

# A physician's guide to Aexcel<sup>®</sup>

For Designations Effective January 1, 2010



# General information



## Background on Aexcel

As one of the oldest and largest insurers in America, Aetna has an obligation and an opportunity to transform health care. We believe a better health care system is more transparent and consumer friendly and also recognizes physicians for their efficient and effective use of health care resources.

Aexcel is a component of our overall health care transparency efforts. It is a designation for specialists who:

- Are part of the broader Aetna network of participating providers
- Have met specific clinical performance and efficiency criteria

Physicians who are not Aexcel-designated remain Aetna participating physicians. And, Aexcel-designation has no bearing on a physician's contracted reimbursement rates.

Aexcel originated from discussions with large employer groups who were challenged by rising health care costs. Patients, in turn, were becoming increasingly engaged as consumers of health care. As such, they wanted access to information about physicians to help them make informed health care decisions before seeking care from a physician.

Members are reminded that Aexcel designation is only a guide to choosing a physician. Members should confer with their treating physicians before selecting specialty physicians for their care. Designations have the risk of error and should not be the sole basis for selecting a physician.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

## Keeping physicians informed of the program

As Aexcel is implemented throughout the country, we make sure affected physicians are aware of its introduction to their area beforehand. We also review the program with specialty societies and other groups within organized medicine. Our goal is to work collaboratively with physicians, employers and members to transform health care in a way that works for all constituents.

## Sharing suggestions about Aexcel

Physicians can provide feedback and suggestions for improving Aexcel by visiting our website at [www.aetna.com](http://www.aetna.com). Select “Contact Us” (on bottom of page), “Health Care Professionals,” then “Provide feedback on Aexcel.”

For more information on our overall consumerism approach, visit our secure provider website via NaviNet®. Once logged in, select “Aetna Support Center” and then “Doing Business with Aetna.”

## Sharing results with physicians to improve care

Along with providing members with information to help them make informed decisions about their care, we work with physicians to help them improve the care they provide. Through your network account manager or local market medical director, you can request a comprehensive description of our Aexcel methodology, the detailed information behind the metrics and other data intended to help improve performance.

Ongoing discussions with the clinical community, including key physician organizations, also provide a valuable opportunity to share information and gather important input about potential Aexcel program enhancements.

In addition to this guide, physicians can access information and detailed descriptions of the Aexcel evaluation methodology through our website at [www.aetna.com](http://www.aetna.com). Under, “I Want To...,” select “Plans & Products,” “Health Benefits and Health Insurance Plans” “Medical” then “Performance Networks.” Our website is available to all current and prospective members, physicians, brokers, plan sponsors and other interested parties.

Similar information is also available on our secure provider website via NaviNet. Once logged in, select “Aetna Support Center,” “Doing Business with Aetna.”

## How we evaluate physicians

We perform our Aexcel evaluation at the physician group or tax identification number (TIN) level rather than at the individual physician level. This approach provides more robust data for evaluation. Outlined within this guide is the 2009 measurement criteria used to determine physician Aexcel designation effective January 1, 2010.

Our evaluation process includes a balance of clinical performance and efficiency measures. We identify those specialists and groups that managed at least 20 Aetna episodes of care over the last 3 years. A reasonable volume of Aetna members is necessary to credibly measure performance.

## Aexcel markets

We introduce Aexcel in markets where:

- There is a significant plan sponsor commitment and willingness to partner.
- The existing Aetna network is sufficiently robust to maintain network adequacy with the establishment of a specialist performance network.
- Variation in efficiency across specialists is distinguishable; establishing a performance network results in benefits to our customers.
- There is sufficient claims experience to enable credible analysis of specialists.

## Aexcel physician specialty categories

We chose to address physician specialty care in developing this program for several reasons.

- 1) Specialty care is more episodic than primary care.
- 2) Specialty care drives most of the advances in treatment, procedures, pharmaceuticals and diagnostic imaging, as well as the cost increases that accompany these advances.
- 3) The specialty categories chosen as part of Aexcel represent approximately 70 percent of specialty costs and approximately 50 percent of Aetna's total medical costs.

**In 2010, Aexcel will be offered in the following markets, which cover all or parts of 23 states and the District of Columbia.**

Arizona	Richmond, VA	Louisville, KY
Delaware	Chicago, IL	Tampa, FL
Oklahoma City, OK	Jacksonville, FL	Columbus, OH
Atlanta, GA	San Antonio, TX	Maine
Detroit, MI	Cincinnati, OH	Tulsa, OK
Orlando, FL	Kansas City, KS and MO	Connecticut
Austin, TX	Seattle, WA	Metro DC (DC, MD, VA)
Houston, TX	Cleveland, OH	Dallas, TX
Pittsburgh, PA	Los Angeles, CA	Metro NY
Central Valley, CA	South Florida	Northern CA
Indianapolis, IN	Colorado	Fort Myers, FL

## Aexcel specialty categories

Cardiology	Obstetrics and gynecology
Neurology	Urology
Otolaryngology/ENT	General surgery
Cardiothoracic surgery	Orthopedics
Neurosurgery	Vascular surgery
Plastic surgery	
Gastroenterology	

## Clinical performance evaluation

In previous years, our clinical performance evaluation was based on claims-based measures. As a result of working with NCQA, the external organization responsible for monitoring our Aexcel program (under our agreement with the New York Attorney General, Patient Charter and NCQA Physician Hospital Quality Program), we have expanded the clinical performance criteria. This allows physicians additional opportunities to meet the Aexcel clinical performance requirement.

A physician needs to fulfill at least one of the following clinical performance criteria to be further considered for Aexcel designation on the basis of efficiency:

- Aetna claims-based measures with minimum member/event volume threshold
- Recognition by NCQA or Bridges to Excellence
- Board certification or re-certification
- Use of health information technology, such as electronic medical records
- Alignment with Aetna's Institutes of Quality®

### Clinical performance criteria in detail

- **Claims-based measures with minimum volume threshold** — Using claims information, we evaluate whether the physician met the claims-based clinical performance standards established by respected professional organizations. Some of these standards pertain to all Aexcel specialties. Other standards are specialty specific.

The physician or group must have at least 10 cases in any given measure. Clinical volume is based on a denominator of 10 in each measure used. The denominator can represent unique members or events, depending on the measure. In some measures, such as breast cancer screening, the denominator is members. In some measures, such as adverse event rate, the denominator is each event, and a member can have multiple events.

- **Recognition by NCQA or Bridges to Excellence** — At least 75 percent of specialists in the group are recognized by either Bridges to Excellence or the National Committee for Quality Assurance through their recognition programs in the areas of diabetes, cardiac/stroke or low back/spine.

- **Board certification or re-certification** — At least 75 percent of specialists in the group maintain current, active board certification by an American Board of Medical Specialties or American Osteopathic Association recognized board in the Aexcel specialty. Note: Board-eligible status does not meet this requirement.
- **Use of health information technology, such as electronic medical records** — At least 75 percent of specialists in the group have earned the Physician Office Link designation or, upon reconsideration, informs us of the use of health information technology, which applies National Quality Forum-endorsed measures.
- **Alignment with Aetna's Institutes of Quality** — The physician maintains an active medical staff appointment at an Aetna Institutes of Quality (IOQ) facility and his/her primary specialty is the specialty for which the facility is recognized for IOQ. IOQ is a designation for facilities that have demonstrated quality care based on measures of clinical performance, access and efficiency.

## More about Aetna claims-based clinical performance standards

Specialty category	Clinical performance standard*	Recognized association
Obstetrics and gynecology	<p><b>Cervical cancer screening rate</b> – How often patients cared for by an Ob/Gyn who should be getting Pap smears are actually getting this test</p> <p><b>Breast cancer screening rate</b> – How often patients cared for by an Ob/Gyn who should be getting mammograms are actually getting this test</p>	<p>ACOG www.acog.org/</p> <p>AQA www.aqaalliance.org/</p> <p>NCQA web.ncqa.org/</p> <p>CMS www.cms.hhs.gov/</p>
Cardiology	<p><b>Use of beta blocker for patients with history of heart attacks</b> – How often patients cared for by a cardiologist take medications that have been proven to prevent heart attacks in people with heart disease</p> <p><b>Use of ACE inhibitor or ARB for patients with heart failure</b> – How often patients cared for by a cardiologist take medications that have been proven to effectively treat heart failure</p> <p><b>Use of ACE inhibitor or ARB for patients with coronary artery disease (CAD) and diabetes</b> – How often patients cared for by a cardiologist take medications that have been proven to effectively treat those with CAD and diabetes</p> <p><b>Use of cholesterol-lowering medications (statin) for patients with CAD</b> – How often patients cared for by a cardiologist take medications that have been proven to effectively treat high cholesterol in people with heart disease</p> <p><b>Annual monitoring of ACE inhibitor or ARB</b> – Patients on ACE inhibitor or ARB who had at least one serum potassium monitoring test and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test</p> <p><b>Annual monitoring of digoxin</b> – Patients on digoxin who had at least one serum potassium monitoring test and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test</p> <p><b>Annual monitoring of diuretics</b> – Patients on a diuretic who had at least one serum potassium monitoring test and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test</p>	<p>American College of Cardiology www.acc.org/</p> <p>American Heart Association www.americanheart.org/</p> <p>CMS www.cms.hhs.gov/</p> <p>JCAHO www.jointcommission.org/</p> <p>AQA www.aqaalliance.org/</p> <p>NCQA web.ncqa.org/</p>
Orthopedics	<p><b>Osteoporosis management following fracture</b> – Patients age 50 years and older with a fracture of the hip, spine or distal radius who had a central DXA measurement ordered or performed, or pharmacologic therapy prescribed</p>	<p>AMA PCPI www.ama-assn.org/ama/pub/category/2946.html</p>
Neurology	<p><b>Annual monitoring of anticonvulsant therapy</b> – Patients on anticonvulsants who had at least one drug serum concentration level monitoring test</p>	<p>NCQA web.ncqa.org/</p>
All Aexcel specialty categories	<p><b>Absence of an unexpected readmission to a hospital</b> – Measurement used to determine the absence of a patient being unexpectedly readmitted to the hospital within 30 days after being discharged from the hospital. There are complications that occur that would require a patient to be readmitted to a facility after discharge from a hospital. We measure the absence of those readmissions for physicians who are managing the first inpatient stay.</p> <p><b>Absence of an adverse event</b>– Measurement used to determine the absence of an adverse event during an inpatient hospital stay. Complications can occur during a hospitalization that could be avoided. We look for an absence of complications or adverse events during inpatient stays being managed by a physician</p>	<p>CMS uses 30-day readmits as a marker for case review. www.cms.hhs.gov/</p> <p>The adverse event rate/index (number of complications or problems for hospitalized patients) is consistent with AHRQ quality indicators. AHRQ is part of the National Institutes for Health. www.ahrq.gov/</p>

\*All claims-based measures are also endorsed by the National Quality Forum with the exception of absence of an unexpected readmission and absence of an adverse event, which are recognized by AHRQ and CMS.

See Appendix A, "Clinical performance evaluation," for more information.

## Efficiency evaluation

For physicians who pass the clinical performance criteria, a measure of the efficiency of their care is developed and compared to that of their peers. We use the Symmetry Episode Treatment Groups® (ETGs) methodology to measure a physician's efficiency.

This methodology is based on episodes of care, which is the current industry standard for measuring efficiency.

Episodes of care methodology focuses on all of the costs (inpatient, outpatient, professional, office, lab, pharmacy and ancillary) required to care for a patient's underlying medical condition.

For statistical validity, physicians must have a minimum of 20 Aetna member episodes of care over a 3-year period to be evaluated for efficiency. An index rating is created based on actual cost for the episode compared with the expected cost of the episode. The expected cost is the average adjusted cost of an episode managed by the peer group. The expected average cost is risk adjusted as described in the following section.

Episodes are then attributed to physicians based upon who was responsible for the majority of the care. For example, surgical episodes are attributed to the surgeon with the highest allowed charges. For non-surgical episodes, the episode is attributed to the physician with the highest number of office visits.

We chose 20 as a minimum threshold based on a comparison of results using random samples of various thresholds, including 10, 20, 30, 50 and 100. We found there was a reasonably similar result for groups with at least 20 episodes versus at the higher thresholds. Furthermore, using 20 episodes as a minimum allows us to be more inclusive in our program.

Physicians do not pass the efficiency standard if their results either did not meet the minimum 20-episode threshold or they did not meet the minimum standard at a statistically significant level. All other physicians pass the efficiency standard. The statistical significance is performed at the 90 percent confidence level.

See Appendix B, "Efficiency Evaluation," for more information about our efficiency evaluation process.





## Risk adjustment

Some physicians may care for more patients with chronic or complex conditions in a given time period than their peers do; therefore, we evaluate physicians by comparing their services for patients with similar conditions. We apply risk-adjustment factors to account for differences in the use of health care resources among individuals. Use of health care resources can differ among patients because of age, gender, chronic disease risk, pharmacy benefit and insurance product type.

In addition, we compare all the resources used to treat a physician's patients to those of other physicians in the same specialty and geographic location. If a physician is a part of a group practice, we evaluate the entire group. In this case, performance measurement results of other physicians in the group practice will have an impact on each individual physician's evaluation.

## Making sure members have access to enough specialists

Once the selections are complete, we may need to supplement the performance network with additional physicians to ensure members have satisfactory access to enough specialists. However, only physicians who have passed the clinical performance evaluation are eligible for consideration to supplement the network.

## Re-evaluating physicians for Aexcel designation

We re-evaluate a physician's performance at least every two years. As a result, a physician's Aexcel designation status could change. Physicians who previously did not receive Aexcel designation may now meet the criteria. Similarly, physicians who are currently designated may lose their designation because they did not meet the clinical performance and/or efficiency standards. This could be due to a physician's individual performance or because the overall performance of the physician's peers in his/her market, whom the physician is measured against, has improved.

Regardless of whether a physician receives Aexcel designation, he/she remains a participating physician in Aetna's broader network.

We realize that physicians, members and employers alike are impacted by changes to the composition of Aetna networks. To reduce these concerns, we consider member and physician disruption when configuring the Aexcel network for physician access.

## How Aexcel specialists are identified in provider directories

Members can easily find Aexcel physicians in DocFind®, our online provider directory, available through our public website at [www.aetna.com](http://www.aetna.com). A blue star next to a physician's name means the physician is Aexcel designated.

For additional detail on each physician, members can log in to Aetna Navigator®, our secure member website, and choose DocFind. On this secure website, members can see the volume, clinical performance and efficiency standards we used to determine the physician's Aexcel status. The detail on each physician shows which of those performance standards the physician met.

## Important information about our data

As Aexcel continues to evolve, we look for opportunities to further enhance our methodology and evaluation process based on new clinical evidence; feedback from physicians, members and employers; as well as emerging industry trends.

While we are committed to using the best available information, there are certain data limitations:

- **The clinical quality claims-based measures and efficiency information is based on Aetna data only.** Using combined claims data from multiple payers (other insurance companies, and self-insured and government plans) may provide a more complete picture of physician performance but is not yet available. We support industry-wide data collection initiatives. When credible combined data becomes available, we will consider using it in our evaluations.
- **The claims data used to evaluate physicians does not include all procedures, lab or pharmacy data.** It only includes those for which we have received claims. Physicians may perform health care services for which they do not provide us with information. Also, because of the way claims are submitted and/or processed, health care service details may not always be available in the claims data we use. Therefore, we strongly encourage physicians to reach out to us with additional data they might have in medical charts that is not available to us.
- **Inclusion of pharmacy data is limited to those members who have Aetna pharmacy benefits.**
- **During the review process, we are aware that some physicians may treat patients with more than one health issue or with more complex conditions. Therefore, we apply risk-adjustment factors to evaluate physicians to take these considerations into account.** While we use an industry-recognized model, a perfect mechanism that accounts for all variations in a patient population still does not exist.

We believe quality and efficiency profiles are meaningful. However, this information represents a partial evaluation of clinical quality and efficiency, and members are encouraged to consider all relevant factors when choosing a physician.

## About our data sources

We use a number of data sources in our measures. Besides the external sources previously listed, from which recognitions and certifications can be reviewed, there are also a number of data sources internal to Aetna that are used, including administrative medical and pharmacy claims, member eligibility data, and provider information.

# Physician reconsideration process

We want physicians to be confident that our decisions are made using a comprehensive set of evidence and data, and engage them as active participants in the evaluation process.

We notify physicians by letter of the results of the Aexcel evaluation process. A reconsideration process is available for those who are not designated, seek corrections or changes to their Aexcel designation, or request additional information. Our notification letter explains that if physicians have more information they'd like us to consider, including that contained in medical charts, they have 30 calendar days to contact us in writing or by email to make this request to initiate further review.

After reviewing the additional information the physician provides, we make a final determination on his/her Aexcel designation status within 50 days of the date of the first letter sent to the physician. We notify physicians by letter of our final determination.

## Additional information may supplement our records

There may be several situations in which physicians have information that supplements our data. They include:

### Clinical performance

- Additional information to substantiate board certification and/or use of health information technology.
- The physician did not have a meaningful role in the management of the case. (Case attributed to the wrong physician.)

Example: Case managed by a covering physician.

- The medical record includes additional information showing that the clinical events in the case had a different clinical significance than apparent in the claims record. (Interpretation of claims record differs substantially from interpretation of medical record.)

Example: A re-admission within 30 days was actually planned at the time of discharge of the index case.

- An event did not actually happen. (Coding error.)

Example: A hospital codes an acute myocardial infarction after a surgical procedure when the member did not have an acute myocardial infarction.

- Other unusual circumstances.

### Efficiency

- The physician did not have a meaningful role in the management of the episode.

Example: Episode predominantly managed by a different physician.

- The physician group did not have a meaningful role in the management of the episode.

Example: Episode predominantly managed by a different group.

- The physician is attributed to the wrong physician group.

Example: Physician associated with another group.

- The specialty designation was incorrect.

Example: Physician designated as a general surgeon rather than correctly designated as a plastic surgeon.

- Other (possible missing or erroneous claims information).

# Updates to the Aexcel methodology

Criteria	Focus	2008	2009	2010
Volume	Volume criteria to be met:	Minimum of 20 episodes in Symmetry's Episodes of Care (EOC) and a minimum of 6 episodes (2 episodes in each of 3 different conditions) from the Marketbasket System for Physician Measurement from Cave Consulting Group.	Minimum of 20 episodes in Symmetry's EOC.	No changes
Efficiency	Efficiency measurement is based on:	Symmetry EOC version 5.0 and the Marketbasket System for Physician Measurement from Cave Consulting Group (CAVE).	Symmetry EOC version 6.5.	No changes
	Determining whether physicians meet the minimum efficiency standard:	Physicians pass the efficiency standard if their results meet the minimum volume threshold and are efficient and statistically so compared to their specialty peers in that market in both the Symmetry EOC version 5.0 and the Marketbasket System for Physician Efficiency Measurement from CAVE.	Physicians do not pass the efficiency standard if their results either did not meet the minimum 20-episode threshold or they did not meet the minimum efficiency standard at a statistically significant level. All other physicians pass the efficiency standard.	No changes
	Efficiency- case mix adjustment:	Physicians are compared to their peers within a defined region.	Physicians are compared to their peers within an assigned market. And, specialty category is added to the variables.	Physicians are compared to their peers within an assigned market. If a market-value is not available, physicians are compared with a peer group from a group of similar markets (market-type). If a market-type value is not available, then physicians are compared to the national level.
	Application of ETGs:	All ETGs are used to evaluate physicians equally.	Each specialty has a limited number of ETGs used in the evaluation process, and they are limited to the ETGs most frequently assigned to that particular specialty.	Episodes for physicians with multiple specialties will be assigned to the Aexcel specialty based on the specialty assigned to the ETG. Where a physician has more than one specialty and an ETG is on more than one of the specialty ETG lists, the episode is assigned to each of their specialties
Clinical performance	Clinical performance measures	Clinical performance measurement includes only claims-based clinical measures.	Clinical performance measurement includes the following new measures:* percentage of physicians in a group who are board certified, or have obtained external recognition through NCQA or BTE, use of health information technology to improve quality or alignment with Aetna's IOQ.	Additional claims-based measures added, and the measure of "appropriate HIV testing for pregnant patients" was retired. Additional clinical measures added for Metro NY market for 2009 effective in all Aexcel markets in 2010.
Other	Reconsideration process	Reconsideration process for clinical performance evaluation implemented.	Reconsideration process expanded to include an opportunity for physicians/ physician groups to ask questions and provide additional information pertaining to their efficiency results along with their clinical performance results.	No changes

\*Criteria effective in Metro New York market beginning in 2009.

A physician's designation could change at any time if he/she moves to another group practice. In this case, the physician's designation would reflect that of the new physician group until the next Aexcel review cycle. If a physician's designation changes, we will notify him/her prior to updating our secure member website. Physicians should promptly notify us of a change in their group affiliation so we can update their profile accordingly.

## About our oversight monitor

The National Committee for Quality Assurance (NCQA) is an independent not-for-profit organization that accredits and evaluates a wide range of health care organizations and recognizes physicians in key clinical areas. Its mission is to improve the quality of health care. NCQA serves as an independent ratings examiner for Aetna, reviewing how our Aexcel program meets criteria required by the state of New York.

The results of the latest NCQA review demonstrate Aetna's full compliance with the requirements related to physician measurement programs. The report is available on the NCQA website at [nyrxreport.ncqa.org](http://nyrxreport.ncqa.org) and allows for a comparison on the extent to which reviewed health plans in New York state comply with provisions of the New York Attorney General agreement.

## Member complaints

If your patients have complaints about Aexcel, please direct them to register their complaint with Aetna. Or, by sending it to NCQA in writing to [customersupport@ncqa.org](mailto:customersupport@ncqa.org) or to NCQA Customer Support, 1100 13th Street, NW, Suite 1000, Washington, DC, 20005.



# Clinical performance evaluation

## Aexcel® designation in Aetna's Performance Network



The Aexcel designation process includes evaluation of four key criteria:

- Volume
- Clinical performance
- Efficiency
- Network adequacy

A physician or physician group must meet at least one of the clinical performance criteria outlined here in order to be further evaluated for Aexcel on the basis of efficiency. An Aetna<sup>†</sup> medical director is available to discuss a physician's satisfaction of the clinical criteria.

Every physician has the opportunity to provide additional information for reconsideration. For example, physicians have the opportunity to advise us if they are board certified in their Aexcel specialty or to provide information about their use of health information technology, which applies National Quality Forum-endorsed measures.

### **Certification by external entity**

At least 75 percent of specialists in the group are recognized by either Bridges to Excellence or the National Committee for Quality Assurance through their recognition programs in the areas of diabetes, cardiac/stroke or low back/spine.

### **Board certification or recertification**

At least 75 percent of specialists in the group maintain current, active board certification by an ABMS or AOA recognized board in their Aexcel specialty. **Note:** Board-eligible status does not meet this requirement.

- Your American Board of Medical Specialties board certification is confirmed via information in Aetna's provider data system
- Aetna is made aware of your American Osteopathic Association board certification through the physician/physician group's self-reported information

### **Use of technology**

At least 75 percent of specialists in the group have earned the Physician Office Link designation or, upon reconsideration, informs us of the use of health information technology, which applies National Quality Forum-endorsed measures.

### **Alignment with Aetna Institutes of Quality (IOQ)**

The physician maintains an active medical staff appointment at an Aetna IOQ facility and his/her primary specialty is the specialty for which the facility is recognized for IOQ.

### **Claims-based measures**

A claims-data evaluation of certain clinical performance standards established by respected professional organizations. Additional information

# Claims-based measures evaluation process overview

## STEP 1

We begin with a view of all Aetna participating physicians in a geographic market who practice in the selected specialty (for example, all cardiologists in the Aetna network in Atlanta).

Physicians are ordered according to an overall index score. Index metrics are based on established evidence-based measures of clinical performance. Metrics include:

- 30-day hospital readmission rate
- Adverse event rate
- Specialty-specific measures
  - > Cardiology: ACE inhibitor/ARB use in CHF; beta blocker after MI; lipid-lowering drug use in IHD; monitoring ACE inhibitor or ARB, digoxin, diuretic
  - > OB: breast cancer screening, cervical cancer screening
  - > Orthopedic: osteoporosis management following fracture
  - > Neurology: monitoring anticonvulsant therapy

Each metric is case-mix adjusted and must have at least 10 eligible cases to be scored. Only scored metrics are included in the index score; metrics are weighted according to the number of eligible cases.

## STEP 2

We identify physicians with the lowest index scores. Physicians whose measured outcomes fall below the 5th percentile of the peer group are reviewed further (steps 3 – 5) and may be excluded from consideration for Aexcel designation, unless other clinical criteria are met.

## STEP 3

We apply a statistical significance formula (95 percent confidence limits) to the lowest group, removing any cases with insufficient statistical significance and reducing the group that may be excluded from Aexcel designation.

## STEP 4

An Aetna medical director reviews metric detail reports of physicians remaining in the lowest group using available clinical data. Some cases have logical clinical explanations and are eliminated from the index score, allowing additional physicians to be considered for Aexcel designation.

## STEP 5

Detailed clinical performance data for each metric is shared with the physicians remaining in the lowest group. An Aetna medical director is available to discuss this data. Every physician has the opportunity to provide additional information for reconsideration.



# Efficiency evaluation

## Aexcel® designation in Aetna's Performance Network



### The Aexcel designation process includes four key criteria:

Volume — Clinical performance — Efficiency — Network adequacy

For specialists who meet the case volume and clinical performance standards for Aexcel network designation, a measure of the efficiency of their care is developed and compared to their peers. Aetna uses Symmetry Episode Treatment Groups™. Physicians do not pass the efficiency standard if their results either do not meet the minimum 20-episode threshold or are determined to be inefficient at a statistically significant level. All other physicians pass the efficiency standard. The statistical significance is performed at the 90 percent confidence level.

#### Step 1: Episodes of care

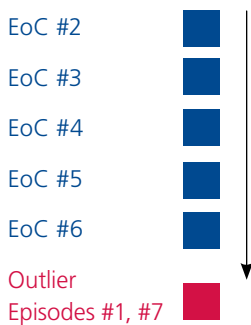
Aetna claims are divided into **episodes of care** (EoC) using Ingenix's Symmetry Episode Grouper Software.

Aexcel utilizes episodes occurring in the most recent three years, managed by the 12 Aexcel specialties in each Aexcel market.



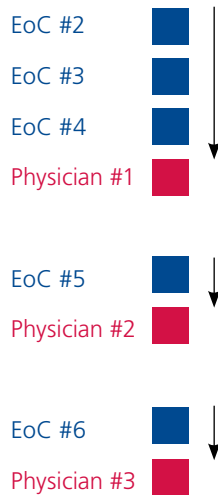
#### Step 2: Outliers

The highest and lowest cost episodes of care are considered **outliers** and are removed from the process:



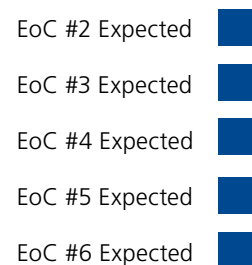
#### Step 3: Attribution

Patient episodes are attributed to physicians. Surgical episodes are attributed to the surgeon with the highest allowed charges. If the episode is non-surgical, the physician with the highest number of visits receives the attribution of the case.



#### Step 4: Expected cost per episode (case-mix adjusted)

The episodes of care for individual patients are severity adjusted for age, co-morbidities and complications. Additional variables are added to the case mix (benefit product, year of service, pharmacy rider, gender), in the efficiency measurement. A **case-mix adjusted** expected cost per episode for each specialty, market, and commonly managed type of episode (for example, orthopedic episodes in Tampa for evaluation and treatment of femoral fractures) is calculated based on actual observed costs in that market. The expected amount is then assigned to each episode of care in the same specialty, market and episode type.



### Step 5: Physician total episode cost

Each physician's total episode cost is calculated. Physician #1 total cost example:

$$\begin{array}{l} \text{EoC \#2 Cost} \\ + \\ \text{EoC \#3 Cost} \\ + \\ \text{EoC \#4 Cost} \end{array} = \text{Physician \#1 Total Cost}$$

### Step 6: Physician expected episode cost

Each physician's total expected episode is calculated Physician #1 example:

$$\begin{array}{l} \text{EoC \#2} \\ \text{Expected Cost} \\ + \\ \text{EoC \#3} \\ \text{Expected Cost} \\ + \\ \text{EoC \#4} \\ \text{Expected Cost} \end{array} = \text{Physician \#1 Expected Cost}$$

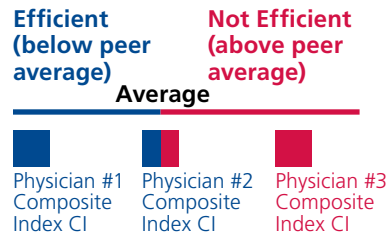
### Step 7: Physician composite index

The physician's cost for each episode and the expected cost for each episode are used to create a composite index. The composite index represents the individual physician's severity-adjusted comparison of costs to same-specialty, same-geographic area peers treating the same or similar conditions.

$$\begin{array}{l} \text{Physician \#1} \\ \text{Total Cost} \\ / \\ \text{Physician \#1} \\ \text{Expected Cost} \end{array} = \text{Physician \#1 Composite Index}$$

### Step 8: Efficiency and statistical significance

Each physician's composite index is compared to the peer average. A statistical analysis for confidence intervals (CI) is then applied to the composite index to determine if the physician's composite index is significantly different from the peer average. This is an important step to adjust for the effect of low number of episodes. In the example below, Physician #1 is Efficient and Statistically Significant, Physician #2 is Efficient but not Statistically Significant, and Physician #3 is Not Efficient and Statistically Significant:



A summary and detailed reports can be run for each physician so physicians can see how their use of resources compares to their peers.

