Center for Data Insights and Innovation (CDII) California Health Care Quality Medical Group - Commercial Report Card, 2022-23 Edition[1]

Scoring Documentation for Public Reporting on Clinical Care

(Reporting Year 2023)

Background

Representing the interests of health plan and medical group members, the California Center for Data Insights and Innovation (CDII) publicly reports on health care quality. CDII's predecessor, the Office of the Patient Advocate (OPA), published the first HMO Health Care Quality Report Card in 2001. The Report Cards have since been annually updated, enhanced and expanded to address a variety of ratings for HMOs, PPOs and Medical Groups. The current version (2022-23 Edition) of the online Health Care Quality Report Cards is available through www.cdii.ca.gov.

The Integrated Healthcare Association (IHA) reports performance results for 199 provider organizations that participate in its Align. Measure. Perform. (AMP) Commercial HMO program. IHA is a multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care. IHA collects quality data on the provider organizations that contract with commercial HMOs for AMP and provides the data to CDII for the Health Care Quality Report Card. The IHA provider organizations are referred to as medical groups in the Report Card and in the remainder of this document.

Sources of Data for California Health Care Quality Report Cards

The 2022-23 Edition of the Report Cards is published in Spring 2023[2], using data reported in Reporting Year (RY) 2023 for performance in Measurement Year (MY) 2021. Data sources are:

1. The National Committee for Quality Assurance's (NCQA) publicly reported HMO and PPO Healthcare Effectiveness Data and Information Set (HEDIS®[3]) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®[4]) commercial measure data. (HEDIS and CAHPS Methodology Descriptions in separate documents)

[1] Also see the Scoring Methodology for the Medical Group Report Card patient experience ratings: https://reportcard.opa.ca.gov/medicalgroupabout.aspx

[2] Beginning with the 2022-23 Edition of the HMO Health Care Quality Report Card, OPA will publish all Medical Group - HMO Report Cards in the spring to align with the release of the Medical Group - Medicare Report Cards.

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a source for data contained in the California Health Care Quality Report Cards obtained from Quality Compass®2022 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2022 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA

[4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

2. **The Integrated Healthcare Association (IHA) AMP Commercial HMO program's medical group clinical performance data.**
3. The Purchaser Business Group on Health (PBGH) Patient Assessment Survey's (PAS) patient experience data for medical groups. (Methodology Description in a separate document)

Medical Group Clinical Methodology Process

1. Methodology Decision Making Process

CDII conducts a multi-stakeholder process to determine the scoring methodology. Beginning with the 2013 Edition of the Report Cards, OPA and now CDII have enhanced the partnership with IHA's AMP programs. IHA's Technical Measurement Committee (TMC) serves as the primary advisory body to OPA regarding methodologies for the Health Plan Report Card for both HEDIS clinical and CAHPS patient experience data and the Medical Group Report Card clinical data. Comprised of representatives from health plans, medical groups, and health care purchaser organizations, TMC members are well-versed in issues of health care quality and patient experience measurement, data collection and public reporting. CDII's Health Care Quality Report Cards are a standing item at the TMC meetings.

TMC Roster (2023)

Chair: Christine Castano, MD, *Optum*
Alyson Spencer, *Blue Shield of California Promise Health Plan*
Andy Dang, MD, *Sharp Rees-Stealy Medical Group*
Bihu Sandhir, MD, *AltaMed*
Cheryl Damberg, PhD, *RAND*
Edward Yu, MD, *Sutter Palo Alto Medical Foundation*
Eric Garthwaite, *Health Net*
Frederick Kuo, MD, *UnitedHealthcare*
Kenneth Phenow, MD, *Cigna*
Leticia Schumann, *Anthem*
Marnie Baker, MD, MPH, *MemorialCare Medical Group*
Pegah Mehdizadeh, DO, *Aetna*
Peter Robertson, MPA, *Purchaser Business Group on Health*
Rachel Brodie, *Purchaser Business Group on Health*
Ralph Vogel, PhD, *Kaiser Permanente*
Sara Frampton, *Kaiser Permanente*
Sherilyn Wheaton, MD, *Primary Medical*
Tory Robinson, *Blue Shield of California*
Alice Gunderson, *PFCC Partners, Patient Advisor Network*
Ting Pun, *PFCC Partners, Patient Advisor Network*

Please note that the methodology and display decisions made by CDII do not necessarily reflect the views of each organization on the advisory committee.

Additionally, CDII values the opinions and perspectives of other stakeholders with interest and expertise in the field of healthcare quality measurement, data collection and display and, as such, welcomes questions and comments sent to OPAReportCard@ncqa.org.

2. Stakeholder Preview and Corrections Period

Each year, prior to the public release of the CDII Report Cards, all participating health plans and medical groups are invited to preview the Health Care Quality Report Cards. Health plans and medical groups are given access to a test web site with updated results and given several days to review their data and submit corrections and questions regarding the data and methodology to CDII and its contractors. If an error in the data is identified within the given time period, it is corrected prior to the public release of the CDII Report Cards.

Medical Group - Commercial Report Card Clinical Scoring Methodology

There are three levels of measurement:

1. **Clinical Measures**: There are 17 clinical measures reported by IHA. Most, but not all, are HEDIS measures.
2. **Topic**: A majority of the 17 total measures are grouped into six condition topic areas.
3. **Category**: "Quality of Medical Care" is one aggregated all-clinical category performance score composed of 15 HEDIS or non-HEDIS performance measures. *All-Cause Readmissions, Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis,* and *Concurrent Use of Opioids and Benzodiazepines* are not included in the category composite.

See Appendix A for mapping of clinical measures to category and topics.

Performance Grading

Medical groups are graded on performance relative to other medical groups for "Quality of Medical Care". All of the performance results are expressed such that a higher score means better performance. Fifteen clinical measures are aggregated to create the All-Clinical category performance score: "Quality of Medical Care." Based on relative performance, groups are assigned star ratings for multi-level composites (category and topics).

For the 2022-23 Edition Medical Group Report Card, RY 2023 (MY 2021) values from medical groups statewide are used to set performance cutpoints for the clinical measures.

1. Composite Calculation for Category and Topic Scoring

Fifteen measures are aggregated to create the category performance score at both the category and topic levels. The scoring process involves the following calculations:

a. **To calculate the category level composite, "Quality of Medical Care":** Calculate the mean of all individual measure scores. Each of the 15 measures are equally weighted. The medical group must have reportable results for at least half of the measures to be eligible for the category performance score.

   A medical group's overall category performance score is first rounded to the 100th decimal point, and then rounded to the 10th decimal point, before adding a 0.5 point buffer to the rounded mean score. This sum (rounded mean + 0.5) is used to assign the star rating performance grade (see section 8).

   For any medical group that has missing data for one or more measures, an adjusted half-scale rule is applied to adjust for the missing values – this rule is described below (see section 3).

b. **To calculate the topic level composites:** Measures are organized into each of six condition topics. A composite score is calculated for each topic by calculating the mean of all individual topic measure scores. The measures are equally weighted within each of the six condition topics. The resulting rate is first rounded to the 100th decimal point, and then rounded to the 10th decimal point, before adding a 0.5 point buffer to the rounded mean score. This sum (rounded mean + 0.5) is used to assign the star rating performance grade (see section 8).

   The medical group must have reportable results for at least half of the eligible measures for a given topic to score that topic. To calculate condition topic scores, for any medical group that has missing data for one or more measures within a given condition topic, an adjusted half-scale rule is applied to adjust for the missing values – this rule is described below (see section 3).

2. Individual Measure Scoring

a. The individual clinical measure scores are calculated as proportional rates using the numerators and denominators that are reported per IHA measurement requirements. Measures will be dropped from star rating calculations and benchmarks if at least 50% of groups cannot report a valid rate. Rates will be reported for all groups with valid rates, regardless

of whether a particular measure has been dropped from a star rating calculation due to less than 50% of California groups having a valid rate.

b. The measure results are converted to a score using the following formula: (Measure numerator/Measure denominator)*100

3. Handling Missing Data

Not all medical groups are able to report valid rates for all measures. Data may be missing because the denominator size for a particular measure may not be large enough for the medical group, or the measure is unable to be rated. In order to calculate category and topic star ratings for as many medical groups as possible, we impute missing data under specific conditions using an adjusted half-scale rule. This is accomplished by developing an actual measure-level imputed result for medical groups with missing data and using those results for star calculations. Imputed results are not reported as individual rates. If a medical group is able to report valid rates for at least half of its measures in a composite, then missing values are replaced using an adjusted half-scale rule for all measures in a composite. Because eligibility for missing value imputation is assessed independently at the topic and category levels, it is possible to have a category score even if measure or topic scores are missing.

Legends to Explain Missing Scores

Three categories are used to explain instances in which a medical group measure is not reported:

- **Too Few Patients to Report.** Medical group score is not reported because the measure's denominator has fewer than 30 patients.
- **Not Willing to Report.** Medical group declined to report its results.
- **Not Rated.** Measure is undefined, has a biased rate, or is not reported for the medical group.

4. Risk Adjustment

The clinical care measures used in IHA's AMP Commercial HMO program, which include HEDIS measures, are not risk adjusted for patient characteristics or socioeconomic status. NCQA is the measure developer for HEDIS measures used in AMP Commercial HMO. NCQA's Committee on Performance Measurement and its Board of Directors determined that risk adjustment would not be appropriate for HEDIS measures because the processes and outcomes being measured should be achieved, regardless of the nature of the population. The one exception is the Preventing Hospital Readmission After Discharge measure, which does include risk-adjustment methodology developed by NCQA.

For AMP Commercial HMO, the results for this measure (numerator, denominator, rates, probability, variance) are generated by IHA's data partner,

Onpoint Health Data, using health plan member level data that was submitted to Onpoint. Onpoint uses these results and applies the risk adjustment to calculate expected rate and observed/expected ratio, based on HEDIS specifications, in order to get risk-adjusted results.

The risk adjustment is based on HCC (Hierarchical Condition Category), which relies on presence of surgeries, discharge conditions, comorbidity, age and gender. More detailed information on the calculation of the risk adjusted rates are available in the Measurement Year 2021 AMP Technical Specifications.

5. **Changes from the 2021-22 Edition Report Card to the 2022-23 Edition Report Card and Notes**
   a. Various methodology updates were made in effort to align the Health Plan and Medical Group for Commercial HMO Members Report Cards:
      i. Benchmarks – CDII has aligned with IHA's AMP program again for this Report Card Edition and utilize same-year benchmarks for MY 2021.
      ii. Rounding – CDII has aligned with IHA's AMP program to adopt a 2-step rounding process for composite star ratings (topic and category ratings):
         1) First round to the 100th decimal point,
         2) Then round to the 10th decimal point,
         3) Then add a 0.5 point buffer before comparing to star rating benchmarks.
      iii. Cutpoints – CDII has aligned with IHA's AMP program to establish percentile cutoffs for star ratings at the composite score level. Instead of calculating the 90th, 65th, 35th and 10th percentiles at the individual measure levels for each topic and category level, the composite scores (unweighted averages of each of the grouped measures at the topic and category level) are calculated first and subsequently the percentile cutoffs are calculated from statewide AMP participants' composite scores by topic and category level. The percentile cutoffs are rounded to the nearest whole number after the composite scores are rounded to the 100^{th} decimal point.
   b. Measures excluded from reporting for MY 2020 that have been re-introduced in MY 2021 include:
      i. Within the 'Preventive Screenings' topic:
         1) Breast Cancer Screening
         2) Cervical Cancer Screening
         3) Chlamydia Screening
      ii. Within the 'Diabetes Care' topic:
         1) Eye Exam for Diabetes Patients

iii. Within the ‘Appropriate Use of Tests, Treatments and Procedures’ topic:
    1) Appropriate Use of Cervical Cancer Screening

c. Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis (AABOVR) is a display measure. AABOVR dropped from the Appropriate Use of Tests, Treatments and Procedures topic because over 50% of groups cannot report a valid rate during this measurement year.

6. Calculating Percentiles

One of five grades is assigned to each of the six condition topics and to the “Quality of Medical Care” category using the cutpoints shown in Table 1. Cutpoints were calculated per the MY 2021 (RY 2023) results for all medical groups. The percentiles are established by first calculating the composites (unweighted averages of each of the grouped measures at the topic and category level). Then the 90th, 65th, 35th, and 10th percentiles are calculated across statewide AMP participants’ topic and category level composite scores.

7. From Percentiles to Stars

There are four thresholds corresponding to five-star rating assignments. If a topic or category composite rate meets or exceeds the “Excellent” thresholds, the medical group is assigned a rating of five stars. If a topic or category composite rate meets or exceeds the “Very Good” threshold (but is less than the “Excellent” threshold) then the medical group is given a rating of four stars. If a topic or category composite rate meets or exceeds the “Good” threshold (but is less than the “Very Good” threshold) then the medical group is given a rating of three stars. If a topic or category composite rate meets or exceeds the “Fair” threshold (but is less than the “Good” threshold) then the medical group is given a rating of two stars. Topic or category scores that are less than the two star “Fair” threshold result in a rating of one star, “Poor”.

The grade spans vary for each of the six condition topics listed in Table 1:

Top cutpoint:	90th percentile for California reporting medical groups
Middle-high cutpoint:	65th percentile for California reporting medical groups
Middle-low cutpoint:	35th percentile for California reporting medical groups
Low cutpoint:	10th percentile for California reporting medical groups

Table 1: Clinical Performance Cutpoints for the 2021-22 Edition of the Medical Group – Commercial Report Card

Condition Topics	Number of Measures Included*	Excellent Cutpoint	Very Good Cutpoint	Good Cutpoint	Fair Cutpoint	Poor Cutpoint
Asthma Care	1	91	87	80	71	<71
Appropriateness of Tests, Treatments and Procedures	1	94	84	77	67	<67
Diabetes Care	4	70	64	51	42	<42
Heart Care	2	82	75	57	42	<42
Preventive Screenings	4	76	70	59	49	<49
Treating Children	3	62	50	38	27	<27
All Clinical Category – Quality of Medical Care	15	72	66	53	47	<47

*Topics with only one measure tend to have more variation in year over year performance.

Special scoring is used for the "Rady Children's Health Network" – an all-pediatric medical group. This group reports five measures: Asthma Medication Ratio, Immunizations for Children, Immunizations for Adolescents, Chlamydia Screening, and Treating Children with Throat Infections. The group's category performance indicator is therefore comprised of these four measures only. Correspondingly, the performance cutpoints for the group's all clinical category rating are based on these five measures and the MY 2021 (RY 2023) results. The Rady Children's Health Network cutpoints for the 2022-23 Edition are 66, 60, 49 and 39 for the 90th, 65th, 35th and 10th percentiles, respectively.

8. Buffer Zones

A buffer zone of a half-point (0.5) span is applied when determining the category and topic star ratings. Any medical group whose score is in the buffer zone 0.5 points below the grade cutpoint is assigned to the next highest category grade. For example, if an Excellent Cutpoint was set at 81, a group whose score is 80.5 would be graded "Excellent." A score of 80.4, which is outside of the buffer zone, would be assigned a grade of "Very Good."

9. Attribution of Patients to Medical Groups

In AMP Commercial HMO, patients are attributed to a medical group in each of the following ways:

- Enrollment at the health plan level, communicated to the medical group

- Encounter data from the medical group, including member identification or physician identification (so health plans can correctly attribute it), and
- Continuous enrollment in the medical group; enrollment in the medical group on the anchor date; and required benefits, as specified for each measure.

10. Reliability Testing/Minimum Number of Observations

IHA considers measurement error and reliability as follows. For the clinical quality measures, the organization uses administrative data based on the universe of a medical group's patients. There is no sampling. Because statistical errors can result from small numbers, IHA requires a total eligible population of 30 or more for a particular measure. In addition, any measure with a bias of five percent or more are excluded, as determined by an NCQA-certified auditor.

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	IHA Measure Name	CDII Measure Name	Definition	Number of Measures in Topic
Asthma Care	Asthma Medication Ratio	Asthma Medicine	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year.	1
Diabetes Care	Eye Exam for Patients with Diabetes	Eye Exam for Patients with Diabetes	The percentage of patients with diabetes who had a retinal eye exam in last year.	4
Diabetes Care	HbA1c Control for Patients with Diabetes (<8.0%)	Controlling Blood Sugar for People With Diabetes	The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) whose HbA1c was <8.0%.	4
Diabetes Care	Blood Pressure Control for Patients with Diabetes <140/90	Controlling Blood Pressure For People With Diabetes	The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) whose blood pressure was <140/90.	4
Diabetes Care	Statin Therapy for Patients with Diabetes	Prescribing Statins to People with Diabetes	The percentage of patients 40-75 years of age with diabetes who were prescribed at least one statin medication in the last year.	4
Heart Care	Controlling High Blood Pressure	Controlling High Blood Pressure	The percentage of adults ages 18-85 who are diagnosed with hypertension and whose blood pressure was controlled (<140/90).	2
Heart Care	Statin Therapy for Patients with Cardiovascular Disease	Prescribing Statins to People with Heart Disease	The percentage of patients ages 21-75 (male) and 40-75 (female) with heart disease who were given at least one statin medication during the last year.	2
Preventive Screenings	Breast Cancer Screening	Breast Cancer Screening	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	4
Preventive Screenings	Cervical Cancer Screening	Cervical Cancer Screening	The percentage of women 21-64 years of age who received cervical cancer screening.	4

Topic	IHA Measure Name	CDII Measure Name	Definition	Number of Measures in Topic
Preventive Screenings	Chlamydia Screening in Women	Chlamydia Screening	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	4
Preventive Screenings	Colorectal Cancer Screening	Colorectal Cancer Screening	The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.	
Treating Children	Childhood Immunization Status	Immunizations for Children	The percentage of enrolled children two years of age who were identified as having completed the following antigen series by their second birthday: four diphtheria, tetanus, acellular pertussis (DtaP) vaccinations; three polio (IPV) vaccinations; one measles, mumps, rubella (MMR) vaccination; three flu (HiB) vaccinations; three hepatitis B (HepB) vaccinations; one chicken pox (VZV) vaccination; and four pneumococcal conjugate (PCV) vaccinations, one hepatitis A (HepA) vaccination, rotavirus vaccination and at least two influenza vaccinations.	3
Treating Children	Immunizations for Adolescents	Immunizations for Early Teens	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), and completed the HPV vaccine series by their 13th birthday.	3
Treating Children	Appropriate Testing for Pharyngitis	Treating Throat Infections	The percentage of patients 3 years of age and older, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	3
Appropriate Use of Tests, Treatments and Procedures	Cervical Cancer Overscreening‡	Avoids Overuse of Cervical Cancer Screening	The percentage of women 21-64 years of age who received more cervical cancer screenings than necessary according to evidence-based guidelines. This measure is inverted to show that a higher rate is better.	1

Topic	IHA Measure Name	CDII Measure Name	Definition	Number of Measures in Topic
Display Only Measures*	All-Cause Readmissions	Preventing Hospital Readmission After Discharge	For members 18 years of age and older, the number of acute inpatient hospital stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	N/A
Display Only Measures*	Concurrent Use of Opioids and Benzodiazepines	Concurrent Use of Opioids and Benzodiazepines	The percentage of patients 18 years of age and older with prescriptions for both opioids and benzodiazepines.	N/A
Display Only Measures*	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis‡‡	Treating Bronchitis: Getting the Right Care	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	N/A

*Display Only Measures are not included on the overall category performance score "Quality of Medical Care".
‡*Cervical Cancer Overscreening* is a non-HEDIS measure.
‡‡Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis is dropped from the Appropriate Use of Tests, Treatments and Procedures topic because over 50% of groups cannot report a valid rate during this measurement year.