Office of the Patient Advocate (OPA)
California Health Care Quality Medical Group Report Card for Medicare Advantage Members, 2021-22 Edition

Scoring Documentation for Public Reporting on Clinical Care (Reporting Year 2021)

Background

Representing the interests of health plan and medical groups, 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 to include ratings for HMO health plans, PPO health plans, commercial HMO Medical Groups, and medical groups serving Medicare Advantage members. The current version (2021-22 Edition) of the online Health Care Quality Report Cards is available at: www.opa.ca.gov.

Of the 169 physician organizations that participate in the Integrated Healthcare Association's (IHA) Align. Measure. Perform. (AMP) Medicare Advantage program, performance results are posted for those organizations that meet the minimum data reporting requirement. IHA is a multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care. IHA collects clinical quality data on the physician organizations that contract with Medicare Advantage health plans 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 2021-22 Edition of the Medical Group Report Card for Medicare Advantage members is published Spring 2022, using data reported in Reporting Year (RY) 2021 for performance in Measurement Year (MY) 2020. The data source is emboldened below:

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 IHA AMP Commercial HMO program's medical group clinical performance data (Methodology Description in a separate document).
3. **The IHA AMP Medicare Advantage program's medical group clinical performance data.**

4. The Purchaser Business Group on Health (PBGH) Patient Assessment Survey's (PAS) commercial patient experience data for medical groups (Methodology Description in a separate document).

Medical Group - Medicare Advantage Clinical Care 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, by using IHA's Technical Measurement Committee (TMC) as the primary advisory body regarding methodologies for the Health Plan and Medical Group Report Cards. The TMC is comprised of representatives from health plans, medical groups, and health care purchaser organizations, and are well-versed in issues of healthcare quality and patient experience measurement, data collection and public reporting.

TMC Roster (2021)

Chair: Christine Castano, MD, Optum
Alyson Spencer, Blue Shield of California Promise Health Plan
Cheryl Damberg, PhD, RAND
Chris Jioras, Humboldt IPA
Dave Schweppe, Kaiser Foundation Health Plan
Edward Yu, MD, Sutter Palo Alto Medical Foundation
Eric Garthwaite, Health Net
Kenneth Phenow, MD, Cigna
Leticia Schumann, Anthem
Marnie Baker, MD, MPH, MemorialCare Medical Group
Pegah Mehdizadeh, DO, Aetna
Rachel Brodie, Purchaser Business Group on Health
Ralph Vogel, PhD, Southern California Permanente Medical Group
Ranyan Lu, PhD, UnitedHealthcare
Sherilyn Wheaton, MD, Primary Medical
Tory Robinson, Blue Shield of California
Alice Gunderson, PFCC Partners, Patient Advisor Network
Ting Pun, PFCC Partners, Patient Advisor Network

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

The Medical Group Report Card for Medicare Advantage Members methodology is based on the methodology that the Centers for Medicare & Medicaid Services (CMS) uses to rate Medicare Advantage health plans, for a subset of the measures used for Medicare Advantage health plan rating and is developed by IHA staff in conjunction with feedback from the TMC.

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 discovered, it is corrected prior to the public release of the OPA Report Cards.

Medical Group - Medicare Advantage Clinical Care Scoring Methodology

There are two levels of measurement:

1. **Clinical Measures:** There are twelve (12) clinical measures reported by IHA. Eight of these are HEDIS measures, and four are Pharmacy Quality Alliance (PQA) measures. They are reported as both a percentage of eligible patients getting the recommended care and as a Medicare Advantage Star rating.

2. **Category:** "Quality of Medical Care" is an aggregated clinical summary performance score composed of all twelve (12) clinical measures collected by IHA and reported as a Medicare overall star rating.

Performance Grading

1. Scoring Calculation for Clinical Care Category Composite

Performance on the twelve (12) clinical measures is combined to calculate a Medicare Advantage medical group overall star rating. Medical groups that have reportable scores for at least half of the measures qualify for an overall star rating. The score is calculated by taking a weighted average of the individual measure level star ratings that are available for a medical group. Intermediate outcome measures (e.g., Controlling Blood Sugar for Diabetes Patients) are given a weight of three times as much as process measures (e.g., Colorectal Cancer Screening), per CMS' Star Ratings methodology for health plans and as shown in Table 1. The weighted average of the available individual measure star ratings is rounded to the nearest half star for the overall scoring. Note that some medical groups may not have enough individual measure results to calculate an overall star rating.

Table 1: Measure Weights for Individual Clinical Care Measure Star Ratings

Medicare Advantage Report Card Measures	Measure Type	Measure Weight
Breast Cancer Screening	Process	1
Colorectal Cancer Screening	Process	1
Controlling Blood Sugar for Diabetes Patients	Intermediate Outcome	3
Testing Kidney Function for Diabetes Patients	Process	1
Eye Exam for Diabetes Patients	Process	1
Number of Days Diabetes Medication Was Filled	Intermediate Outcome	3
Prescribing Statins to People with Diabetes	Intermediate Outcome	3
Treating Arthritis with Medications	Process	1
Managing Osteoporosis in Women after a Fracture	Process	1
Number of Days High Blood Pressure Medications Were Filled	Intermediate Outcome	3
Number of Days High Cholesterol Medications Were Filled	Intermediate Outcome	3
Prescribing Statins for People with Heart Disease	Process	1

2. Individual Clinical Care Measure Scoring

The medical group Medicare Advantage clinical care ratings include twelve (12) measures, which are collected from participating health plans and from self-reporting medical groups. They are a subset of the Medicare Advantage Stars measures that Medicare Advantage health plans report to the Centers for Medicare and Medicaid Services (CMS). Results are audited to ensure accuracy and consistency across groups. The rates for Medicare Advantage Stars clinical care measures are calculated for all members who are eligible based on their age, gender and/or a particular health condition they have. For example, the measure Eye Exam for Diabetes Patients looks at all Medicare Advantage members aged 18 to 75 who have a diagnosis of diabetes. The score reported is the percent of these members whose records indicate that they obtained at least one eye exam to check for damage that can lead to eye problems, like blindness, during the year being measured. The measures are based on the services provided to Medicare Advantage members who were patients of the medical group during the measurement year.

The rates for a clinical care measure are then assigned ratings from one to five stars, with five stars representing the highest quality. The star ratings used are the same as cut-points determined by CMS to rate Medicare Advantage health plans, which are displayed in Table 2.

Table 2: Clinical Care Performance Cut-points for the Medical Group Medicare Advantage Report Card

Clinical Care Medicare Advantage Stars Measure	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
Breast Cancer Screening	< 42%	≥ 42% to < 61%	≥ 61% to < 69%	≥ 69% to < 76%	≥ 76%
Colorectal Cancer Screening	< 49%	≥ 49% to < 62%	≥ 62% to < 71%	≥ 71% to < 80%	≥ 80%
Controlling Blood Sugar for Diabetes Patients*	< 41%	≥ 41% to < 60%	≥ 60% to < 72%	≥ 72% to < 81%	≥ 81%
Testing Kidney Function for Diabetes Patients	<82%	≥ 82% to < 88%	≥ 88% to < 94%	≥ 94% to < 97%	≥ 97%
Eye Exam for Diabetes Patients	< 52%	≥ 52% to < 62%	≥ 62% to < 71%	≥ 71% to < 79%	≥ 79%
Number of Days Diabetes Medication Was Filled	< 80%	≥ 80% to < 85%	≥ 85% to < 87%	≥ 87% to < 91%	≥ 91%
Prescribing Statins to People with Diabetes	< 76%	≥ 76% to < 80%	≥ 80% to < 84%	≥ 84% to < 88%	≥ 88%
Treating Arthritis with Medications	< 68%	≥ 68% to < 75%	≥ 75% to < 79%	≥ 79% to < 85%	≥ 85%
Managing Osteoporosis in Women after a Fracture	< 27%	≥ 27% to < 40%	≥ 40% to < 50%	≥ 50% to < 68%	≥ 68%
Number of Days High Blood Pressure Medications Were Filled	< 74%	≥ 74% to < 82%	≥ 82% to < 87%	≥ 87% to < 90%	≥ 90%
Number of Days High Cholesterol Medications Were Filled	< 78%	≥ 78% to < 83%	≥ 83% to < 87%	≥ 87% to < 91%	≥ 91%
Prescribing Statins to People with Heart Disease	< 76%	≥ 76% to < 81%	≥ 81% to < 84%	≥ 84% to < 89%	≥ 89%

* Results for the “Controlling Blood Sugar for Diabetes Patients” measure are typically reported as a lower is better measure but have been inverted such that a higher rate reflects a better outcome.

3. **Rounding Rule**
   Measure scores are rounded using standard rounding to nearest rules prior to cut point analysis. Measure scores that end in 0.49 (0.049, 0.0049) or less are rounded down and measure scores that end in 0.50 (0.050, 0.0050) or more are rounded up. For example, a measure that has a value of 83.49 rounds down to 83, while a value of 83.50 rounds up to 84.

4. **Handling Missing Data**
   Not all medical groups are able to report valid rates for all measures. Medical groups with fewer than half of the reportable individual measures are not assigned an overall star rating and have "Not enough data to score reliably" as the designation for the overall Quality of Medical Care star rating. The "Not enough data to score reliably" designation is also used for individual clinical care measures for which a medical group does not have at least 30 members who meet the requirements for inclusion in the measure.

5. **Attribution of Patients to Medical Groups**
   In IHA's AMP Medicare Advantage program, patients are attributed to a medical group in 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.

6. **Explanation for Missing Results**
   "Not Enough Data to Score Reliably" indicates that the medical group score is not reported for the following reason:
   - **Reliability of Results** - IHA's AMP Medicare Advantage program considers measurement error and reliability. The clinical care measures use administrative data based on the universe of a medical group's patients. There is no sampling. Because statistical errors can result from small numbers, the program requires a total eligible population of 30 or more for a particular measure. In addition, the program excludes any measure with a bias of five percent or more, as determined by the auditor.

7. **Risk Adjustment**

IHA's AMP Medicare Advantage program's clinical care measures, which include HEDIS measures, are not risk adjusted for patient characteristics or socioeconomic status as is the protocol for CMS' Medicare Advantage Star Rating System. As the measure developer for HEDIS measures used in the Stars Rating System, 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.

8. Changes from the 2020-21 Edition Medical Group Report Card for Medicare Advantage Members

- The Centers for Medicare and Medicaid Services (CMS)' Medicare Advantage Star Rating System has retired Adult BMI Assessment (ABA) in MY 2020. Additionally, *Adult BMI Assessment (ABA)* has been retired from the MY 2020 AMP Measure Set for Medicare Advantage members, and thus will not be publicly reported. OPA has historically displayed this measure as Checking if Weight Could Cause Health Problems.

Appendix A. Mapping of Medical Group Clinical Measures to OPA Measure Name

IHA Measure ID	AMP Measure (measure steward)	Medicare Advantage Stars Measure Name	OPA Measure Name	Definition
BCS5274	Breast Cancer Screening (NCQA)	Breast Cancer Screening	Breast Cancer Screening	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
COL	Colorectal Cancer Screening (NCQA)	Colorectal Cancer Screening	Colorectal Cancer Screening	The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.
HBACON	Diabetes Care: Hemoglobin A1c Control > 9.0% (NCQA)	Diabetes Care—Blood Sugar Controlled	Controlling Blood Sugar for Diabetes Patients	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c test during the measurement year is >9.0%. Rates are inverted for the OPA Report Card such that a higher rate represents better performance.
NEPHSCR	Diabetes Care: Medical Attention for Nephropathy (NCQA)	Diabetes Care—Kidney Disease Monitoring	Testing Kidney Function for Diabetes Patients	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who were tested for adequate kidney function during the measure year.
CDCE	Diabetes Care: Eye Exam (NCQA)	Diabetes Care—Eye Exam	Eye Exam for Diabetes Patients	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed during the measurement year.
PDCD	Proportion of Days Covered by Medications—Oral Diabetes (PQA)	Medication Adherence for Oral Diabetes Medications	Number of Days Diabetes Medication Was Filled	The percentage of members 18 years of age and older who had enough medication to cover at least 80% of the days in the measurement period.
SUPD	Statin Use in Persons with Diabetes (PQA)	Statin Use in Persons with Diabetes	Prescribing Statins to People with Diabetes	The percentage of patients ages 40 to 75 years who were dispensed a medication for diabetes that receive a statin medication.

IHA Measure ID	AMP Measure (measure steward)	Medicare Stars Measure Name	OPA Measure Name	Definition
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (NCQA)	Rheumatoid Arthritis Management	Treating Arthritis with Medications	The percentage of Medicare members who were diagnosed with rheumatoid arthritis and who were dispensed at least one prescription for a disease modifying anti-rheumatic drug (DMARD).
OMW	Osteoporosis Management in Women Who Had a Fracture (NCQA)	Osteoporosis Management in Women Who Had a Fracture	Managing Osteoporosis in Women After a Fracture	The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.
PDCA	Proportion of Days Covered by Medications—Renin Angiotensin System (RAS) Antagonists (PQA)	Medication Adherence for Hypertension (RAS Antagonists)	Number of Days High Blood Pressure Medications Were Filled	The percentage of members 18 years of age and older who had enough medication to cover at least 80% of the days in the measurement period.
PDCS	Proportion of Days Covered by Medications—Statins (PQA)	Medication Adherence for Cholesterol (Statins)	Number of Days High Cholesterol Medications Were Filled	The percentage of members 18 years of age and older who had enough medication to cover at least 80% of the days in the measurement period.
SPC1	Statin Therapy for Patients with Cardiovascular Disease (NCQA)	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.