

Office of the Patient Advocate (OPA)
California Health Care Quality Medical Group - Commercial Report Card, 2016-17 Edition*

Scoring Documentation for Public Reporting on Clinical Care
(Reporting Year 2016)

Background

Representing the interests of health plan and medical group members, the California Office of the Patient Advocate (OPA) publicly reports on health care quality. OPA published its first HMO Health Care Quality Report Card in 2001 and has since annually updated, enhanced and expanded the Report Cards on HMOs, PPOs and Medical Groups. The current version (2016-17 Edition) of the online Health Care Quality Report Cards is available at: www.opa.ca.gov and via mobile apps.

Performance results are reported for 205 physician organizations that participate in the Integrated Healthcare Association (IHA) Pay for Performance initiative (P4P) (see details on this initiative at: http://www.ih.org/pay_performance.html). IHA is a multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care. IHA collects quality data on the physician organizations that contract with commercial HMOs for P4P and provides the data to OPA for the Health Care Quality Report Card. The IHA physician 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 2016-17 Edition of the Report Cards is published in October 2016, using data reported in Reporting Year (RY) 2016 for performance in Measurement Year (MY) 2015. Data sources are:

1. The National Committee for Quality Assurance's (NCQA) publicly reported HMO and PPO Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) commercial measure data. (HEDIS and CAHPS Methodology Descriptions in separate documents)
2. **The Integrated Healthcare Association (IHA) Pay for Performance (P4P) Initiative's medical group clinical performance data.**
3. The Integrated Healthcare Association (IHA) Pay for Performance (P4P) program's commercial medical group total cost of care data, called *Average Annual Payment for Care*. (Methodology Description in a separate document)
4. The California Healthcare Performance Information System, Inc. (CHPI) Patient Assessment Survey's (PAS) patient experience data for medical groups. (Methodology Description in a separate document)

* Also see the Scoring Methodology for the Medical Group Report Card patient experience ratings:
<http://reportcard.opa.ca.gov/rc2016/medicalgroupabout.aspx>

Medical Group Clinical Methodology Process

1. Methodology Decision Making Process

OPA conducts a multi-stakeholder process to determine the scoring methodology. Beginning with the 2013 Edition of the Report Cards, OPA enhanced its partnership with IHA's Pay for Performance Initiative. IHA's Technical Measurement Committee (TMC) serves as the primary advisory body to OPA regarding methodologies for the HMO and PPO Report Cards 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. OPA's Health Care Quality Report Cards are a standing item at the TMC meetings.

TMC Roster (2016)

Chair: Mike Weiss, DO: *CHOC Health Alliance*
Marnie Bakier, MD: *MemorialCare Medical Group*
Christine Castano, MD: *Healthcare Partners*
Cheryl Damberg, PhD: *RAND*
Ellen Fagan: *Cigna Healthcare of California*
John Ford, MD: *Family Practice Physician*
Peggy Haines: *Health Net*
Chris Jioras: *Humboldt-Del Norte IPA*
Marcus Lee: *Blue Shield of California*
Ranyan Lu, PhD: *UnitedHealthcare*
Leticia Schumann: *Anthem Blue Cross*
Kristy Thornton: *Pacific Business Group on Health*
Ralph Vogel, PhD: *SoCal Permanente Medical Group*

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

OPA also consults with Dr. Patrick Romano, who is a national expert in health care quality and public reporting, and a practicing physician and professor at the University of California, Davis Medical School.

Additionally, OPA 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, began conducting regular annual Stakeholder Briefings in 2014.

2. Stakeholder Preview and Corrections Period

Each year, prior to the public release of the OPA 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

OPA and its contractors. If an error in the data is discovered, it is corrected prior to the public release of the OPA Report Cards.

Medical Group - Commercial Report Card Clinical Scoring Methodology

There are three levels of measurement:

1. **Category:** “Medical Group Provides Recommended Care” is the one aggregated all-clinical summary performance score composed of fifteen (15) HEDIS or similar-to-HEDIS commercial measures.
2. **Topic:** There are five condition topic areas composed of groupings of fifteen (15) clinical measures.
3. **Clinical Measures:** There are twenty-one (21) clinical measures reported by IHA. Most, but not all, are HEDIS measures. Six (6) of these are standalone clinical measures.

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 “Medical Group Provides Recommended Care”. All of the performance results are expressed such that a higher score means better performance. Fifteen (15) clinical measures are aggregated to create the All-Clinical summary performance score: “Medical Group Provides Recommended Care.” Based on relative performance, groups are assigned star ratings for multi-level composites (category and topics).

For the 2016-17 Edition Medical Group Report Card, RY 2015 (MY 2014) values from medical groups statewide are used to set performance cutpoints for the clinical measures.

1. Composite Calculation for Category and Topic Scoring

Fifteen (15) measures are aggregated to create the summary performance score. The summary scoring process is a two-step method:

- a) **In Step 1**, calculate topic level composite: Measures are organized into each of six condition topics. A mean score is calculated for each topic by summing the proportional rates for each measure within the topic and dividing by the number of measures. With the exception of outlier results which are excluded from the dataset, the scores for all reporting groups are used to calculate topic and summary scores. Valid results for non-reporting groups are included.

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. The condition topic measures are equally weighted when combining them and calculating a condition topic score.

- b) **In Step 2**, calculate the category level composite “Medical Group Provides Recommended Care.” Calculate the mean of all individual measure scores.

The medical group must have reportable results for at least half of the measures to be eligible for the summary performance score.

A medical group’s overall summary performance score is rounded to the tenths decimal and the performance grade is assigned per the cutpoints and the buffer zone adjustment factor (see section 7).

2. Individual Measure Scoring

- a) The individual clinical measure scores are calculated as proportional rates using the numerators and denominators that are reported per the P4P 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:
$$(\text{Measure numerator}/\text{Measure denominator}) * 100$$

3. Handling Missing Data

Not all medical groups are able to report valid rates for all measures. 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 an individual rate. If a medical group is able to report valid rates for at least half of its measures in a topic, then missing values will be replaced using an adjusted half-scale rule for all measures in the topic. Because eligibility for missing value re-assignment (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.

4. Changes from the 2015-16 Edition Report Card to the 2016-17 Edition Report Card and Notes

- a) The following measures were added to the Medical Group – Commercial Report Card for the 2016-17 Edition:
 - i. Controlling High Blood Pressure. The total rate (ages 18-85) will be reported. This measure will be a stand-alone measure and not included in any star ratings at this time.
 - ii. Successfully Controlling Diabetes. This measure will be a stand-alone measure and not included in any star ratings at this time.
- b) Measure Change – The Testing Blood Sugar for People with Diabetes measure will replace the current “Hba1C Test” indicator with the “Two HbA1c Tests” indicator for the 2016-17 Edition of the Medical Group – Commercial Report Card.
- c) The outlier criteria used for Controlling Blood Pressure for People with Diabetes no longer applies, beginning with the 2016-17 Edition of the Medical Group – Commercial Report Card.

5. Calculate Percentiles

One of four grades is assigned to each of the five condition topics and to the “Medical Group Provides Recommended Care” category using the cutpoints shown in Table 1. Cutpoints were calculated per the MY 2014 (RY 2015) results for all medical groups. The cutpoints are calculated by summing the statewide scores for the respective percentile value for each measure in a given topic. In turn, the measure-specific percentile scores are summed and an average score is calculated for each of the three cutpoints for that topic.

6. From Percentiles to Stars

- a) Medical group performance in MY 2015 (RY 2016) is graded against score thresholds derived from MY 2014 (RY 2015) data. There are three thresholds corresponding to four-star rating assignments. If a topic or category composite rate meets or exceeds the “Excellent” thresholds, the medical group is assigned a rating of four stars. If a topic or category composite rate meets or exceeds the “Good” threshold (but is less than the “Excellent” 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”.
- b) The grade spans vary for each of the six condition topics listed in Table 1:
 - Top cutpoint: 90th percentile California reporting medical groups
 - Middle cutpoint: 50th percentile California reporting medical groups
 - Low cutpoint: 25th percentile California reporting medical groups

Table 1: Clinical Performance Cutpoints for the 2016-17 Edition of the Medical Group – Commercial Report Card

Condition Topics	Number of Measures Included	Excellent Cutpoint	Good Cutpoint	Fair Cutpoint	Poor Cutpoint
Asthma Care	1	90	80	74	<74
Checking For Cancer	3	84	62	53	<53
Chlamydia Screening	1	71	54	46	<46
Diabetes Care	4	80	62	48	<48
Treating Children	6	73	60	47	<47
All Clinical Summary – Medical Group Provides Recommended Care	15	78	62	50	<50

Special scoring is used for the “Children’s Physician Medical Group” – an all-pediatric group. This group reports eight measures: Asthma Medication Ratio, Chlamydia Screening, Immunizations for Children, Immunizations for Adolescents, Human Papillomavirus Vaccine for Female Adolescents, Human Papillomavirus Vaccine for Male Adolescents, Treating Children with Throat Infections and Treating Children with Upper Respiratory Infections. The group’s summary performance indicator is comprised of these eight measures. Correspondingly, the performance cutpoints for the group’s all clinical summary rating are based on these eight measures and the MY 2014 (RY 2015) results. The cutpoints for the 2016-17 Edition are 75, 62, and 51 for the 90th, 50th and 25th percentiles respectively.

c) Buffer Zones

A buffer zone of a half-point (0.5) span is applied. Any medical group whose score is in the buffer zone that is 0.5 point below the grade cutpoint is assigned the next highest category grade. For example, for “Medical Group Provides Recommended Care” using a cutpoint of 78, a group whose score is 77.5 would be graded “Excellent.” A score of 77.4, which is outside of the buffer zone, would be assigned a grade of “Good.”

d) Legends to Explain Missing Scores

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

- i. **Too Few Patients to Report.** Medical group score is not reported because the measure’s denominator has fewer than 30 patients.
- ii. **Not Willing to Report.** Medical group declined to report its results.

8. Attribution of Patients to Medical Groups

In the P4P program, 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.

9. Reliability Testing/Minimum Number of Observations

P4P 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, P4P requires a total eligible population of 30 or more for a particular measure. In addition, P4P excludes any measure with a bias of five percent or more, as determined by the auditor.

10. Risk Adjustment

NCQA is the measure developer for most P4P clinical quality measures. Therefore, P4P follows NCQA's risk adjustment protocol. 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.

NCQA also creates the technical specifications for clinical quality measures that are not HEDIS based. Because those measures are also process and outcomes measures, NCQA determined that risk adjustment was not appropriate.

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	P4P Measure ID	P4P Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Display Only Measure*	MPMOV	Annual Monitoring for Patients on Persistent Medications	Giving Lab Tests for Patients Taking Medications for a Long Time	The percentage of patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	N/A
Display Only Measure*	LBP	Use of Imaging Studies for Low Back Pain	Testing for Cause of Back Pain	The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	N/A
Display Only Measure*	AAB	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 Measure*	PCR	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 Measure**	CBPH_1885	Controlling Blood Pressure for People with Hypertension	Controlling High Blood Pressure	The percentage of nondiabetic members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled according to the appropriate criteria based on their age (age 18-59, BP <140/90 mm Hg; age 60-85, BP <150/90 mm Hg. The percentage is calculated by totaling the two rates for members 18–59 years of age and members 60–85 years of age.	N/A
Display Only Measure**	ODCCOMBO	Optimal Diabetes Care	Successfully Controlling Diabetes	The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) whose HbA1c was <8.0%, who received at least two HbA1c tests, whose blood pressure was <140/90, and received testing for Nephropathy	N/A

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Topic	P4P Measure ID	P4P Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Asthma Care	AMROV64	Asthma Medication Ration	Asthma Medicine	The percentage of patients 5–50 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
Checking for Cancer	ECSASOV†	Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women	Cervical Cancer Screening	Women 21 years of age and older who received cervical cancer screening in accordance with evidence-based standards.	3
	BCS5274	Breast Cancer Screening	Breast Cancer Screening	The percentage of women 50–69 years of age who had a mammogram to screen for breast cancer.	
	COL	Colorectal Cancer Screening	Colorectal Cancer Screening	The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.	
Chlamydia	CHLAMSCR	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.	1
Diabetes Care	HBASCR2X	HbA1c Testing	Testing Blood Sugar for People with Diabetes	The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who received at least two HbA1c tests	4
	HBAC8	HbA1c Control (<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%	
	NEPHSCR	Nephropathy Monitoring	Testing Kidney Function for People With Diabetes	The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) received testing for Nephropathy	
	CBPD4	Blood Pressure Control for Diabetes Patients<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	

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	P4P Measure Abbreviation	P4P Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Treating Children	HPV	Human Papillomavirus Vaccine for Female Adolescents	HPV Vaccine for Female Adolescents	The percentage of female adolescents 13 years of age who had three doses of human Papillomavirus (HPV) vaccine by their 13th birthday.	6
	HPVM [‡]	Human Papillomavirus Vaccine for Male Adolescents	HPV Vaccine for Male Adolescents	The percentage of male adolescents 13 years of age who had three doses of human Papillomavirus (HPV) vaccine by their 13th birthday.	
	CISCOMBO	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.	
	IMATD	Immunizations for Adolescents	Immunizations for Early Teens	The percentage of adolescents 13 years of age who had one dose of diphtheria toxoids and acellular pertussis vaccine (DtaP) by their 13th birthday.	
	CWP	Appropriate Testing for Children with Pharyngitis	Treating Children with Throat Infections	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	
	URI	Appropriate Treatment for Children with Upper Respiratory Infection	Treating Children with Upper Respiratory Infections	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	

*Display Only Measures are not included on the overall summary performance score “Medical Group Provides Recommended Care”

[‡]ESCASOV and HPVM are non-HEDIS measures in the P4P measure set.