2026 quality, cost efficiency, and Cigna Care Designation methodology

For health care providers and customers

cigna healthcare

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Introduction

Many of our customers want more information about provider quality and cost efficiency to help them make informed health care decisions. To provide them with relevant information, we evaluate quality and cost-efficiency information of in-network providers in 21 specialty types, including primary care, using a methodology consistent with national standards and that incorporates contracted provider feedback. Groups that 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 white paper explains the methodology used to measure the quality and cost-efficiency results of individual providers at the specialty level, the criteria a group must meet to achieve the CCD, and details regarding the profile information displayed in the provider directories.

Customer inquiries regarding CCD

If customers need additional clarity regarding the quality, cost efficiency, and Cigna Care Designation evaluation, or Tier 1 information listed on our directories, they can contact us using one of the following methods:

- Call the number on the back of their Cigna Healthcare® ID card.
- Send an email to PhysicanEvaluationInformationRequest@CignaHealthcare.com, and a Quality Clinical Manager (QCM) will reach after they receive the request.

Quality and cost-efficiency display principles

Cigna Healthcare follows three key principles when providing 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 that are endorsed by the PQM™ Partnership for Quality Measurement Powered by Battelle, National Committee for Quality Assurance (NCQA), and Healthcare Effectiveness Data and Information Set (HEDIS®*), or that are developed by national provider organizations.
2. **Responsible use of information.** The profiles reflect only a partial assessment of quality and cost efficiency based on our claims data and we recognize that it should not be the sole basis for decision-making, as such measures have a risk of error. We encourage our customers to consider all relevant factors and to consult their treating provider when selecting a provider for care.

   In general, in-network 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 in-network 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 are 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, 2023, through December 31, 2024, for the review period to assess for 2026 quality and cost-efficiency profiles and directory displays. This review includes claims data that comprises the providers' total patient population from our managed care and preferred provider organization (PPO) plans, and

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

excludes government and capitated plans.

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. NCQA Quality Certification Standards meet the 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

The 21 provider specialty types we review are listed below. These specialty types account for more than 77.7 percent of primary and specialty health care spending based on Cigna Healthcare claims data.

Please note that a provider can only be evaluated under one specialty, one Taxpayer Identification Number (TIN), and one 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. Our current process looks for the most recent TIN in the claims data for the review period. If there are multiple TINs on the most recent date, the TIN with the greatest quantity of claims on that date is selected.

Assessed specialty types

Allergy and Immunology	Cardiology	Cardiothoracic 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 that comprise more than one specialty type.

Market availability

The ZIP code of a provider's primary office address is used to align them with a given geographic market. The provider's primary specialty and geographic market is then used to determine the provider's peer group for comparison of quality and cost-efficiency results.

Cigna Referral Regions (CRRs) are custom-built regions composed of ZIP code areas, grouped together to delineate health care markets based on our internal claims data. CRRs were developed using predictive analytics and behavior technology, such as customer travel patterns, primary care provider/specialty access, and customer/provider interactions, and leverage our current data showing where our customers live and where they access common provider-based care.

A list of markets, including the volume and percentage of providers with the CCD in each market, is available to providers and customers upon request by sending an email to PhysicanEvaluationInformation@CignaHealthcare.com. The providers identified will have the CCD effective January 1, 2026.

Quality evaluation and displays

Providers are evaluated on a number of criteria identified as markers of practice quality. Information relative to specific quality criteria met by a provider is displayed in our online provider directories 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 that qualifies for a *specific* quality indicator is identified in our online provider directories.

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 certified care standard criteria help determine whether board-certified physicians in the group predominantly provide 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 158 evidence-based medicine (EBM) rules derived from measures endorsed by the PQM™ or HEDIS or developed by provider organizations. These rules span 49 diseases and preventive care conditions (see Appendix) 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 in the next section, "Evidence-based medicine assessment process."

3. 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 directories who have received recognition in any of the following five NCQA physician recognition programs:

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

Additional information about these programs is available on the NCQA website at 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 (American Society of Clinical Oncology [ASCO] Practice Central, 2021). The QOPI Certification Program builds upon the success of the ASCO Quality Oncology Practice Initiative. We identify physicians in our online provider directories who have received this certification.

Additional information about this program is available on the ASCO Practice Central website at ASCO.org > Practice & Patients > Quality Improvement > Quality Programs > QOPI Certification Program.

Evidence-based medicine assessment process

The EBM rules used in the 2026 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 9.98 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, 0.59 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)	Ear, Nose, and Throat (ENT)	Pediatrics
Pulmonary	Rheumatology	Urology

Determining EBM rule compliance

The 2026 EBM assessment component review includes measuring compliance with 158 EBM rules obtained from Optum® Symmetry® EBM Connect® software, version 13.0, where applicable, for the medical conditions displayed in the Appendix.

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 2026 displays, that period is January 1, 2023, through December 31, 2024.
- 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.
- EBM rule adherence is compared to peer groups, which include other providers or provider groups of the same specialty in the same geographical market.

Individual provider or group practice EBM rule adherence

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

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). 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 with medical groups (practices). EBM rule opportunities, successes, and expected successes are then summed to obtain totals. Provider performance is aggregated:

  - At the specialty level within a group for quality displays.
  - At the group level to determine CCD.
- A Quality Index (QI) 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 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. Therefore, risk adjustment is incorporated into the definition of the measure.
- A 90 percent confidence interval (CI) around the QI is determined, allowing EBM quality performance to be measured with a strong degree of certainty. The lower bound of the 90 percent CI for a particular provider or provider group is defined as the Adjusted Quality Index (AQI) for that provider group.
- Provider groups must have 30 or more total EBM rule-adherence opportunities.
- Provider groups with an AQI 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 are placed in the bottom category. The remainder are in the middle category.
- Specialties within each group are assessed in a similar manner to determine the EBM score at the specialty level. If there are only one to two groups eligible for evaluation for a specific specialty in a geographic area, then the group's Raw Quality Index (instead of AQI) will be compared against the National Quality Index for that specialty to award EBM. Specialty level scoring will drive directory displays at the provider/specialty level. (i.e., "Evidence-Based Medicine Standards" language will display on the directories for those providers in the top 34 percent for their specialty.)

Cost-efficiency evaluation and displays

In-network 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.

Based on the results of this evaluation, one, two, or three stars (★) may display for a provider in our online directory on 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 within the geographic market.
- Two stars for cost efficiency represent the middle 33 percent of providers or provider groups.
- One star for cost efficiency represents the bottom 33 percent of providers or provider groups.

Providers that do not meet the volume criteria for the cost-efficiency assessment will have a message next to their name in the provider directories indicating there was not enough Cigna Healthcare claim volume to assess their cost efficiency. The rankings are based on a weighted percentile of total medical spend by market to account for variations in group sizes.

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

The geographical markets and volume of providers reviewed for quality and cost efficiency for the displays beginning January 1, 2026, are available by request. Please submit a request to our Quality Clinical Management Team. You can also reach us via email at PhysicianEvaluationInformationRequest@CignaHealthcare.com.

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 OptumInsight™ Episode Treatment Groups® is available on the Optum website (Optum.com) or in the Symmetry Episode Treatment Groups white paper. Optum ETG software version 13.0 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, when 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 at 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 ETGs are excluded from the assessment process, including routine immunizations and other inoculations, transplants, and ETGs with low volume or wide cost variations. 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. For an episode to be attributed to a provider group, the following 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 (management, surgery, facility, ancillary inpatient, ancillary outpatient, and pharmacy) 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 ETGs (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

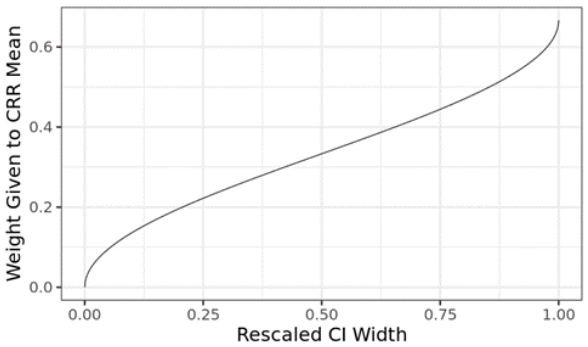
Dividing the average actual cost of all episodes of care attributable to the provider group by average expected episode cost for the ETGs on which the provider group's cost-efficiency performance is being evaluated yields a PI of 0.825.

A 90 percent CI 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 (2023–2024) and the published result (2026), 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 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 and 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 a year-over-year disruption and prediction error, while equalizing the chances for small and large groups to earn designation.



3. Finally, calculate the API.

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

Example: Consider a group with a PI=1.22 (90 percent 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 x (1.00-0.25) + 0.83 x 0.25 = 1.12.

Using a weighted percentile, groups are ranked by their API against their peers within their geographic market. They are not compared with groups outside of 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. If there are only one to two groups eligible for evaluation for a specific specialty in a geographic area, then the group's raw performance index (instead of API) will be compared against the raw average PI for that specialty to award cost efficiency. Three stars will display in the directories for providers in the top 34 percent for their specialty, two stars will display for those falling between 34 and 66 percent, and one star will display for those in the bottom 34 percent.

2026 outlier methodology

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 ETGs 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 (cost less than $25) identified by the Optum software are excluded from the evaluation.

Level of evaluation (unit of analysis)

While we review in-network providers at the individual level, the CCD is conferred at the provider group or practice level 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 choose a group rather than a specific provider within the group, and
- Initially choose a specific provider but frequently receive care from another provider within the practice or group.

Cigna Care Designation inclusion methodology

In 2026, providers who meet our specific quality and cost-efficiency criteria can receive the CCD and will have the CCD ( ) symbol display next to their name in our online provider directories. 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) > Get questions answered: Resource > 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 below. If the provider or group achieves those results, then the provider or group may be assigned the CCD.

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

- Is located in a market that currently participates in this program.
- Practices in one of the 21 assessed specialties.

- Meets the Board Certified Care Standard.
- Has a minimum volume of 30 complete ETG occurrences **AND**
  - Has group performance in the top 34 percent for quality, **OR** 50 percent of providers in the practice achieve NCQA or QOPI certification **AND** meets the cost-efficiency criteria of being in the top 34 percent, **OR**
  - Has group performance in the top 34 percent for quality, **OR** 50 percent of providers in the practice achieve NCQA or QOPI certification **AND** have less than 30 ETG episodes (with no cost ranking), **OR**
  - Has group performance in the top 25 percent for cost **AND** is either between 2.5 and 66 percent for quality **OR** has less than 30 EBM opportunities (with no quality ranking), **OR**
  - Specialties not evaluated for EBM quality (dermatology, gastroenterology, general surgery, neurosurgery, ophthalmology, orthopedic surgery), have group performance in top 34 percent for cost.
    - To qualify for this pathway, at least 50 percent of physicians within a group would need to be in a specialty not evaluated for EBM quality.

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. There could be a risk of error in the data used to perform the review; therefore, earning the CCD does not mean the provider offers equal or greater quality and cost efficiency than other in-network providers. We encourage our customers to consider all relevant factors when choosing a primary care provider (PCP) or specialist for their care and to speak with their treating provider when selecting a specialist.

Performance Carryover Exception methodology

Variations in provider group or provider group performance (e.g., positive or negative, substantial or minimal) are 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). Performance Carryover Exception methodology addresses small-scale variations for providers or provider groups that experience CCD changes from the previous review cycle. The practice may maintain its designation status if the group earned CCD last year and their API and/or AQI are within three percent of the lowest performing group that qualified for the corresponding pathway, achieving CCD in their geographical market for 2026.

2026 provider evaluation methodology changes

Changes to our 2026 provider evaluation methodology are outlined below.

Methodology	Change/enhancement	Details/rationale
Software update	EBM and ETG are moving to version 13.0.	Consistency with matrix partners.
Data review period	Reporting years of 2023–2024.	Utilizing the most recent data.
EBM Quality pathway revision	Elimination of the criteria will require the practice to achieve the top 34 percent cost-efficiency criteria when the specialty cannot be assessed for EBM quality, due to no or limited EBM measures.	Specialties without applicable EBM measures or specialties with limited EBM measures will now have the same cost-efficiency criteria to meet, top 34 percent, as specialties who have volume to be assessed for applicable EBM measures.

Data sources

The table below outlines the evaluation data sources and how they are used.

Data source	How information is used
Cigna Healthcare provider metrics (January 2023–December 2024) *These metrics combine 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.
Health Care Provider Manager (HPCM)	File extracts are used to identify contracted providers, TINs, provider group demographics, specialty, board certification status, networks, and products contracted.
Physician Recognition Program File obtained from the NCQA (as of February 2025) and at least six times per year	The status of physicians recognized for diabetes, heart/stroke, patient-centered medical home and patient-centered specialty practice recognition programs is updated based on information received from the NCQA. The percentage 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	The percentage 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 them in evaluations when credible data is available.
- We can only use received claims data in evaluations. Claims we receive, that 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 details may not always be available due to the way claims are 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 the Cigna Healthcare tiered benefit

- The Cigna Healthcare tiered benefit is offered in various markets through employer-sponsored health plans. This benefit has copay and coinsurance levels for covered services provided by Tier 1

providers that differ from those of other in-network 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.

- A provider's reimbursement remains unchanged as a result of their Tier 1 status. However, Cigna Healthcare customers enrolled in a plan with a tiered benefit option may pay a lower coinsurance or copay when selecting a Tier 1 provider.
- Inclusion as a Tier 1 provider does not indicate that the provider offers services of equal or greater quality and cost efficiency than any other in-network provider.

Feedback process

We welcome and encourage in-network providers, customers, and employer groups to provide feedback and suggestions for how we can improve the evaluation, reports, or other aspects of the program by submitting an intake. Patients with Cigna Healthcare plans can also call the telephone number listed on the back of their ID card or access the feedback button available online at myCigna.com. In-network providers can also give feedback by accessing the feedback button on Cigna.com or CignaforHCP.com, or calling Cigna Healthcare Provider Service at **800.88Cigna (882.4462)**.

Feedback and suggestions will be reviewed, and changes to the provider evaluation methodology, reporting formats, and processes will be implemented, as appropriate. Methodology changes are generally reviewed and implemented annually.

Removal of Cigna Care Designation

Cigna Healthcare reserves the right to remove a provider's CCD if they no longer meet 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

In-network providers and provider groups have a right to request detailed reports and additional information, correction of inaccuracies, and reconsideration of their quality and cost-efficiency displays, as well as submit additional information. To do so, please submit a request to our Quality Clinical Management Team. You can also reach us via email at PhysicianEvaluationInformationRequest@CignaHealthcare.com, or by fax at **866.448.5506**.

The request for reconsideration must include the reason and documentation to support the request. If the group meets the criteria for CCD inclusion upon reconsideration, the provider will have the symbol display next to their name in our online provider directories.

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 or provider group to clarify the information received for reconsideration and generate detailed reports. A QCM may change the 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 will be sent to the provider group after the committee makes the determination. The National Selection Review Committee process and final decision will be completed within 45 days of receipt of a reconsideration request.

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 the criteria required by the state of New York.

Complaints about the CCD, quality, and cost-efficiency displays in New York may be registered with NCQA, in addition to registering them with Cigna Healthcare, by submitting the complaints in writing to NCQA Customer Support at www.NCQA.org, or by mail at 1100 13th Street, NW, Suite 1000, Washington, DC 20005.

Appendix: 2026 EBM rules used for provider evaluation

Condition/treatment	Rule description	Source	Specialty types	Primary care types
Admissions and Emergency Department (ED) Visits for Chemotherapy-related Symptoms in 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.	• Centers for Medicare & Medicaid Services (CMMS) • Partnership for Quality Management (PQM) # 3490	• Hematology and Oncology	• Family Practice • Internal Medicine
Admissions and Emergency Department (ED) Visits for Chemotherapy-related Symptoms in 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.	• CMS • PQM number 3490	• Hematology and Oncology	• Family Practice • Internal Medicine
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Patient(s) 20 years and older 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
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Patient(s) 20 - 44 years that had a preventive or ambulatory care visit during the 36 month report period.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Patient(s) 65 years and older that had a preventive or ambulatory care visit during the 36-month report period.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Antidepressant Medication Management (AMM)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 6 months (effective continuation phase treatment).	• HEDIS • NCQA • PQM #0105	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology
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 • PQM #0105	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology
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 • Obstetrics and Gynecology • Pediatrics

Appropriate Treatment for Upper Respiratory Infection (URI)	Patient(s) with a diagnosis of URI that did not have a prescription for an antibiotic on or within three days after the initiating visit.	• HEDIS • NCQA	• Allergy and Immunology • Ear, Nose and Throat (ENT)	• Family Practice • Obstetrics and Gynecology • Pediatrics
Appropriate Treatment for Upper Respiratory Infection (URI)	Patient(s) 3 months -17 years of age with a diagnosis of URI that did not have a prescription for an antibiotic on or within three days after the initiating visit.	• HEDIS • NCQA	• Allergy and Immunology • Ear, Nose and Throat (ENT)	• Family Practice • Obstetrics and Gynecology • 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 • PQM #1800	• Allergy and Immunology • Pulmonology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Atrial Fibrillation	Patient(s) taking warfarin that had 3 or more prothrombin time tests in last 6 reported months.	• 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	• Allergy and Immunology • Ear, Nose and Throat (ENT) • Pulmonology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Patient(s) 3 months to 17 years of age 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	• Allergy and Immunology • Ear, Nose and Throat (ENT) • Pulmonology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Patient(s) 18-64 years of age 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	• Allergy and Immunology • Ear, Nose and Throat (ENT) • Pulmonology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Blood Pressure Control for Patients with Diabetes (BPD Part 2 –	Patient(s) with diabetes who had a blood pressure less than 140/90 mm Hg documented in the last 12 months.	• HEDIS • NCQA	• Cardiology • Endocrinology • Nephrology • Neurology	Family Practice • Internal Medicine • Obstetrics and Gynecology
Breast Cancer - Part 1	Patient(s) compliant with prescribed anti-estrogen for chemotherapeutic use (minimum compliance 80%).	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Breast Cancer - Part 1	Patient(s) compliant with prescribed aromatase inhibitor	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine • Obstetrics and Gynecology

	(minimum compliance 80%).			
Breast Cancer - Part 1	Patient(s) that had an annual provider visit.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Breast Cancer - Part 1	Breast cancer patient(s) without evidence of metastases that had an annual mammogram.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
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.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Breast Cancer Screening (BCS)	Patient(s) 52-74 years that had a screening mammogram in last 27 reported months.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Cardiac Rehabilitation (CRE)	Patient(s) 18 years or older that attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event (Initiation).	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery	• Family Practice • Internal Medicine
Cardiac Rehabilitation (CRE)	Patient(s) 18 years or older that attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event (Engagement 1).	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery	• Family Practice • Internal Medicine
Cardiac Rehabilitation (CRE)	Patient(s) 18 years or older that attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event (Engagement 2).	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery	• Family Practice • Internal Medicine
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 (U.S. commercial enrollment).	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology

Cesarean Section for Nulliparous Singleton Vertex	Women that had a cesarean section for a singleton vertex delivery (women with a code indicating nulliparous or primigravida).	• PQM #0471e	• N/A	• Family Practice • Obstetrics and Gynecology
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
Childhood Immunization Status (CIS)	Patient(s) 2-years-old at the end of the report period that had four DTaP immunizations by their 2nd birthday.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics
Childhood Immunization Status (CIS)	Patient(s) 2-years-old at the end of the report period that had three polio vaccinations by their 2nd birthday.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics
Childhood Immunization Status (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	• N/A	• Family Practice • Pediatrics
Childhood Immunization Status (CIS)	Patient(s) 2-years-old at the end of the report period that had three HiB immunizations by their 2nd birthday.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics
Childhood Immunization Status (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	• N/A	• Family Practice • Pediatrics
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	• N/A	• Family Practice • Pediatrics
Childhood Immunization Status (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	• N/A	• Family Practice • Pediatrics
Childhood Immunization Status (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	• N/A	• Family Practice • Pediatrics
Childhood Immunization Status (CIS)	Patient(s) year-old at the end of the report period that had the required number of rotavirus immunizations by their 2nd birthday.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics

Childhood Immunization Status (CIS)	Patient(s) 2-years-old at the end of the report period that had two influenza immunizations by their 2nd birthday.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics
Chlamydia Screening in Women (CHL)	Patient(s) 16-24 years that had a chlamydia screening test in last 12 reported months.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Chronic Kidney Disease	Patient(s) with stage 5 or end stage renal disease that had a serum calcium in last 12 reported months.	• 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 the last 12 reported months.	• 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 the last 12 reported months.	• Optum	• Endocrinology • Nephrology	• Family Practice • Internal Medicine • Pediatrics
Chronic Kidney Disease	Patient(s) with proteinuria currently taking an ACE-inhibitor or angiotensin II receptor antagonist.	• Optum	• Endocrinology • Nephrology	• Family Practice • Internal Medicine • Pediatrics
Colon Cancer - Part 1	Patient(s) newly diagnosed with colon cancer that had a PET scan.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine
Colon Cancer - Part 2	Patient(s) with newly diagnosed colon cancer that had CT staging prior to colon resection.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine
Colon Cancer Surveillance	Patient(s) newly diagnosed with non-obstructing colon cancer that had a surveillance colonoscopy approximately one year after diagnostic colonoscopy.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine
Colorectal Cancer Screening (COL)	Patient(s) 50-75 years as of the report period end date that had appropriate screening for colorectal cancer.	• HEDIS • NCQA • PQM #0034	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Continued Opioid Use (COU)	Patient(s) age 18 years and older who were opioid-naive and were prescribed access to opioid medication for 15 or more days during the first 30 days following first opioid treatment initiation.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Continued Opioid Use (COU)	Patient(s) age 18 years and older who were opioid-naive and were	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and

	prescribed access to opioid medication for 31 or more days during the first 62 days following first opioid treatment initiation.			Gynecology • Pediatrics
Coronary Artery Disease	Patient(s) with CAD currently taking an ACE-inhibitor or angiotensin receptor blocker (ARB).	• Optum	• Cardiology • Cardiothoracic Surgery	• Family Practice • Internal Medicine
Coronary Artery Disease	Patient(s) with CAD currently taking a statin.	• Optum	• Cardiology • Cardiothoracic Surgery	• Family Practice • Internal Medicine
Depression	Patient(s) taking lithium that had a lithium level in last 6 reported months.	• Optum	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • 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 • Obstetrics and Gynecology • Pediatrics
Depression	Patient(s) hospitalized for depression that had a mental health evaluation within 7 days after discharge.	• Optum	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • 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 • Obstetrics and Gynecology • 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	• Neurology	• Family Practice • Pediatrics
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	• 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	• Neurology	• Family Practice • Pediatrics
Diabetes Mellitus	Patient(s) compliant with prescribed statin-containing medication (minimum compliance 80%).	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics

			• Nephrology • Neurology	
Diabetes Mellitus	Adult(s) 18-75 years of age that had a serum creatinine or estimated glomerular filtration rate in last 12 reported months.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) that did not have a diabetes related hospitalization in the last 12 reported months.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) that had at least 2 HbA1c tests in the last 12 reported months.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) with most recent HbA1c result 9.0% or lower.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) that had at least one HbA1c test in the last 6 reported months.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) that had ambulatory care for diabetes in the last 12 reported months.	• Optum	• Cardiology • Cardiothoracic surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) that did not have a diabetes related emergency department encounter in the last 12 reported months.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) that did not have diabetes related observation stay in the last 12 reported months.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) with most recent HbA1c result 8.0% or lower.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Mellitus	Patient(s) with most recent HbA1c result 7.0% or lower.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics

Diabetes Mellitus	Patient(s) with type 1 diabetes with a TSH level in the last 12 reported months.	• Optum	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med	Patient(s) with schizophrenia, schizoaffective disorder or bipolar disorder taking an antipsychotic medication who were screened for diabetes during the report period.	• HEDIS • NCQA	N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Epilepsy	Patient(s) with one or more hospitalizations or two or more emergency room encounters for epilepsy that had neurology evaluation in the last 3 reported months.	• Optum	• Neurology	• Family Practice • Internal Medicine • Pediatrics
Eye Exam for Patients with Diabetes (EED)	Patient(s) 18-75 years of age with diabetes that had an annual retinal eye exam.	• HEDIS • NCQA	• Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • 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 substance use that had a follow-up visit or pharmacotherapy dispensing event within 30 days.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Pediatrics
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Patient(s) 6-17 years of age with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 7 days.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Pediatrics
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Patient(s) 18-64 years of age with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 7 days.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Pediatrics
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Patient(s) 6-17 years of age with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 30 days.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Pediatrics
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Patient(s) 18-64 years of age with an ED visit for mental illness or intentional self-harm that had a follow-up visit within 30 days.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Pediatrics
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Patients with a discharge or detoxification visit for substance use disorder who received follow-up treatment within 7 days after the visit or discharge.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Patients with a discharge or detoxification visit for substance use disorder who received follow-up treatment within 30 days after the visit or discharge.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Patient(s) with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a prescribing provider during the 30 days after the initial ADHD prescription.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Patient(s) with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a prescribing provider during the 30 days after the initial ADHD prescription, AND two follow-up visits during the 31 days through 300 days after the initial ADHD prescription.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics
Foot Imaging for Plantar Fasciitis	Patient(s) with newly diagnosed plantar fasciitis that had foot imaging.	• Optum	• N/A	• Family Practice • Internal Medicine
Heart Failure - Part 1	Patient(s) currently taking a beta-blocker specifically recommended for heart failure management.	• Optum	• Cardiology	• Family Practice • Internal Medicine
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Patient(s) 18-75 years of age with diabetes whose most recent HbA1c result is less than 8.0%.	• HEDIS • NCQA	• Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Patient(s) 18-75 years of age with diabetes whose most recent HbA1c result is greater than 9.0%.	• HEDIS • NCQA • PQM #0059	• Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Hyperlipidemia	Patient(s) with an LDL cholesterol test in the last 24 reported months.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Hyperlipidemia	Patient(s) with an HDL cholesterol test in the last 24 reported months.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology

Hyperlipidemia	Patient(s) with a triglyceride test in the last 24 reported months.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Hyperlipidemia	Patient(s) with the most recent triglyceride result <500 mg/dL.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Hyperlipidemia	Patient(s) with the most recent LDL result <190 mg/dL.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Hypertension	Patient(s) that had an annual physician visit.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Hypertension	Patient(s) 18-85 years of age with hypertension and most recent blood pressure less than 140/90 mm Hg in the last 12 months.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Hypertension	Patient(s) taking an ACE-inhibitor, angiotensin receptor blocker (ARB), diuretic, or aldosterone receptor antagonist-containing medication that had a serum potassium in the last 12 reported months.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Hypertension	Patient(s) that had a serum creatinine in the last 12 reported months.	• Optum	• Cardiology • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
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	• N/A	• Family Practice • Obstetrics and Gynecology • Pediatrics
Immunizations for Adolescents (IMA)	Patient(s) 13-years-old at the end of the report period that had the Tdap vaccine by their 13th birthday.	• HEDIS • NCQA	• N/A	• Family Practice • Obstetrics and Gynecology • Pediatrics
Immunizations for Adolescents (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	• N/A	• Family Practice • Obstetrics and Gynecology • Pediatrics

Kidney Health Evaluation for Patients with Diabetes (KED)	Patient(s) 18-85 years with diabetes that had kidney health evaluation in the last 12 reported months.	• HEDIS • NCQA	• Endocrinology • Nephrology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Patient(s) 1-17 years who had two or more antipsychotic medications and had blood glucose testing during the report period.	• HEDIS • NCQA	N/A	• Family Practice • Pediatrics
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Patient(s) 1- \17 years who had two or more antipsychotic medications and had cholesterol testing during the report period.	• HEDIS • NCQA	N/A	• Family Practice • Pediatrics
Migraine	Adult(s) with frequent use of acute medications that also received prophylactic medications.	• Optum	• Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Migraine	Patient(s) with frequent ER encounters or frequent acute medication use that had an ambulatory visit in the last 6 reported months.	• Optum	• Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Multiple Sclerosis	Patient(s) that had neurology evaluation in the last 12 reported months.	• Optum	• Neurology	• Family Practice • Internal Medicine
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 • Obstetrics and Gynecology • Pediatrics
Obesity and Overweight	Patient(s) that had a blood glucose or hemoglobin A1C test in the last 36 reported months.	• Optum	• Cardiology • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Obesity and Overweight	Adult(s) with an LDL cholesterol test in the last 36 reported months.	• Optum	• Cardiology • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Obesity and Overweight	Adult(s) with an HDL cholesterol test in the last 36 reported months.	• Optum	• Cardiology • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Obesity and Overweight	Adult(s) with a triglyceride test in the last 36 reported months.	• Optum	• Cardiology • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Obesity and Overweight	Adult(s) with the most recent triglyceride result <500 mg/dL.	• Optum	• Cardiology • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology

Obesity and Overweight	Adults with the most recent LDL result <190 mg/dL.	• Optum	• Cardiology • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Oncology – Appropriate Use of Antiemetics	Patient(s) receiving parenteral highly emetogenic single agent chemotherapy who received appropriate antiemetic prophylaxis.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine
Opioids Multiple Prov (UOP)	Patient(s) ages 18 or older that received opioid prescriptions from four or more different prescribers and from four or more different pharmacies.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
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	• Endocrinology • Nephrology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Osteoporosis Screening in Older Women (OSW)	Women 65-75 years that had appropriate screening for osteoporosis.	• HEDIS • NCQA	• Endocrinology • Nephrology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Otitis Externa, Acute	Patient(s) 2 years of age and older with acute otitis externa who were prescribed systemic antimicrobial therapy.	• Optum	• Ear, Nose, and Throat (ENT)	• Family Practice • Internal Medicine • Pediatrics
Otitis Media, Acute	Patient(s) on antibiotic therapy with acute otitis media that received amoxicillin, a first line antibiotic.	• Optum	• Allergy and Immunology • Ear, Nose and Throat (ENT)	• Family Practice • Obstetrics and Gynecology • Pediatrics
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery	• Family Practice • Internal Medicine
Pharmacotherapy for Opioid Use Disorder (POD)	Patient(s) 16 years or older with continuous OUD pharmacotherapy for at least 180 days.	• HEDIS • NCQA	N/A	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Pharmacotherapy Management of COPD Exacerbation (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
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
Pharyngitis (CWP)	Patient(s) 3-17 years of age who were treated with an antibiotic for	• HEDIS • NCQA	• Allergy and Immunology	• Family Practice • Obstetrics and Gynecology

	pharyngitis that had a Group A streptococcus test.		• Ear, Nose and Throat (ENT)	• Pediatrics
Pneumonia, Community-Acquired Bacterial	Adult(s) with community-acquired bacterial pneumonia who have a CXR.	• Optum	• Pulmonology	• Family Practice • Internal Medicine
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
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)	Older adult patients with dementia that 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 that had HIV testing.	• Optum	• N/A	• Family Practice • Obstetrics and Gynecology
Pregnancy Management	Pregnant women less than 25 years of age that had chlamydia screening.	• Optum	• N/A	• Family Practice • Obstetrics and Gynecology
Pregnancy Management	Pregnant women that had syphilis screening.	• Optum	• N/A	• Family Practice • Obstetrics and Gynecology
Pregnancy Management	Pregnant women that had HBsAg testing.	• Optum	• N/A	• Family Practice • Obstetrics and Gynecology
Pregnancy Management	Pregnant women that received Group B Streptococcus testing.	• Optum	• N/A	• Family Practice • Obstetrics and Gynecology
Prenatal and Postpartum Care (PPC)	Women that received a prenatal visit in the appropriate time period.	• HEDIS • NCQA	• N/A	• Family Practice • Obstetrics and Gynecology
Prenatal and Postpartum Care (PPC)	Women that received a prenatal visit (excluding bundled prenatal services).	• HEDIS • NCQA	• N/A	• Family Practice • Obstetrics and Gynecology
Prenatal and Postpartum Care (PPC)	Women that received postpartum care (excluding bundled postpartum services).	• HEDIS • NCQA	• N/A	• Family Practice • Obstetrics and Gynecology
Prostate Cancer - Part 1	Patient(s) that had a prostate specific antigen test in the 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 methotrexate, sulfasalazine, or leflunomide that had a	• Optum	• Rheumatology	• Family Practice • Internal Medicine • Pediatrics

	CBC in the last 3 reported months.			
Rheumatoid Arthritis	Patient(s) taking methotrexate that had a serum creatinine in the last 6 reported months.	• Optum	• Rheumatology	• Family Practice • Internal Medicine • Pediatrics
Rheumatoid Arthritis	Patient(s) taking methotrexate, sulfasalazine, or leflunomide that had serum ALT or AST test in the last 3 reported months.	• Optum	• Rheumatology	• Family Practice • Internal Medicine • Pediatrics
Rheumatoid Arthritis	Patient(s) taking hydroxychloroquine that had an eye exam in the last 12 reported months.	• Optum	• Rheumatology	• Family Practice • Internal Medicine • Pediatrics
Rheumatoid Arthritis	Patient(s) with complex RA treatment regimens or complications that had rheumatology evaluation in the last 6 reported months.	• Optum	• Rheumatology	• Family Practice • Internal Medicine • Pediatrics
Rheumatoid Arthritis	Patient(s) taking chronic oral corticosteroids that had rheumatology evaluation in the last 6 reported months.	• Optum	• Rheumatology	• Family Practice • Internal Medicine • Pediatrics
Sickle Cell Anemia	Patient(s) that had a hemoglobin/hematocrit in the last 12 reported months.	• Optum	• Hematology and Oncology	• Family Practice • Internal Medicine • Pediatrics
Sinusitis, Acute	Patient(s) that had a sinus computerized axial tomography (CT) or magnetic resonance imaging (MRI) test that was not clinically indicated.	• Optum	• Allergy and Immunology • Ear, Nose and Throat (ENT) • Pulmonology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Sinusitis, Acute	Patient(s) treated with an antibiotic for acute sinusitis that received a first line antibiotic.	• Optum	• Allergy and Immunology • Ear, Nose and Throat (ENT) • Pulmonology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Patient(s) with cardiovascular disease that received a high-intensity or moderate-intensity statin medication.	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • 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 • NCQA	• Cardiology • Cardiothoracic Surgery • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Women 40-75 years with cardiovascular disease that received a high-intensity or moderate-intensity statin medication.	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery • Endocrinology	• Family Practice • Internal Medicine • Obstetrics and Gynecology • Pediatrics

Statin Therapy for Patients with Diabetes (SPD)	Patient(s) 40-75 years with diabetes that received a statin medication.	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Statin Therapy for Patients with Diabetes (SPD)	Patient(s) with statin adherence (proportion of days covered) at least 80% during the treatment period.	• HEDIS • NCQA	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Statin Use in Persons with Diabetes (National Standard)	Patient(s) 40-75 years of age with diabetes that received a statin medication.	•Pharmacy Quality Alliance	• Cardiology • Cardiothoracic Surgery • Endocrinology • Nephrology • Neurology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Use of Imaging Studies for Low Back Pain (LBP)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	• HEDIS • NCQA	• Rheumatology	• Family Practice • Internal Medicine • Obstetrics and Gynecology
Use of Opioid Meds (HDO)	Patient(s) 18 years or older with an average morphine milligram equivalent (MME) >= 90 mg/day during the treatment period.	• HEDIS • NCQA	• N/A	• Family Practice • Internal Medicine
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
Well-Child Visits in the First 30 Months of Life (W30) – Part 1	Patient(s) that had six or more well-child visits with a PCP during the first 15 months of life.	• HEDIS • NCQA	• N/A	• Family Practice • Pediatrics
Well-Child Visits in the First 30 Months of Life (W30) – Part 2	Patient(s) aged 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