

**Office of the Patient Advocate**  
**California Health Care Quality Report Card 2012 Edition**  
**HMO CAHPS® Reporting Year 2011**

## **Background**

The California Office of the Patient Advocate (OPA) is charged with representing the interests of health plan members and OPA has the mandated responsibility to publicly report on health care quality. OPA published its first Health Care Quality Report Card in 2001 and has since successfully updated and enhanced the Report Card every year. The current version (2012 Edition) of the online Health Care Quality Report Card is at: [www.opa.ca.gov](http://www.opa.ca.gov).

Performance results are reported at a health plan reporting unit level. With the exception of Kaiser Northern California and Kaiser Southern California, the plans report a single, statewide set of performance results.

Nine (9) participating health plans report HMO 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.
- Kaiser Foundation Health Plan of Northern California, Inc.
- Kaiser Foundation Health Plan of Southern California, Inc.
- United Healthcare of California, Inc. (formerly PacifiCare)
- Western Health Advantage

The 2012 Edition of the Report Card is published in February 2012, using data reported by HMO plans in Reporting Year (RY) 2011 for performance in Measurement Year (MY) 2010. Data sources are the California Cooperative Healthcare Reporting Initiative's (CCHRI) publicly reported HMO Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) commercial measures for RY 2011.

CCHRI is a nonprofit collaborative of health care purchasers, plans and providers that collects HEDIS and CAHPS health quality data and the medical group Patient Assessment Survey (PAS) data and provides these data to OPA. The National Committee for Quality Assurance (NCQA) develops and maintains the HEDIS performance measures as the national standard set of health plan clinical process and outcomes measures. The Agency for Healthcare Research and Quality (AHRQ) develops and maintains the Consumer Assessment Health Plan Survey (CAHPS) measures as the national standard set of health plan members' experience. NCQA sponsors the CAHPS member-reported experience and satisfaction survey measures as the national standard health plan member experience survey.

\*The source for data contained in this publication is Quality Compass®2011 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2011 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. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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## Scoring Methodology

There are three levels of measurement:

1. **Summary Performance:** There are three composite summary performance indicators.
2. **Topic:** There are seven composite topic areas that are reported as single measures.
3. **CAHPS Measures:** The eligible measures consist of the CAHPS\* 4.0H commercial measures for reporting year 2011, reported by CCHRI.

See Appendix A for mapping of CAHPS measures to Summary Indicators and Topics.

### Performance Grading

HMOs are graded on performance relative to the nation for CAHPS for Member Experience. 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 indicator topics:

Performance grading is based on the NCQA RY 2010 Quality Compass® All Lines of Business (HMO, POS and PPO) benchmarks. Quality Compass RY 2011 values are used to set performance cutpoints for new or revised measures.

#### 1. Summary Indicator Performance Scoring

Three summary performance indicator results are reported: 1) HMO Overall Rating, 2) Plan Service, and 3) Getting Care Easily.

- a. The HMO Overall Rating (Q. 42) item is reported as an overall summary rating. The Overall Rating is scored as the proportion of respondents reporting an 8, 9 or 10 on a 0-10 scale.
- b. The 'Plan Service' indicator is an aggregation of three composites: Plan Customer Service, Paying Claims, and Plan Information on What You Pay. The respondents included in the 'Plan Service' indicator are members of the survey sample who contacted their plan.
- c. The 'Getting Care Easily' indicator is an aggregation of two composites: Getting Doctors and Care Easily and Getting Appointments and Care Quickly.
- d. See Appendix B for a detailed description of the composite results scoring method.
- e. The summary indicators, Plan Service and Getting Care Easily, are scored using a two-step method:
  - i. **In Step 1**, the proportional rate is calculated for each question included in the summary indicator. The proportional rate is a two-year rolling average for RY

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2011 – the MY 2009 and MY 2010 numerators and denominators are summed to calculate the rate.

- The minimum denominator standard is applied at the summary indicator level – a plan must have an aggregate minimum of 100 respondents when summing the question denominators for that summary indicator.
- ii. **In Step 2**, the proportional rates are summed for all of the relevant questions and divided by the number of questions to yield an overall rate.
- Each question rate is equally weighted.
  - Results are rounded to the tenths value – this summary indicator score is used to assign the performance grade per the instructions below. The questions that comprise the Plan Service and Getting Care Easily summary indicators are listed in Appendix A.

**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. Changes from 2011 Edition Report Card to 2012 Edition Report Card**

The Helping Smokers Quit: Getting Advice measure is added to CAHPS.

**4. 2012 Edition Report Card Notes**

The Flu Shot for Older Adults CAHPS measure is included in the Treating Adults HEDIS composite – it is not included in CAHPS scoring and reporting (same as 2011 Edition).

An individual plan result will not be reported for an individual composite or item if the NCQA CAHPS 100 minimum respondents per question standard is not achieved. For these missing scores the phrase “Too few members in sample to report” is displayed.

Per the CCHRI rule, if a minimum of 3 plans have reportable scores (100 minimum respondent standard met) the measure is publicly reported for those plans that have reportable scores. The measure is not reported if fewer than 3 plans have reportable scores. The Medical Assistance for Smoking and Tobacco Use measure is reported in RY 2011, since at least three plans meet the 100 minimum respondent standard for this measure.

The Paying Claims measure is reported as a stand alone measure in RY 2011 (note in RY 2010, there were not enough plans to report this measure as a stand alone measure). It was part of the Plan Service composite in both the 2011 and 2012 Editions of the Report Card.

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**5. Calculate Percentiles**

One of four grades is assigned to each of the 3 summary indicators using Table 1 cutpoints. Three cutpoints are used to calculate the performance grades. Cutpoints were calculated per the RY 2010 NCQA Quality Compass nationwide results for all plans (Health Maintenance Organizations-HMO, Point of Service-POS and Preferred Provider Organizations-PPO).

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 3 cutpoints for that topic.

**6. From Percentiles to Stars**

The grade spans vary for each of the 3 summary performance indicator topics listed in Table 1:

Top cutpoint: 90<sup>th</sup> percentile nationwide  
 Middle cutpoint: 50<sup>th</sup> percentile nationwide  
 Low cutpoint: 25<sup>th</sup> percentile nationwide

Table 1. HMO CAHPS Performance Cutpoints for Grade Assignment

Grade	Grade Icon	Plan Service	Getting Care Easily	HMO Overall Rating
Poor*	1 Star	<76	<83	<54
Fair	2 Star	76-78	83-86	54-58
Good	3 Stars	79-85	87-90	59-72
Excellent	4 Stars	86-100	91-100	73-100

\*Scores below the Fair cutpoint are graded "Poor"

A buffer zone of a half-point (0.5) span is applied. Any HMO 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 Plan Service score of 75.5 would be assigned a grade of fair; a score of 75.4, which is outside of the buffer zone, would be assigned a grade of poor.

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**Appendix A  
Mapping of CAHPS measures to Performance Topics**

Summary Indicator	Composite or Topic	Definition	Question #	Reported as Stand Alone Measure
Getting Care Easily	Getting Doctors and Care Easily	In the last 12 months, how often was it easy to get appointments with specialists? (never-always)	23	√
		In the last 12 months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan? (never-always)	27	
	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 thought you needed? (never-always)	4	√
		In the last 12 months, not counting the times you needed health care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? (never-always)	6	
Plan Service	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	
	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	
Stand Alone Measure Only	Finding a Personal Doctor	How satisfied were you with your ability to choose a personal doctor that you were happy with? (0-10)	21a	√
	Plan Website	In the last 12 months, please rate your satisfaction with your health plan's website.	29a	√
	Member Complaints	In the last 12 months, if you called or wrote your health plan's customer service with a complaint or problem, how satisfied were you with how it was resolved?	36a	√

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Summary Indicator	Composite or Topic	Definition	Question #	Reported as Stand Alone Measure
HMO Overall rating	Global Plan	What number would you use to rate your health plan? (0-10)	42	√ Star Rating only
Stand Alone Measure Only	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)	15	√
		In the last 12 months, how often did your personal doctor listen carefully to you? (never-always)	16	
		In the last 12 months, how often did your personal doctor show respect for what you had to say? (never-always)	17	
		In the last 12 months, how often did your personal doctor spend enough time with you? (never-always)	18	
	Shared Decision Making	In the last 12 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?	10	√
		In the last 12 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?	11	
	Health Care Highly Rated	What number would you use to rate all your health care in the last 12 months? (0-10)?	12	√
	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?	20	√
	Preventive Care	In the last 12 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness?	8	√
	Helping Smokers Quit: Getting Advice	In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	46	√

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**Appendix B**

Composite Results Scoring Method

**Composite Global Proportion**

- Step 1* For each question, count the number of members who selected each response choice.
- For composites with response choices of “Never,” “Sometimes,” “Usually,” and “Always,” response choices of “Never” and “Sometimes” are combined.
- For composites with response choices of “Definitely yes,” “Somewhat yes,” “Somewhat no” and “Definitely no,” response choices of “Somewhat no” and “Definitely no” are combined.
- Step 2* For each question, determine the proportion selecting each response choice.
- Step 3* Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.
- For composites with response choices of “Never,” “Sometimes,” “Usually” and “Always” an additional global proportion is calculated by summing the “Always” and “Usually” proportions.

*Note: Each question in a composite is weighted equally, regardless of how many members respond.*