranked physicians, CIGNA designates some of these physicians, depending on how many specialists CIGNA wants to include in this program for each locale and specialty. CIGNA claims it generally designates between 30 and 70 percent of its physicians, depending on patient access needs. As in Aetna's Aexcel program, CIGNA also employs some proxy measures for quality measurement. However, CIGNA's measures differ in that they serve as a proxy for the entire CCD program—not just for the quality designation as with the Aexcel program. CIGNA physicians who achieved any of the five NCQA Physician Recognition Programs receive the symbol for CCD as well as NCQA recognition in CIGNA's directory. In 2010, CIGNA utilizes a "buffer zone" or "grandfathering" methodology to address small-scale variation among physician groups that did not achieve designation in the CCD in the current year but were designated in the previous year. Using the buffer zone methodology, if a physician or physician group is within 3 percent of the market Adjusted Performance Index cutoff, the physician/group is eligible for CCD in the current year. In 2009, a total of 631 physician groups in several markets met the efficiency buffer zone criteria, and 193	to move to the next step in the assessment process (i.e., an evaluation of cost efficiency). Physicians who fail to meet the quality metrics are listed in UHC's directory with no stars. However, physicians who have fewer than 10 unique patients and 30 clinical observations are classified as having "Not enough health plan claims to assess conditions included in UHPD measurement," in order to differentiate them from physicians who failed to meet the quality standards. Quality-designated physicians are evaluated for cost efficiency using the methodology previously described. Physicians qualify for the second star, representing cost efficiency designation, based on where their rankings fall in relation to UHC's cost efficiency market threshold. UHC developed quality and cost-efficiency assessment rules for physicians who practice in a group setting if they are on a standard UHC contract. The physician group is evaluated for quality and cost efficiency based on its specialty-specific group. If a physician has insufficient data on his or her own and his or her specialty within the physician group meets the quality and/or cost efficiency criteria, the individual physician can receive the designation for his or her specialty in the group. In 2009, approximately 45 percent of eligible UHC network physicians achieved both the quality and cost efficiency designations, and approximately 11 percent of eligible physicians achieved the quality	insurer and, unfortunately, dependent upon the medical specialty profiled. In some specialties, these resultant ratings can be virtually no more accurate than random choice.

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Designation process of the program (cont.)		physician groups across multiple markets met the quality buffer zone criteria. In 2010, 1697 specialty groups were recognized for EBM quality performance and received the CCD through their quality performance. Also, 4709 primary care physician groups received recognition for EBM quality performance. For 2010, on average, 46.4 percent of the CCD-profiled specialists achieved designation.	designation alone.	
Episode of care attribution	Each clinical measure used in Aexcel has its own physician attribution logic. For efficiency measurement, episodes are attributed to physicians based upon who was responsible for the majority of the care. If the episode is non-surgical, the physician with the highest number of visits receives attribution of the case. For procedural episodes, the case is attributed to the surgeon with the highest allowed charges.	For quality assessment in the CCD and the PQCED programs, attribution is assigned to any relevant physician who saw the patient for at least two visits in the previous 24 months with at least one of the visits occurring in the previous 12 months. For specific screening tests, acute conditions and pregnancy management, attribution is assigned if there is one visit in 24 months. An EBM rule may be attributed to any specialist who treats the condition and meets the minimum volume criteria of visits. For efficiency assessment, episode attribution is assigned to the physician who accounts for at least 30 percent of the total management and/or surgery fees. In cases in which no treating physician meets the criteria, the episode of care is not attributed to any physician.	EBM measures are attributed to non-proceduralists assigned the corresponding episodes of care. If more than one episode is associated with a given EBM condition, the episode is assigned to the physician in a Premium-designated specialty with the most recent date of service. Among non-interventional cardiologists, quality measure attribution requires that a physician have three separate interactions with a patient. For cost-efficiency, physicians who are responsible for at least 30 percent of the total costs associated with an episode are assigned the episode. All episodes in which the highest percentage of involvement was less than 30 percent are discarded. About 90 percent of episodes used for Premium Designation are managed by one physician. For proceduralists (for both quality and cost efficiency), episodes are assigned to the physician who performed the major procedure for that episode and submitted the claims for it. In cases in which multiple claims occur on the same day for the same type of procedure with different	Attribution methodologies vary greatly from program to program. Which is the best? What is the science behind these methodologies? Perhaps no other aspect of these programs is as worrisome to physicians. Programs that judge physicians on acts performed by others, over which they have no control, are troubling. Though used to rate often minor differences between physicians, the methods of attribution are highly arbitrary.

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Episode of care attribution (cont.)			physicians of equally relevant specialties, the physician with the largest total claim costs for the relevant type of procedure on that day is assigned responsibility for the procedure episode.	
Number of cases used to profile physicians	Physicians must have a minimum volume of episodes of care and pass clinical performance criteria to be considered for Aexcel designation. All physicians are included in the clinical performance evaluation, which uses five categories of measures. One of these categories is claim-based measures. A physician must have at least 10 Aetna cases for each applicable measure to be evaluated. For evaluation of efficiency, Aetna identifies specialists and physician groups currently participating in Aetna's network who have managed at least 20 episodes of care for Aetna members over the past three years.	In order to be considered for the CCD and PQCED programs, a participating specialist or physician group must have managed episodes of care for a minimum of 30 unique CIGNA members over a two-year period.	To meet the requirement for assessment in UHPD, non-procedural physicians must have a minimum of 30 clinical observations among five patients over a two-year period. Although physicians can be designated with as few as five cases, physicians must have at least 10 patients in order to be designated as not meeting the quality benchmark. Physicians with less than the required minimum observations and cases have "Not enough health plan claims to assess conditions included in UHPD measurement," rather than "No Stars," displayed beside their name in the consumer directory.	The number of cases is a critical factor in determining the reliability of the results. A rating based on data from 50 cases is far more likely to be reliable than a rating based on five cases, for which one high-cost case can dramatically affect the results.
Program transparency to patients	Aetna publicizes the quality and efficiency ratings of Aexcel physicians to members on its Web site (**www.aetna.com**) through its online physician directory, DocFind. Along with details about the Aexcel program, Aetna advises its members of the limitations of data and methodologies used in the program. Additional evaluation information is available through the "view clinical quality and efficiency" tab to registered users of Aetna's Web site.	CIGNA's Web site (**www.cigna.com**) provides detailed information on the CCD program. The Physician Quality and Cost Efficiency display information is available only to CIGNA members, who may visit **www.mycigna.com** to view physicians' designations. Included in the material on its programs, CIGNA advises its members of the limitations of risk adjustment and sample size in determining physician quality and cost efficiency profiles.	UHC's consumer Web site (**www.myuhc.com**) provides information on the UHPD program to the public. Included in the UHPD information for UHC members are advisories of the risk of errors in claims data, episode attribution and physician ratings.	Lack of program transparency, invalid methodologies and inaccurate reports have resulted in some states taking legal action against the sponsors of these programs (e.g., the New York Attorney General settlements; the Texas Attorney General agreement; the Massachusetts Medical Society and the Washington State lawsuits; and the enactment of new state laws—all of which mandate these programs follow a set of standards, disclose methodology limitations and have independent oversight).

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Program transparency to physicians	Aetna re-evaluates a physician's performance at least every two years and allows physicians to view their clinical quality and efficiency evaluation results through NaviNet, its secure Web site. Physicians have a dedicated Aexcel page on NaviNet, which provides them with access to reference materials and a detailed description of the methodology. Aetna makes detailed measure specifications available to physicians through online access, meetings with physician groups and letters. Details of the methodology used in the Aexcel program are explained to physicians through these venues and phone conversations with Aetna medical directors and provider relations contacts.	Prior to the publication of performance results, CIGNA notifies physicians that their individual assessments are complete and that their results are available online through newsletters, CIGNA's Provider Portal, letters and facsimiles. CIGNA offers physicians and physician groups an opportunity to meet with CIGNA's medical staff either face-to-face or via telephone to reach an understanding of the methodology utilized and their results.	UHC provides physicians with a report that indicates the number of cases in their performance assessment, individual physician results and the market average comparison rankings, individual quality and cost efficiency results, and patient-level detail. UHC's Web site (**www.unitedhealthcareonline.com**) provides physicians with detailed methodology and other UHPD information and tools.	Many of the reports that are generated from these programs fail to provide sufficient information for physicians to appeal their ratings. Additionally, physicians contend that the information provided to them in their reports is not actionable at the point of care. Physicians can only use real-time information to effectively support their efforts with quality improvement and appropriate use of health care resources. Physicians report multiple problems accessing and understanding the information on health insurers' Web sites. UHC has revised its physician performance reports to provide physicians with patient-level detail, which is needed to confirm ratings or change practice patterns.
Risk adjustment case mix	The episodes of care for individual patients are case mix adjusted for age, gender, co-morbidities and complications (overall risk score), benefit product, geographic area, year for which the services were paid, pharmacy coverage, and physician specialty.	The ETG methodology CIGNA uses to determine quality and cost efficiency scores for physicians participating in the CCD and the PQCED programs incorporates case mix and severity adjustment for age, co-morbidities and complications.	UHC adjusts for risk by dividing cases into severity levels and then compares the cases to the corresponding case-severity level average. UHC applies the software tool, All Patient Refined Diagnosis Related Groups, to create severity levels for inpatient procedures and employs the Episode Risk Groups software tool to create severity levels for outpatient procedures.	Case mix and risk adjustment should control for differences among patients in severity, co-morbidities, compliance, benefit design, socio-economic factors and demographics. If indicators are not properly adjusted to control for such differences, programs can create perverse incentives for the treatment of certain patients. Focusing on health care costs without appropriate adjustment for health risk may promote an inappropriate under-use of health care services, which could have a profound impact on patients' health outcomes. These programs should

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Risk adjustment case mix (cont.)				provide a mechanism for physicians to report patients' non-compliance with treatment plans, such as the use of Current Procedural Terminology (CPT) II® codes,* and should factor lack of patient compliance into the physician performance rating process. Additionally, all risk adjustment methodologies remain imprecise.
Network adequacy	Aetna re-examines its network at least every two years. Aetna may add specialists from the broad network to the Aexcel network to ensure that its members have satisfactory access to Aexcel specialists. However, Aetna does not add physicians who were previously excluded because they did not meet the clinical performance standards.	CIGNA's market threshold is determined by market-specific considerations. Depending upon the need for specialists in a market, CIGNA adjusts its thresholds to include anywhere from 30 to 70 percent of specialists in its programs to ensure members have adequate access to care. Across all CIGNA's markets, CCD-eligible physicians achieved the lowest average percentage of designations among the three health insurers.	UHC members have access to all physicians in the network; however, some employers may apply benefit incentives, such as lower co-payments or co-insurance for accessing quality- and cost efficiency-designated physicians (does not apply to primary care specialists). The number of physicians with quality and cost-efficiency designations may be limited in rural areas for certain specialties.	One of the primary concerns physicians have with tiered and narrow networks is that these schemes may place profits ahead of patients by decreasing patient access to physicians who are not included in the preferred tier or in the networks, which may result in irrevocable damage to patient-physician relationships.
Physician eligibility for participation	The program does not offer voluntary participation. Specialists within 12 specialty categories in targeted Aexcel markets are evaluated for inclusion in the program. Physicians who lack sufficient data for performance evaluation are not designated for Aexcel.	The program does not offer voluntary participation. Specific specialists are targeted for inclusion in the program, and physicians who do not practice in these specialties are excluded. Also, physicians who lack sufficient data for profiling are excluded. Physicians may decline public display of their designations.	Physicians in the targeted markets and 20 specialties are included for evaluation in the program. Physicians may decline public display of their designations if they meet the quality or quality and cost efficiency criteria. In this situation, the phrase "not displayed upon physician's request" will be displayed next to the physician's name.	All three programs operate the same way on this key element. The programs do not offer voluntary participation. Specific specialists are targeted for inclusion in the programs, and physicians who do not practice in these specialties are excluded. Also, physicians who lack sufficient data for profiling are excluded. Physicians may decline public display of their designations.

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Data	Aetna uses claims data in its physician performance evaluation program. Aetna also supports and participates in industry-wide data collection initiatives. When this credible combined data becomes available, Aetna will consider using it in the evaluations. If Aetna has access to pharmacy data, it incorporates this data into the clinical quality and cost-of-care measurement processes. Physician profiles are constructed using two- to three-year-old data, which may not reflect physicians' current practice patterns. The use of real-time information may support physicians' efforts with quality improvement and appropriate use of health care resources.	CIGNA uses claims data in its profiling program. Even though CIGNA supports the use of aggregated data for physician profiling, CIGNA uses only its own data to profile physicians for designation in the program. If CIGNA has access to pharmacy data, it incorporates this data into the quality and cost-of-care measurement processes. Physician profiles are constructed using two- to three-year-old data, which may not reflect physicians' current practice patterns. The use of real-time information may support physicians' efforts with quality improvement and appropriate use of health care resources.	Although UHC supports the use of aggregated data for physician assessment, to date it uses only its own data to evaluate physicians for designation in UHPD. If UHC has access to pharmacy data, it incorporates these data into the quality and cost efficiency measurement processes. Physician assessments are based on paid claims data that may be two- to three-years old due to the need to evaluate complete episodes of care. These results may not reflect physicians' current practice patterns. UHC is looking into the feasibility of using more current or real-time information in the future.	All three health insurers use claims data in their profiling programs. Even though the three health insurers support the use of aggregated data for physician profiling, they use only their own data to profile physicians for designation in their programs. If health insurers have access to pharmacy data, they incorporate it into the quality and cost-of-care measurement processes. However, if health insurers use data from other sources to profile physicians, they should use complete data and should not place the burden on physicians to supply the missing data. Physician profiles are constructed using two- to three-year-old data, which may not reflect physicians' current practice patterns. The use of real-time information may support physicians' efforts with quality improvement and appropriate use of health care resources.
Program design (pay for performance/tiered network/narrow network)	Employers may use Aexcel as either a tiered network, whereby patients receive incentives through lower co-payments when they obtain their health care services from Aexcel-designated physicians, or as a narrow network, in which patients are required to seek care from Aexcel-designated specialists.	The CCD and the PQCED programs are tiered networks that rate eligible specialists on quality, cost and other factors and rank them into three tiers. CIGNA incentivizes patients, typically with a reduction in co-payment or co-insurance, when they receive care from designated specialists.	The UHPD program is made available to employers as a tiered network, which may offer employees incentives to use specialists who have received the quality and cost efficiency designation. Physicians who receive both quality and cost efficiency designations (two stars) and physician groups with at least one member of the group receiving two stars under the UHPD are eligible for evaluation for a separate UHC program, the Practice Rewards Program. Through its incentive	None of these programs provide financial incentives directly to physicians, although UHC provides incentives to physicians through its Practice Rewards program, which is based on achieving a two-star rating in UHPD. Instead, patients may be steered, with lower co-payments, to select physicians. The use of tiered and narrow networks limits patients' choice of physicians and may sever long-term patient-physician

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Key elements	Aetna's Aexcel program	CIGNA Care Network and Physician Quality and Cost Efficiency Designations programs	UnitedHealthcare's Premium Designation program	Concerns and issues
Program design (pay for performance/tiered network/narrow network) (cont.)			program, UHC provides financial incentives to qualifying physicians and physician groups who have a standard contract and fee schedule with UHC.	relationships, which may threaten continuity and quality of care.
Method used to publicize designated physicians to patients	Aetna designed Aexcel to encourage members to seek care from Aexcel-designated specialists. Patients can log onto Aetna Navigator and search for specific specialists using the DocFind tool. A blue star beside a physician's name in this directory indicates that he or she is an Aexcel-designated physician. Depending on the health benefit plan, some patients receive incentives through lower co-payments to seek care from Aexcel-designated physicians, or the plan may require patients to see only Aexcel-designated physicians.	CIGNA members are able to compare participating specialists in the CCD and the Physician Quality and Cost Efficiency Designations programs based on their performance on select quality and cost efficiency measures. In CIGNA's physician directory, the "CIGNA Tree of Life" display designates physicians in the CCD program. For the Physician Quality and Cost Efficiency Designations, symbols represent quality criteria met, and stars are used to report cost efficiency results. Three stars denote top score for cost efficiency, two stars signify results in the middle category, and one star indicates results in the bottom tier for cost efficiency measurement.	UHC makes physician ratings in the UHPD program publicly available through an online directory. Physicians meeting or exceeding the quality standards receive one star, and physicians who meet both quality and efficiency criteria for the UHPD program are awarded two stars. Physicians who were evaluated by UHC and failed to achieve quality designation are listed in the directory with no stars. Physicians who lack sufficient data for designation are listed as "Not enough health plan claims to assess conditions included in Premium Program measurement." If a physician practices in a specialty that UHC does not evaluate, "Specialty Not Evaluated" appears beside his or her name. Physicians who are eligible for designation (meet quality or quality and cost efficiency designation standards) but decline the designations are identified as "Not Displayed on Physician Request."	Patients and physicians have the right to understand how physician profiles are developed as well as an expectation that the results accurately reflect the realities of physician practices. Not only can incorrect and misleading information tarnish a physician's reputation but it is also unfair to patients who may consider these profiles when choosing physicians. Erroneous information can erode patients' trust in physicians and disrupt long-standing relationships.
Appeal process	Aetna notifies physicians of their designation results by letter. For those physicians who seek corrections or changes to their Aexcel designation or request additional information, a reconsideration review process is available. The designation results letter explains that if physicians have more information, including information contained in medical	CIGNA has a formalized selection review (appeal) process. CIGNA works with eligible physicians and physician groups on quality and cost of care or resource use measurement activities at least 90 days prior to using or reporting the measurement results. CIGNA provides physicians with lower quality scores the opportunity to review their patient data and submit	UHC has a reconsideration process for physicians who want their UHPD status reviewed or wish to amend information supporting their designation status. UHC notifies physicians of their designation status at least 45 days prior to public disclosure of the results. UHC provides UHPD-eligible physicians with their confidential online patient summary and	Physicians report that the appeal processes of profiling programs place numerous administrative burdens on themselves and their staff: time and resources required to review and extract data from medical charts; telephone wait times required to speak with health insurers' representatives to obtain appeal

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Appeal process (cont.)	charts, they have 30 calendar days to contact Aetna for further review. After reviewing more detailed claims reports or the additional information the physician provides, Aetna will make a final determination and provide the physician with an explanation of his or her Aexcel designation status within 50 days of the date of the first letter.	additional information. If the physician accepts the offer to provide additional chart information and it improves their status, CIGNA revises the physician's results.	patient detail reports. Physicians can provide UHC with their comments on the patient detail report. Requests for reconsideration must include the specific rationale for reconsideration. Before submitting the request for reconsideration, physicians are required to sign the attestation section included in the report. If a physician does not agree with the outcome of the reconsideration, an additional review request may be submitted. A physician may request reconsideration of their designation at any time during the designation cycle. However, to avoid display of the new designation on UHC's Web site, the request and all information to be used for a review must be submitted to UHC prior to the date noted in the physician's assessment results letter. In this event, UHC will not change the physician's rating until it completes the reconsideration process and relays the result to the physician.	process information; and time required to read the vast amount of information, including year-to-year programmatic changes, which health insurers post on their Web sites or mail to physicians. Burdensome appeal processes may discourage physicians from filing appeals. Sponsors of physician profiling programs need to use a standardized report form that provides physicians with comprehensive, accurate, complete, detailed and timely data; quality and cost-of-care measurement methodologies; and the method in which rankings are compiled so physicians may use the information to ensure the rankings are correct. This data must be patient- and procedure-specific so physicians can compare their data with the health insurers' data. For physicians who choose to appeal their designation, there may be several situations in which they have information that supplements claims data: • The physician or physician group did not have a meaningful role in the management of the case—the case was managed by a covering physician or a different physician group. • The physician is attributed to the wrong physician group—the physician is associated with another physician group. • The medical record includes

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Key elements	Aetna's Aexcel program	CIGNA Care Network and Physician Quality and Cost Efficiency Designations programs	UnitedHealthcare's Premium Designation program	Concerns and issues
Appeal process (cont.)				additional information showing that the clinical events in the case had a different clinical significance from apparent in the claims record—a readmission within 30 days was actually planned at the time of discharge of the index case. • An event did not actually occur—a hospital codes an acute myocardial infarction (MI) after a surgical procedure when the patient did not have an acute MI. • The specialty designation was incorrect—physician designated as a general surgeon rather than correctly designated as a plastic surgeon. • Other causes—possible missing or erroneous claims information. Finally, health insurers should work with the AMA and medical societies to maximize the clarity and completeness of reported results to physicians and to ensure that the appeal mechanism is as clear and simple to complete as possible.

Readers are encouraged to check with the insurer to ascertain if program changes made by the insurer subsequent to the date this chart was prepared impact its currency or completeness.

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