Office of the Patient Advocate
California Health Care Quality Report Card – 2012 Edition
Medical Groups HEDIS® 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.

Performance reports are reported for 212 physician organizations that participate in the Integrated Healthcare Association (IHA) Pay for Performance initiative (P4P) (see details on this initiative at: http://www.iha.org/pay_performance.html). IHA is a statewide 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 P4P 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.

The 2012 Edition of the Report Card is published in February 2012, using data reported by medical groups 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) commercial measures and the medical group Patient Assessment Survey (PAS) data for RY 2011, also collected by CCHRI.

CCHRI is a nonprofit collaborative of health care purchasers, plans and providers that collects HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan quality data, as well as the medical group 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 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. IHA developed and sponsors the PAS.

Scoring Methodology

There are three levels of measurement:

1. **Category**: Meeting National Standards of Care is the aggregated All-HEDIS summary performance score composed of seventeen (17) HEDIS or similar to HEDIS commercial measures.

2. **Topic**: There are six condition topic areas composed of groupings of seventeen (17) clinical measures.

3. **Clinical Measures**: There are twenty (20) clinical measures reported by CCHRI. Most, but not all, are HEDIS measures. Three of these are stand alone clinical measures. See Appendix A for mapping of clinical measures to Topic and Categories.

The eligible measures consist of the IHA P4P publicly reported physician organization (medical group) clinical domain measures for Reporting Year 2011. A measure must have a denominator of 30 or more patients to be publicly reportable. Based on relative performance, plans are assigned star ratings for multi-level composites (category and topic). See Appendix A for mapping of clinical measures to Topics and Categories.

Performance grading

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

1. **Composite Calculation for Category and Topic Scoring**

   Seventeen (17) measures are aggregated to create the summary performance score. The summary scoring process is a two-step method:

   a) **In Step 1,** calculate topic level composite: Measures are organized into each of 6 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. With the exception of outlier results which are excluded from the dataset, the scores for all reporting groups are used to calculate topic and summary scores. Valid results for non-reporting groups are included.

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

b) **In Step 2,** calculate the category level composite: Calculate the mean of the 6 condition topic means. Each of the 6 condition topic means is differentially weighted based on the number of measures that comprise a topic (e.g., a topic comprised of 4 measures is weighted twice the value of a topic comprised of 2 measures). For each topic, the weight is calculated by determining the proportion of the seventeen (17) total measure counts.

The medical group must have reportable results for at least half of the measures to be eligible for the summary performance score.

A medical group's overall summary performance score is rounded to the tenths decimal and the performance grade is assigned per the cutpoints and the buffer zone adjustment factor (see pg. 6).

2. Individual Measure Scoring

The individual measure scores are calculated as proportional rates using the numerators and denominators that are reported per the P4P measurement requirements.* The measure results are converted to a score using the following formula:

(Measure numerator/Measure denominator)*100

An adjusted half-scale rule is applied. A two-part rule is applied to each medical group that has one or more missing measures:

a) A medical group is eligible for a summary performance score if it has a minimum of half (50%) of the eligible measures – in RY 2011, given the set of 17 measures, the rule is a minimum of eight (8) measures. A minimum number of reportable topics are not required; rather the summary performance score eligibility is tied to a minimum number of measures.

To calculate condition topic scores, for any medical group that has missing data for a given condition topic, we apply an adjusted half-scale rule formed by subtracting the all-group mean of each measure from the group's mean for that measure, averaging the differences, and adding the average difference to the all-item grand mean. The all-item grand mean is constructed by calculating the mean of all eligible measures' means and NOT by calculating a mean from all of the individual measure results. See Appendix C for an example of the adjusted half-scale rule.

*See the IHA California Pay for Performance Measurement Year 2011 P4P Manual for measure specifications.

Per Appendix B, Controlling Blood Pressure for Diabetes Patients is the single measure for which an outlier rule is used. Scores below 35% are designated as an extreme outlier and are excluded from the scoring given the premise that the scores represent deficient information systems and not true performance. This measure is not reportable for 101 medical groups due to its outlier status. Groups with scores of zero (0) are labeled as "Not willing to report" and scores of 0.1-34.9 are labeled as "No report due to incomplete data."

3. Changes from 2011 Edition Report Card to 2012 Edition Report Card and Notes

a) Two medical group measures are publicly reported for the first time: Controlling Blood Pressure for Diabetes Patients and Immunizations for Adolescents.

b) Replace the Childhood Immunizations measure [unweighted average of the measles, mumps and rubella (MMR) and the chicken pox (VZV) antigen scores] with the Childhood Immunizations "all antigens" measure.

c) Replace the Asthma Medications measure with the Asthma Medications Ratio measure.

d) Limit the outlier exclusion rule to the Controlling Blood Pressure for Diabetes Patients only; no outlier thresholds will be applied to the other measures.

e) The Optimal Diabetes Care measure used by P4P is not included in the reportable measures set.

f) The Controlling Blood Sugar for Diabetes Patients is reverse-scored (100 - score) for public reporting (e.g., higher is better).

g) A single Diabetes Blood Sugar Control measure, HbA1c Control (<8.0%), is reported.

h) The Diabetes HbA1c Poor Control (>9.0%) and the Diabetes HbA1c Control (<7%) for a Selected Population measures are <u>not</u> reported.

i) The Chlamydia Screening All Ages measure is the sum of the respective age cohort numerators and denominators.

j) Three measures are reported as stand alone measures and are not included in the 6 condition topic scores or in the overall summary performance score: 1) Low Back Pain Care, 2) Antibiotic Treatment for Acute Bronchitis and 3) Monitoring for Persistent Medications.

4. Calculate Percentiles

Each medical group is assigned one of four grades to each of the 6 condition topics and to its overall summary performance result using the Table 1 cutpoints.

The performance thresholds that are used in defining the grade spans are listed in Table 1 below. These cutpoints are based on the distribution of the RY 2008 scores for all of the reporting medical groups: the "excellent" cutpoint is set at the 90th percentile score; the "good" cutpoint set at the 50th percentile score and the "fair" cutpoint set at the 25th percentile score. Scores below the 25th percentile are graded "poor".

The topic cutpoints for Treating Children, Diabetes Care and Asthma Care have been adjusted for RY 2011 given the measure changes for each of these topics. In turn, the All HEDIS summary performance cutpoints are revised to reflect changes to the cutpoints for these three underlying topics.

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 3 cutpoints for that topic.

5. From percentiles to stars

The grade spans vary for each of the 6 condition topics listed in Table 1:

Top cutpoint:	90th percentile California reporting medical groups
Middle cutpoint:	50th percentile California reporting medical groups
Low cutpoint:	25th percentile California reporting medical groups

Table 1: Medical Group Clinical Performance Cutpoints RY 2011

Condition Topics	Number of Measures Included	Excellent Cutpoint	Good Cutpoint	Fair Cutpoint	Poor* Cutpoint
Checking for Cancer	3	71	49	41	<41
Chlamydia Screening	1	66	48	38	<38
Treating Children	4	85	64	45	<45
Asthma Care	1	77	68	62	<62
Diabetes Care	6	79	68	56	<56
Heart Care	2	83	76	69	<69
All HEDIS Summary Performance	17	79	64	52	<52

*Scores below the Fair cutpoint are graded "Poor"

Special scoring is used for the Children's Physician Medical Group – an all-pediatric group. This group reports 5 measures: asthma, Chlamydia screening, child immunizations, children with upper respiratory infection and children with pharyngitis. The group's summary indicator is comprised of these 5 measures. Correspondingly, the performance cutpoints for the group are based on these 5 measures and the RY 2011 cutpoints are 80, 62, and 46 for the 90th, 50th and 25th percentiles respectively.

Buffer Zone

We apply a 0.5 point buffer below each of the 3 performance cutpoints – any medical group summary performance score that falls within the buffer zone is assigned the grade in the next highest category. For example, using a cutpoint of 79, a group whose score is 78.5 would be graded "excellent." A score of 78.4, which is outside of the buffer zone, would be assigned a grade of "good."

Legends to Explain Missing Scores

Three categories are used to explain instances in which a medical group measure is not reported:

1. **No Report Due to Incomplete Data**.
    a. **Coded as 6666**. Medical group's score is not reported because the score is ruled an outlier given its extreme difference from the all-medical groups' mean score. For RY 2011, the outlier rule applies to a single measure: Controlling Blood Pressure for Diabetes Patients. Groups with scores of zero (0) are labeled as "Not willing to report"

and scores of 0.1-34.9 are labeled as "No report due to incomplete data" on the OPA website.

b. **Coded as 9999**. Medical group's score is not reported if the group's encounter rate does not meet the IHA threshold encounter rate. The P4P clinical measures rely on an encounter rate threshold to ensure that health plans have the minimal level of data completeness for medical groups. This is reported as "No report due to incomplete data" on the OPA website.

2. Too Few Patients to Report.

a. Coded as 8888. Medical group score is not reported because the measure's denominator has fewer than 30 patients. This is reported as "Too few patients to report" on the OPA website.

3. Not Willing to Report.

a. Coded as 7777. Medical group declined to report its results. This is reported as "Not willing to report" on the OPA website.

Appendix A

Table A. Topics and Weights

Topic	Measure	Weight
Asthma Care	Medications for People with Asthma (AMROV)	**1**
Checking for Cancer	Cervical Cancer Screening (Appropriately Screened Women) (ECSASOV)	**3**
	Breast Cancer Screening (BCSOV)	
	Colorectal Cancer Screening (COL)	
Chlamydia	Chlamydia Screening in Women (CHLAMSCR)	**1**
Diabetes Care	HbA1c Testing (HBASCR)	**6**
	HbA1c Control (<8.0%) (HBAC8)	
	LDL Screening (LDLSCR)	
	LDL Control <100 (LDL100)	
	Nephropathy Monitoring (NEPHSCR)	
	Blood Pressure Control for Diabetes Patients<140/90 (CBPD4)	
Heart Care	LDL Screening for Patients with Cardiovascular Conditions (CMCSCR)	**2**
	LDL Control <100 for Patients with Cardiovascular Conditions (CMC100)	
Treating Children	Childhood Immunization (CISCOMBO)	**4**
	Adolescent Immunizations (IMACOMBO)	
	Appropriate Testing for Children with Pharyngitis (CWP)	
	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	

Appendix B

Handling of Extreme Low Outliers

Measures with extreme low outlier scores shall be removed from a medical group's eligible measures set to calculate the summary indicator. These extreme low outliers shall be treated as missing values and the adjusted half-scale rule is applied. For RY 2011, an outlier exception rule is applied to a single measure:

Table B. Outliers

Measures	Measure ID	RY2011 Outlier Status
Controlling Blood Pressure for Diabetes Patients	CBPD4	<35 %

Appendix C

Adjusted Half Scale Rule Example

The adjusted half-scale rule calculates the mean of those items present, provided – as in this example – it is at least 2 of the 3 measures. That is, at least half of the scale needs to be present. The following example illustrates how the rule is applied:

Table C. Example of Half-Scale Rule

	Group 1	Group 2	All-Group Mean
Measure 1	77	73	75
Measure 2	49	41	45
Measure 3	Missing	81	85
Total Mean	63	65	68.3 = all item grand mean
Adjusted Half-Scale Rule Applied	71.3	65*	

*Rule is not applied to groups with no missing data

Without the adjusted half-scale rule, we have a score for Group 1 for 2 of 3 cases, so we calculate the mean of those, which is 63. Group 2 has all of the measurements and its mean score is 65. However, the evidence strongly suggests Group 1 may be doing a better job because it has higher scores than Group 2 in the two measurements that we have for both groups.

We can fix this problem by using an adjustment. We subtract the all-group mean from each measure first, and then average; and then add the average difference to the all item grand mean:

Group 1: Score = [(77-75) + (49-45)]/2 + Mean of (75,45,85) = 3 + 68.3 = 71.3.

Group 2: Score = [(73-75) + (41-45) + (81-85)]/3 + Mean of (75,45,85) = -3.3+68.3 = 65

The rule that comes from this adjustment is the adjusted half-scale rule.