Office of the Patient Advocate (OPA)
California Health Care Quality Health Plan Report Cards, 2020-21 Edition

Scoring Documentation for Public Reporting on CAHPS[1]
(Reporting Year 2019)

CAHPS data has been reused from Measurement Year 2018 (Reporting Year 2019) for the 2020-21 Ed. Health Plan Report Card. The methodology has remained unchanged – what is reflected below is the same methodology used for calculating star ratings for 'Patients Rate Overall Experience' in RY 2019.

The decision to use previous year data (MY 2018) was made by OPA after NCQA withheld the option to publicly report patient experience data for Measurement Year 2019. The rationale for withholding individual plan performance revolved around concern of the impact of COVID-19 on CAHPS data collection. Low response rates and the potential for response bias (patients reflecting on care provided in the previous year, but amidst the global pandemic) contributed to this decision. For more information please visit https://www.ncqa.org/covid/.

Background

Representing the interests of health plan 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 (2020-21 Edition) of the online Health Care Quality Report Cards is available at www.opa.ca.gov.

Performance results are reported at a health plan reporting unit level in the Health Plan Report Cards. Ten (10) participating health plans report HMO Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) results.

Aetna Health of California, Inc.
Anthem Blue Cross of California
Blue Shield of California
CIGNA HealthCare of California, Inc.
Health Net of California, Inc.
Kaiser Foundation Health Plan of Northern California, Inc.
Kaiser Foundation Health Plan of Southern California, Inc.
Sharp Health Plan
United Healthcare of California, Inc.
Western Health Advantage

Six (6) participating health plans report PPO Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results.

Aetna Health of California, Inc.
Anthem Blue Cross of California
Blue Shield of California
CIGNA HealthCare of California, Inc.
Health Net of California, Inc.
United Healthcare Insurance Co., Inc.

[1] Also see the Scoring Methodology for the HMO and PPO Report Cards HEDIS clinical care ratings: http://www.opa.ca.gov/Pages/AboutRatingsandMore.aspx

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

Sources of Data for California Health Care Quality Report Cards

The 2020-21 Edition of the Report Cards is published in November 2020, using data reported in Reporting Year (RY) 2019 for performance in Measurement Year (MY) 2018. Data sources are:

1. **The National Committee for Quality Assurance's (NCQA) publicly reported Consumer Assessment of Healthcare Providers and Systems (CAHPS) commercial measure data** and HMO and PPO Healthcare Effectiveness Data and Information Set (HEDIS[3])**.** (HEDIS Methodology Description in a separate document)
2. The Integrated Healthcare Association (IHA) Align. Measure. Perform. (AMP) Commercial HMO program's medical group clinical performance data. (Methodology Description in a separate document)
3. The Pacific Business Group on Health (PBGH) Patient Assessment Survey's (PAS) patient experience data for medical groups. (Methodology Description in a separate document)

Health Plan CAHPS 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 program. IHA's Technical Measurement Committee (TMC) now 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 (2019)

Chair: Michael-Anne Browne, MD, *Stanford Health Care*
Alyson Spencer, *Blue Shield of California Promise Health Plan*
Cheryl Damberg, PhD, *RAND*
Chris Jioras, *Humboldt IPA*
Christine Castano, MD, *HealthCare Partners*
Dave Schweppe, *Kaiser Foundation Health Plan*
Edward Yu, MD, *Sutter Palo Alto Medical Foundation*
Eric Garthwaite, *Health Net*
John Ford, MD, MPH, *Practicing Physician*
Kenneth Phenow, MD, *Cigna*
Leticia Schumann, *Anthem*
Marnie Baker, MD, MPH, *MemorialCare Medical Group*
Meg Durbin, MD, *Canopy Health*
Rachel Brodie, *Pacific Business Group on Health*
Ralph Vogel, PhD, *Kaiser Permanente*

[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®2019 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2019 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

Ranyan Lu, PhD, *UnitedHealthcare*
Tory Robinson, *Blue Shield of California*

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, welcomes questions and comments sent to OPAReportCard@ncqa.org.

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 identified within the given time period, it is corrected prior to the public release of the OPA Report Cards.

Health Plan CAHPS Scoring Methodology

There are three levels of measurement:

1. **Stand Alone CAHPS Measures:** The two eligible measures consist of the CAHPS* 5.0H commercial measures for Reporting Year 2019, reported by the National Committee for Quality Assurance (NCQA).

2. **Topic:** There are three composite topic areas composed of eleven (11) commercial CAHPS measures.

3. **Summary Performance**: There is one composite category, "Patients Rate Overall Experience," which is the aggregated All-CAHPS summary performance score composed of eleven (11) commercial CAHPS measures.

See Appendix A for mapping of CAHPS measures to performance topics and Appendix B for mapping of CAHPS measures to stand-alone patient experience ratings.

2-year Rolling Average

There are three specific measures that are calculated by multi-question composites, based on a 2-year rolling average; *Plan Customer Service, Plan Information on What You Pay,* and *Paying Claims.* Two of these measures are calculated manually for the OPA Report Cards; *Plan Customer Service* and *Paying Claims.* Each question over two years is summed, and the total of each question over two years is averaged to create the rate of performance for each composite (e.g. Question 35 responses are summed from MY 2017 and MY 2018 and averaged with the same sum for Question 36 to create the rate of performance displayed for Customer Service in RY2019). The purpose for a 2-year rolling average is to amass a denominator large enough to report, given the difficulty most plans have in reaching the minimum reporting threshold in one measurement year across the entire composite.

Performance Grading

HMOs and PPOs are graded on performance relative to the nation for CAHPS for "Patients Rate Overall Experience" for HMO/PPOs. All of the performance results are expressed such that a higher score means better performance. Based on relative performance, plans are assigned star ratings for multi-level summary indicators.

Star rating performance grading is based on the NCQA RY 2019 Quality Compass® All Lines of Business (Health Maintenance Organization-HMO, Point of Service-POS and Preferred Provider Organization-PPO) benchmarks. Quality Compass RY 2019 values are used to set performance cutpoints for new or revised measures.

1. **Summary Performance Indicator Scoring**
   One summary performance indicator result is reported: "Patients Rate Overall Experience." This summary rating is an aggregation of three composites: 1) "Getting Care Easily", 2) "Satisfaction with Plan Services" and 3) "Satisfaction with Plan Doctors."

   a) Refer to HEDIS® 2019 Volume 3: Specifications for Survey Measures for a detailed description of the composite results scoring method.

2. **Composite Topic Scoring**

   The NCQA CAHPS proportional scoring specifications are used to score the composites and items in Appendix A. Per NCQA scoring rules, CAHPS composite and item results are rounded using the tenths value as calculated in the raw proportional rate (e.g., a value of 79.4999 is rounded down to 79 and a value of 79.5111 is rounded up to 80).

3. **Handling Missing Data**

   Not all health plans are able to report valid rates for all measures. In order to calculate summary performance indicator star ratings for as many health plans as possible, we impute missing data under specific conditions using an adjusted half-scale rule. This is accomplished by developing an actual measure level result for plans with missing data and using those for star calculations. Imputed results are not reported as an individual rate. If a plan is able to report valid rates for at least half of its measures in a topic, then missing values are replaced using this adjusted half-scale rule for all measures in the topic. Because eligibility for missing value re-assignment (imputation) is assessed independently at the summary indicator level, it is possible to have a summary indicator score even if topic scores are missing.

4. **Changes from the 2019-20 Edition Report Card to the 2020-21 Edition Report Card and Notes**

   There were no measure additions or retirements for the Health Plan Report Card. The data displayed for 'Patients Rate Overall Experience' for the 2020-21 Edition Report Card is the same data that was displayed for the 2019-20 Edition.

5. **Calculate Percentiles**

   a) One of five grades are assigned to each of the three summary performance indicators using Table 1 cutpoints. Four cutpoints are used to calculate the performance grades. Cutpoints were calculated per the NCQA RY 2018 Quality Compass® All Lines of Business (Health Maintenance Organization-HMO, Point of Service-POS and Preferred Provider Organization-PPO) results. The cutpoints are calculated by summing the nationwide scores for the respective percentile value for each measure in a given summary indicator. In turn, the measure-specific percentile scores are summed and an average

score is calculated for each of the four cutpoints for that category performance indicator.

6. From Percentiles to Stars

a) Health plan performance in MY 2018 is graded against score thresholds derived from MY 2017 (RY 2018) data. There are four thresholds corresponding to five-star rating assignments. If a category performance indicator composite rate meets or exceeds the "Excellent" threshold, the plan is assigned a rating of five stars. If a summary performance indicator composite rate meets or exceeds the "Very Good" threshold (but is less than the "Excellent" threshold) then the plan is given a rating of four stars. If a summary performance indicator composite rate meets or exceeds the "Good" threshold (but is less than the "Very Good" threshold) then the plan is given a rating of three stars. If a summary performance indicator composite rate meets or exceeds the "Fair" threshold (but is less than the "Good" threshold) then the plan is given a rating of two stars. Summary performance indicator 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 three summary performance indicator topics listed in Table 1:

Top cutpoint:	90th percentile nationwide
Middle-high cutpoint:	65th percentile nationwide
Middle-low cutpoint:	35th percentile nationwide
Low cutpoint:	10th percentile nationwide

Table 1. Health Plan CAHPS Performance Cutpoints for Grade Assignment 2019-20 Ed. Report Card

	Number of Measures Included	*Excellent Cutpoint*	*Very Good Cutpoint*	*Good Cutpoint*	*Fair Cutpoint*	*Poor Cutpoint*
Topic Ratings						
Getting Care Easily	2	90	88	85	81	<81
Satisfaction with Plan Services	4	77	71	67	61	<61
Satisfaction with Plan Doctors	5	75	70	67	62	<62
Category Rating						
Patients Rate Overall Experience	11	78	74	70	65	<65

c) A buffer zone of a half-point (0.5) span is applied. Any HMO or PPO 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, a "Getting Care Easily" score of 84.5 would be assigned a

grade of “Good”. A score of 84.4, which is outside of the buffer zone, would be assigned a grade of “Fair”.

Appendix A
Mapping of CAHPS Measures[i] to Topics

Summary Performance Indicator	Composite or Topic	Definition	Question #
Getting Care Easily	Getting Doctors and Care Easily	In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed? (never-always)	25
		In the last 12 months, how often was it easy to get the care, tests, or treatment you needed? (never-always)	14
	Getting Appointments and Care Quickly	In the last 12 months, when you needed care right away, how often did you get care as soon as you needed? (never-always)	4
		In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? (never-always)	6
Satisfaction with Plan Services	Plan Customer Service	In the last 12 months, how often did your health plan's customer service give you the information or help you needed? (never-always)	35
		In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? (never-always)	36
	Plan Information on What You Pay	In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment? (never-always)	31
		In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines? (never-always)	33
	Paying Claims	In the last 12 months, how often did your health plan handle your claims quickly? (never-always)	40
		In the last 12 months, how often did your health plan handle your claims correctly? (never – always)	41
	Rate Their Plan	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan? (OPA uses the responses of 9 or 10 for this question).	42

Summary Performance Indicator	Composite or Topic	Definition	Question #
Satisfaction with Plan Doctors	Rating of Doctor	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor? (OPA uses the responses of 9 or 10 for this question).	23
	Rating of Specialist	Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist? (OPA uses the responses of 9 or 10 for this question).	27
	Health Care Highly Rated	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months? (0-10)? (OPA uses the responses of 9 or 10 for this question).	13
	Coordinated Care	In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	22
	Health Promotion	In the last 12 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?	8

Appendix B

Stand-alone Patient Experience Ratings (not included in star ratings)

Stand Alone Measures	Composite or Topic	Definition	Question #
	Doctor Communication	In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand? (never-always)	17
		In the last 12 months, how often did your personal doctor listen carefully to you? (never-always)	18
		In the last 12 months, how often did your personal doctor show respect for what you had to say? (never-always)	19
		In the last 12 months, how often did your personal doctor spend enough time with you? (never-always)	20
	Shared Decision Making	When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine?	10
		When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine?	11
		When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?	12

[i] The questions sampled in this table correspond with the CAHPS 5.0H survey