Office of the Patient Advocate (OPA)
California Health Care Quality Medical Group - Commercial Report Card, 2018-19 Edition*

Scoring Documentation for Public Reporting on Clinical Care
(Reporting Year 2018)

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 (2018-19 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 199 physician organizations that participate in the Integrated Healthcare Association (IHA) Align. Measure. Perform. (AMP) Commercial HMO program (see details on this initiative at: http://www.iha.org/). 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 AMP 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 2018-19 Edition of the Report Cards is published in Fall 2018, using data reported in Reporting Year (RY) 2018 for performance in Measurement Year (MY) 2017. 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) AMP Commercial HMO program's medical group clinical performance data.**
3. The Integrated Healthcare Association (IHA) AMP Commercial HMO program's medical group total cost of care data. (Methodology Description in a separate document)
4. The Pacific Business Group on Health (PBGH) 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
† HEDIS and CAHPS are registered trademarks of the national Committee for Quality Assurance (NCQA)

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 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. OPA's Health Care Quality Report Cards are a standing item at the TMC meetings.

TMC Roster (2018)

Chair: Parag Agnihotri, *Sharp Rees-Stealy Medical Group*
Boyd Lebow, *Blue Shield of California*
Cheryl Damberg, PhD, *RAND*
Chris Jioras, *Humboldt IPA*
Christine Castano, MD, *HealthCare Partners*
Ellen Fagan, *Cigna*
John Ford, MD, MPH, *Practicing Physician*
Leticia Schumann, *Anthem*
Marnie Baker, MD, MPH, *MemorialCare Medical Group*
Michael-AnneBrowne, *Stanford Health Care*
Peggy Haines, *Health Net*
Rachel Brodie, *Pacific Business Group on Health*
Ralph Vogel, PhD, *Kaiser Permanente*
Ranyan Lu, PhD, *UnitedHealthcare*

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

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**: "Quality of Medical Care" is the one aggregated all-clinical category performance score composed of nineteen (19) HEDIS or non-HEDIS performance measures.

2. **Topic**: There are six condition topic areas composed of groupings of eighteen (18) clinical measures. One (1) measure does not belong to a specific topic group, but is included in the "Quality of Medical Care" category rating.

3. **Clinical Measures**: There are twenty (20) clinical measures reported by IHA. Most, but not all, are HEDIS measures. One (1) of these is a display-only clinical measure and does not roll up into the star ratings.

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. Nineteen (19) 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 2018-19 Edition Medical Group Report Card, RY 2017 (MY 2016) values from medical groups statewide are used to set performance cutpoints for the clinical measures.

1. **Composite Calculation for Category and Topic Scoring**
   Nineteen (19) 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, except *Successfully Controlling Diabetes.* Each of the 19 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 rounded to the tenths decimal and the performance grade is assigned per the cutpoints and the buffer zone adjustment factor (see section 7).

   b) **To calculate the topic level composites:** 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. The measures are equally weighted within each of the six condition topics. A buffer of 0.5 is added to the mean, which is assigned a star rating (see section 7) after rounding to the tenth decimal.

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

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. 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 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. Risk Adjustment

IHA's AMP Commercial HMO program's clinical care measures, which include HEDIS measures, are not risk adjusted for patient characteristics or socioeconomic status. As the measure developer for HEDIS measures used in the AMP Commercial HMO program, 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 the AMP Commercial HMO Program, the results for this measure (numerator, denominator, rates, probability, variance) comes from the audited health plan results that were submitted to

TransUnion by plans in May 2018. IHA data partner, Onpoint Health Data, 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 AMP Manual.

5. Changes from the 2017-18 Edition Report Card to the 2018-19 Edition Report Card and Notes

a) The overall category and topic star ratings will now be assigned a star rating between 1 and 5 stars, versus the previous 4-star scale.
b) The cutpoints for assigning star ratings are now at the 10th, 35th, 65th, and 90th percentiles. The previous cutpoints were the 25th, 50th, and 90th percentiles.
c) The Medical Group Report Card overall category rating will include all displayed measures except for 'Successfully Controlling Diabetes'. This measure has historically been displayed within the *Diabetes Care* topic but is not included in either the topic or overall category rating calculations, as it is a combination of other diabetes measures already included in the star rating.
d) 'Preventing Hospital Readmission After Discharge' data was unavailable at the time of the fall launch but has been incorporated in May 2018. This data is displayed in the Appropriate Use of Tests, Treatments and Procedures topic, but is not included in the star rating due to its unique nature as a risk-adjusted measure rather than a standard performance rate.
e) The *Checking for Cancer* and *Chlamydia Screening* topics were combined and renamed *Preventive Screenings;* this topic includes the following measures: Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, and Chlamydia Screening.
f) 'Controlling Blood Pressure for People with Hypertension' was previously a standalone measure not included within a topic; it will now be combined with the new measure 'Prescribing Statins for People with Heart Disease' to create the *Heart Care* topic.
g) 'Prescribing Statins for People with Heart Disease': This measure was added to the newly established *Heart Care* topic and reflects how well medical groups prescribe statins to patients to control their heart disease.
h) Numerous measures related to overuse or appropriate treatment were combined into a single topic labeled *Appropriateness of Tests, Treatments and Procedures.* This topic is comprised of three measures: 'Cervical Cancer Overscreening', 'Testing for Cause of Back Pain', and 'Treating Bronchitis with Antibiotics'.
i) 'Prescribing Statins for People with Diabetes': This measure was added to the *Diabetes Care* topic and reflects how well medical groups prescribe statins to patients with diabetes, in order to prevent heart disease.
j) 'Treating Children with Upper Respiratory Infections' has been retired from the Medical Group Report Card, in alignment with its retirement from IHA's AMP programs.

6. Calculate 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 2016 (RY 2017) 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 four cutpoints for that topic.

7. From Percentiles to Stars

Medical group performance in MY 2017 (RY 2018) is graded against score thresholds derived from MY 2016 (RY 2017) data. 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 California reporting medical groups
Middle-high cutpoint:	65th percentile California reporting medical groups
Middle-low cutpoint:	35th percentile California reporting medical groups
Low cutpoint:	10th percentile California reporting medical groups

Table 1: Clinical Performance Cutpoints for the 2018-19 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	86	81	71	<71
Appropriateness of Tests, Treatments and Procedures	3	85	74	64	53	<53
Diabetes Care	5	79	70	58	45	<45
Heart Care	2	85	73	52	34	<34
Preventive Screenings	4	81	72	61	50	<50
Treating Children	3	67	57	41	19	<19
All Clinical Category – Quality of Medical Care	19*	80	71	59	45	<45

***This count includes the Annual Monitoring for Patients on Persistent Medications measure, which does not belong to a specific topic, but is included in the overall category star calculation.*

Special scoring is used for the "Rady Children's Health Network" – an all-pediatric medical group. This group reports five measures: Asthma Medication Ratio, Chlamydia Screening, Immunizations for Children, Immunizations for Adolescents, and Treating Children with Throat Infections. The group's category performance indicator is comprised of these five measures. Correspondingly, the performance cutpoints for the group's all clinical category rating are based on these five measures and the MY 2016 (RY 2017) results. The cutpoints for the 2018-19 Edition are 73, 64, 50 and 34 for the 90th, 65th, 35th and 10th percentiles, respectively.

8. 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 "Quality of Medical Care" using a cutpoint of 80, a group whose score is 79.5 would be graded "Excellent." A score of 79.4, which is outside of the buffer zone, would be assigned a grade of "Very Good."

a) 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 AMP Commercial HMO 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

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, IHA excludes any measure with a bias of five percent or more, as determined by a certified auditor.

10. Risk Adjustment

NCQA is the measure developer for most clinical quality measures used in IHA's AMP Commercial HMO program. Therefore, IHA 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, IHA or other measure developers create the technical specifications for AMP clinical quality measures that are not HEDIS based. Because those measures are also process and outcomes measures, IHA staff determined that risk adjustment was not appropriate.

The Preventing Hospital Readmission After Discharge measure, which is also a HEDIS measure and part of the AMP Commercial HMO Resource Use Domain, however is risk-adjusted. The specifications from the AMP program manual describe the risk adjustment used for this measure.

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	IHA Measure ID	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Stand Alone Measureº	MPMOV2	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
Appropriate Use of Tests, Treatments and Procedures	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 (plan X-ray, MRI, CT scan) within 28 days of the diagnosis.	3
	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.	
	CCO‡	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.	

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	IHA Measure ID	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Asthma Care	AMROV64	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	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	**5**
	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	
	SPD1	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	

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	IHA Measure ID	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Heart Care	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.	2
	SPC1	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	
Preventive Screenings	CCS	Cervical Cancer Screening	Cervical Cancer Screening	Women 21-64 years of age who received cervical cancer screening.	**4**
	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.	
	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.	

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	IHA Measure ID	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Treating Children	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.	**3**
	CISCOMBO10	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.	
	IMACOMBO2	Immunizations for Adolescents	Immunizations for Early Teens	The percentage of adolescents 13 years of age who had one dose of tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) and completed the HPV vaccine series by their 13th birthday.	

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	IHA Measure ID	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
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
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 Measures are not included on the overall category performance score "Quality of Medical Care".

ºStandalone Measures are not displayed within a topic but are included in the overall category performance score "Quality of Medical Care".

‡CCO, CBPH_1885, HBASCR2x and ODCCOMBO are non-HEDIS measures in the AMP Commercial HMO measure set.