

Office of the Patient Advocate
California Health Care Quality Report Cards 2013 Edition
Scoring Documentation for Consumer Reporting
HMO CAHPS® Reporting Year 2012

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 Cards every year. The current version (2013 Edition) of the online Health Care Quality Report Cards is at: www.opa.ca.gov.

Performance results are reported at a health plan reporting unit level. Ten (10) participating health plans report HMO 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.
Kaiser Foundation Health Plan of Northern California, Inc.
Kaiser Foundation Health Plan of Southern California, Inc.
United Healthcare of California, Inc.
Western Health Advantage
Sharp Health Plan

Sources of Data for California Health Care Quality Report Cards

The 2013 Edition of the Report Cards is published in March 2013, using data reported by HMO plans in Reporting Year (RY) 2012 for performance in Measurement Year (MY) 2011. Data sources are the National Committee for Quality Assurance's (NCQA) 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 2012.

NCQA develops, maintains and reports the HEDIS performance measures as the national standard set of health plan clinical process and outcomes measures. The Integrated Healthcare Association (IHA) collects and provides medical group HEDIS and other clinical performance data. Pacific Business Group on Health (PBGH) maintains and collects the medical group Patient Assessment Survey (PAS) data and provides these data to OPA. 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 and reports 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®2012 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2012 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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Star ratings are based upon composite rates calculated across groups of measures. Measures are organized into topics and composites. Not all measures that are eligible for reporting are included in the summary performance indicator and topic star calculations. See Appendix A.

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. **Stand Alone CAHPS Measures:** The twelve eligible measures consist of the CAHPS* 4.0H commercial measures for reporting year 2012, reported by National Committee for Quality Assurance (NCQA).

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

Performance Grading

HMOs are graded on performance relative to the nation for CAHPS for “Patients Rate Their Experience” for HMOs. 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:

Performance grading is based on the NCQA RY 2011 Quality Compass® All Lines of Business (Health Maintenance Organization-HMO, Point of Service-POS and Preferred Provider Organization-PPO) benchmarks. Quality Compass RY 2012 values are used to set performance cutpoints for new or revised measures.

1. Summary Performance Indicator Scoring

Three summary performance indicator results are reported: 1) Patients Rate Their HMO (“Rate Their HMO”), 2) “Getting Care Easily” and 3) “HMO Helps Members Get Answers”.

- a) The “Rate Their HMO” 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 “Getting Care Easily” indicator is an aggregation of two composites: 1) “Getting Doctors and Care Easily” and 2) “Getting Appointments and Care Quickly”.

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- c) The respondents included in the “HMO Helps Members Get Answers” indicator are members of the survey sample who contacted their plan. The “HMO Helps Members Get Answers” indicator is an aggregation of three composites:
 - “Plan Customer Service”
 - “Paying Claims”
 - “Plan Information on What You Pay”
- d) See Appendix B for a detailed description of the composite results scoring method.
- e) The summary indicators, “Getting Care Easily” and “HMO Helps Members Get Answers”, 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 2012 – the MY 2010 and MY 2011 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 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. Handling Missing Data

- a) 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 will be replaced using this adjusted half-scale rule for all measures in the topic. Because eligibility for missing value re-assignment (imputation) is assessed

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independently at the summary indicator level, it is possible to have a summary indicator score even if topic scores are missing.

- b) For performance summary indicator star rating levels, a missing value is NOT applicable for health plans. All the plans are assigned stars for all levels.

4. Changes from 2012 Edition Report Card to 2013 Edition Report Card

- a) The “Doctors Advising Smokers to Quit” measure is included in the “Treating Adults” HEDIS composite – it is not included in CAHPS scoring and reporting.
- b) The summary performance indicator label “Patients Rate Their Experience” was previously called “Member Ratings Compared to Plans Nationwide”.
- c) The summary performance indicator label “HMO Helps Members Get Answers” was previously called “Plan Service”.
- d) The definition of “HMO Helps Members Get Answers” was revised to: “Members who contacted their plan rate the customer service and whether they got accurate information on plan costs and claims payment during 2010 and 2011.”

5. 2013 Edition Report Card Notes

- a) The Call Answer Timeliness measure is reported as a stand-alone measure within the “Customer Service” topic for the CAHPS member experience results.
- b) An individual plan result will not be reported for an individual composite or item if the NCQA CAHPS standard of requiring a minimum 100 respondents per question is not achieved. For these missing scores the phrase “Too few members in sample to report” is displayed.
- c) Per the NCQA 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.
- d) The following measures are a 2-year rolling average. The responses for the numerator across two years are summed and divided by the responses for the denominator across two years to create a 2- year rolling average.
 - “Plan Customer Service”
 - “Paying Claims”
 - “Plan Information on What You Pay”

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6. Calculate Percentiles

- a) One of four grades is assigned to each of the 3 summary performance indicators using Table 1 cutpoints. Three cutpoints are used to calculate the performance grades. Cutpoints were calculated per the RY 2011 NCQA Quality Compass nationwide results for all plans (Health Maintenance Organizations-HMO, Point of Service-POS and Preferred Provider Organizations-PPO).
- b) 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 summary performance indicator.

7. From Percentiles to Stars

- a) Health plan performance in MY 2011 is graded against score thresholds derived from MY 2010 (RY 2011) data. There are three thresholds corresponding to 4 star rating assignments. If a summary performance indicator composite rate meets or exceeds the “Excellent” thresholds, the plan is assigned a rating of four stars. If a summary performance indicator composite rate meets or exceeds the “Good” threshold (but is less than the “Excellent” 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 3 summary performance indicator topics listed in Table 1:

Top cutpoint: 90th percentile nationwide
Middle cutpoint: 50th percentile nationwide
Low cutpoint: 25th percentile nationwide

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Table 1. HMO CAHPS Performance Cutpoints for Grade Assignment 2013 Edition Report Card

<i>Topic</i>	<i>Number of Measures Included</i>	<i>Excellent Cutpoint</i>	<i>Good Cutpoint</i>	<i>Fair Cutpoint</i>	<i>Poor Cutpoint</i>
HMO Helps Members Get Answers	6	88	83	79	< 79
Getting Care Easily	4	91	87	84	< 84
Rate Their HMO	1	75	61	56	< 56

*Scores below the Fair cutpoint are graded "Poor"

- c) 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, an HMO Helps Members Get Answers score of 79.5 would be assigned a grade of Fair; a score of 78.4, 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 Summary Indicators

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	
HMO Helps Members Get Answers	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 HMO	Global Plan	What number would you use to rate your health plan? (0-10)	42	√ Star Rating only

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Appendix A

Mapping of CAHPS measures to Performance Topics

Stand Alone Measures	Composite or Topic	Definition	Question #	Reported as Stand Alone Measure	
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	√	
	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	√

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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.