Center for Data Insights and Innovation (CDII) California Health Care Quality Medical Group - Commercial Report Card, 2024-25 Edition

Scoring Documentation for Public Reporting on Clinical Care (Reporting Year 2024)

Background

Representing the interests of health plan and medical group members, the California Center for Data Insights and Innovation (CDII) publicly reports on health care quality. CDII's predecessor, the Office of the Patient Advocate (OPA), published the first HMO Health Care Quality Report Card in 2001. The Report Cards have since been annually updated, enhanced and expanded to address a variety of ratings for HMOs, PPOs and Medical Groups. The current version (2024-25 Edition) of the online Health Care Quality Report Cards is available through https://www.cdii.ca.gov/consumer-reports/.

The Integrated Healthcare Association (IHA) reports performance results for 204 provider organizations that participate in its Align. Measure. Perform. (AMP) Commercial HMO program. IHA is a multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care. IHA collects quality data on the provider organizations that contract with commercial HMOs for AMP and provides the data to CDII for the Health Care Quality Report Card. The IHA provider 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 2024-25 Edition of the Medical Group Commercial Report Card is published in Spring 2025, using data reported in Reporting Year (RY) 2024, for performance in Measurement Year (MY) 2023. The data source for the clinical rating and measures addressed in this document is:

- The IHA AMP Commercial HMO program's medical group clinical performance data.

The Medical Group Report Card also relies on additional data sources for patient experience and Total Cost of Care data (methodology descriptions in separate documents):

1. The IHA AMP Commercial HMO program's medical group total cost of care data, called Total Cost of Care.

2. The Purchaser Business Group on Health (PBGH) Patient Assessment Survey's (PAS) patient experience data for medical groups.

The Medicare Advantage Medical Group Report Card is based on the IHA AMP Medicare Advantage program's medical group clinical performance data (Methodology description in a separate document).

1. Methodology Decision Making Process

CDII conducts a multi-stakeholder process to determine the best scoring methodology for capturing patient experience appropriately and accurately. Through OPA and now CDII's partnership with IHA's AMP programs, IHA's Technical Measurement Committee (TMC) serves as an advisory body for the Medical Group Report Cards clinical data, and the TMC provides insight and thought partnership on the Health Plan Report Cards. The TMC reviews industry changes, the AMP proposed measure set, and recommendations for public reporting options. 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.

TMC Roster (2024)

Chair: Edward Yu, MD, *Sutter Palo Alto Medical Foundation*

Alyson Spencer, *Blue Shield of California Promise Health Plan*
Andy Dang, MD, *Sharp Rees-Stealy Medical Group*
Bihu Sandhir, MD, *AltaMed*
Cheryl Damberg, PhD, *RAND*
Eric Garthwaite, *Health Net*
Kenneth Phenow, MD, *Cigna*
Kristina Petsas, MD, *UnitedHealthcare*
Marnie Baker, MD, MPH, *MemorialCare Medical Group*
Pegah Mehdizadeh, DO*, Aetna*
Peter Robertson, MPA, *Purchaser Business Group on Health*
Rachel Brodie, *CalPERS*
Ralph Vogel, PhD, *Permanente Medical Groups*
Sara Frampton, *Kaiser Permanente*
Sherilyn Wheaton, MD, *Primary Medical*
Swati Awsare, MD, *Anthem*
Ting Pun, *PFCC Partners, Patient Advisor Network*
Tory Robinson, *Blue Shield of California*

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

Additionally, CDII 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 CDIIReportCard@ncqa.org.

2. Stakeholder Preview and Corrections Period

Each year, prior to the public release of the CDII 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 CDII 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 CDII Report Cards.

Medical Group - Commercial Report Card Clinical Scoring Methodology

There are three levels of measurement:

1. **Clinical Measures**: There are 18 clinical measures reported by IHA. Most, but not all, are HEDIS measures.
2. **Topic**: A majority of the 18 total measures are grouped into six condition topic areas.
3. **Category**: “Quality of Medical Care” is one aggregated all-clinical category performance score composed of 16 HEDIS or non-HEDIS performance measures. *All-Cause Readmissions* and *Concurrent Use of Opioids and Benzodiazepines* are not included in the category composite.

See Appendix A for mapping of clinical measures to category and topics.

Performance Grading

Medical groups are graded on performance relative to other medical groups for “Quality of Medical Care”. All of the performance results are expressed such that a higher score means better performance. Sixteen clinical measures are aggregated to create the All-Clinical category performance score: “Quality of Medical Care.” Based on relative performance, groups are assigned star ratings for multi-level composites (category and topics).

For the 2024-25 Edition Medical Group Report Card, RY 2024 (MY 2023) values from medical groups statewide are used to set performance cutpoints for the clinical measures.

1. Composite Calculation for Category and Topic Scoring

Sixteen measures are aggregated to create the category performance score at both the category and topic levels. The scoring process involves the following calculations:

a. **To calculate the category level composite, "Quality of Medical Care":** We calculate the mean of all individual measure scores. Each of the 16 measures are equally weighted. The medical group must have reportable results for at least half of the measures to be eligible for the category performance score.

   A medical group's overall category performance score is first rounded to the 100th decimal point, and then rounded to the 10th decimal point, before adding a 0.5 point buffer to the rounded mean score. This sum (rounded mean + 0.5) is used to assign the star rating performance grade (see section 8).

   For any medical group that has missing data for one or more measures, an adjusted half-scale rule is applied to adjust for the missing values – this rule is described below (see section 3).

b. **To calculate the topic level composites:** Measures are organized into each of six condition topics. A composite score is calculated for each topic by calculating the mean of all individual topic measure scores. The measures are equally weighted within each of the six condition topics. The resulting rate is first rounded to the 100th decimal point, and then rounded to the 10th decimal point, before adding a 0.5 point buffer to the rounded mean score. This sum (rounded mean + 0.5) is used to assign the star rating performance grade (see section 8).

   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 (see section 3).

2. Individual Measure Scoring

a. The individual clinical measure scores are calculated as proportional rates using the numerators and denominators that are reported per IHA measurement requirements. Measures are dropped from star rating calculations and benchmarks if at least 50% of groups cannot report a valid rate. Rates are reported for all groups with valid rates, regardless of

whether a particular measure has been dropped from a star rating calculation due to less than 50% of California groups having a valid rate.

b. The measure results are converted to a score using the following formula: (Measure numerator/Measure denominator) * 100

3. Handling Missing Data

Not all medical groups are able to report valid rates for all measures. Data may be missing because the denominator size for a particular measure may not be large enough for the medical group, or the measure is unable to be rated. In order to calculate category and topic star ratings for as many medical groups as possible, we impute missing data under specific conditions using an adjusted half-scale rule. This is accomplished by developing an actual measure-level imputed result for medical groups with missing data and using those results for star calculations. Imputed results are not reported as individual rates. If a medical group is able to report valid rates for at least half of its measures in a composite, then missing values are replaced using an adjusted half-scale rule for all measures in a composite. Because eligibility for missing value imputation is assessed independently at the topic and category levels, it is possible to have a category score even if measure or topic scores are missing.

Legends to Explain Missing Scores

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

- **Not Enough Data to Score Reliably.** Medical group score is not reported because the measure's denominator has fewer than 30 patients and/or the medical group didn't have enough data to score reliably.
- **Not Rated.** Measure is undefined, has a biased rate, or is not reported for the medical group.

4. Risk Adjustment

The clinical care measures used in IHA's AMP Commercial HMO program, which include HEDIS measures, are not risk adjusted for patient characteristics or socioeconomic status. NCQA is the measure developer for HEDIS measures used in AMP Commercial HMO. 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. The one exception is the Preventing Hospital Readmission After Discharge measure, which does include risk-adjustment methodology developed by NCQA.

For AMP Commercial HMO, the results for this measure (numerator, denominator, rates, probability, variance) are generated by IHA's data partner,

Onpoint Health Data, using health plan member level data that was submitted to Onpoint. Onpoint uses these results and applies the risk adjustment to calculate expected rate and observed/expected ratio, based on HEDIS specifications, in order to get risk-adjusted results.

The risk adjustment is based on HCC (Hierarchical Condition Category), which relies on presence of surgeries, discharge conditions, comorbidity, age and gender. More detailed information on the calculation of the risk adjusted rates are available in the IHA MY 2023 AMP Technical Specifications.

5. Changes for the 2024-25 Edition Medical Group Commercial Report Card

- In alignment with HEDIS, the age range for Colorectal Cancer Screening (COL) has changed from 50-75 to 46-75.

6. Calculating Percentiles

One of five grades is assigned to each of the six condition topics and to the "Quality of Medical Care" category using the cutpoints shown in Table 1. Cutpoints were calculated per the MY 2023 (RY 2024) results for all medical groups. The percentiles are established by first calculating the composites (unweighted averages of each of the grouped measures at the topic and category level). Then the 90th, 65th, 35th, and 10th percentiles are calculated across statewide AMP participants' topic and category level composite scores.

7. From Percentiles to Stars

There are four thresholds corresponding to five-star rating assignments. If a topic or category composite rate meets or exceeds the "Excellent" thresholds, the medical group is assigned a rating of five stars. If a topic or category composite rate meets or exceeds the "Very Good" threshold (but is less than the "Excellent" threshold) then the medical group is given a rating of four stars. If a topic or category composite rate meets or exceeds the "Good" threshold (but is less than the "Very Good" threshold) then the medical group is given a rating of three stars. If a topic or category composite rate meets or exceeds the "Fair" threshold (but is less than the "Good" threshold) then the medical group is given a rating of two stars. Topic or category scores that are less than the two star "Fair" threshold result in a rating of one star, "Poor".

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

Top cutpoint:	90th percentile for California reporting medical groups
Middle-high cutpoint:	65th percentile for California reporting medical groups
Middle-low cutpoint:	35th percentile for California reporting medical groups
Low cutpoint:	10th percentile for California reporting medical groups

Table 1. Clinical Performance Cutpoints for the 2024-25 Edition of the Medical Group – Commercial Report Card

Condition Topics	Number of Measures Included*	Poor Cutpoint 1 Star	Fair Cutpoint 2 Stars	Good Cutpoint 3 Stars	Very Good Cutpoint 4 Stars	Excellent Cutpoint 5 Stars
Asthma Care	1	<74%	≥ 74% to < 82%	≥ 82% to < 87%	≥ 87% to < 90%	≥ 90%
Appropriateness of Tests, Treatments and Procedures	2	<58%	≥ 58% to < 67%	≥ 67% to < 76%	≥ 76% to < 87%	≥ 87%
Diabetes Care	4	<47%	≥ 47% to < 56%	≥ 56% to < 67%	≥ 67% to < 73%	≥ 73%
Heart Care	2	<48%	≥ 48% to < 64%	≥ 64% to < 78%	≥ 78% to < 84%	≥ 84%
Preventive Screenings	4	<51%	≥ 51% to < 60%	≥ 60% < 69%	≥ 69% to < 75%	≥ 75%
Treating Children	3	<29%	≥ 29% to < 46%	≥ 46% to < 61%	≥ 61% to < 69%	≥ 69%
All Clinical Category – Quality of Medical Care	16	<49%	≥ 49% to < 57%	≥ 57% to < 69%	≥ 69% to < 75%	≥ 75%

*Topics with only one measure tend to have more variation in year over year performance.

Special scoring is used for the "Rady Children's Health Network" – an all-pediatric medical group. This group reports five measures: Asthma Medication Ratio, Immunizations for Children, Immunizations for Adolescents, Chlamydia Screening, and Treating Children with Throat Infections. The group's category performance indicator is therefore comprised of these five measures only. Correspondingly, the performance cutpoints for the group's all clinical category rating are based on these five measures and the MY 2023 (RY 2024) results. The Rady Children's Health Network cutpoints for the 2024-25 Edition are 72, 65, 54, 42 for the 90th, 65th, 35th and 10th percentiles, respectively.

8. Buffer Zones

A buffer zone of a half-point (0.5) span is applied when determining the category and topic star ratings. Any medical group whose score is in the buffer zone 0.5 points below the grade cutpoint is assigned to the next highest category grade. For example, if an Excellent Cutpoint was set at 81, a group whose score is 80.5 would be graded "Excellent." A score of 80.4, which is outside of the buffer zone, would be assigned a grade of "Very Good."

9. Attribution of Patients to Medical Groups

In AMP, Commercial HMO patients are attributed to a medical group in each of 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.

10. Reliability Testing/Minimum Number of Observations

IHA considers measurement error and reliability as follows. For the clinical quality measures, the organization uses administrative data based on the universe of a medical group's patients. There is no sampling. Because statistical errors can result from small numbers, IHA requires a total eligible population of 30 or more for a particular measure. In addition, any measure with a bias of five percent or more are excluded, as determined by an NCQA-certified auditor.

Appendix A. Mapping of Medical Group Clinical Measures to Topics

Topic	IHA Measure Name	CDII Measure Name	Definition	Number of Measures in Topic
Asthma Care	Asthma Medication Ratio	Asthma Medicine	The percentage of patients ages 5–64 who were identified as having persistent asthma and had a ratio of controller medicines to total asthma medicines of 0.50 or greater during the measurement year.	1
Diabetes Care	Eye Exam for Patients with Diabetes	Eye Exam for People with Diabetes	The percentage of patients ages 18–75 with diabetes (type 1 and type 2) who had a retinal eye exam in last year.	4
Diabetes Care	HbA1c Control for Patients with Diabetes (<8.0%)	Controlling Blood Sugar for People With Diabetes	The percentage of patients ages 18–75 with diabetes (type 1 and type 2) whose HbA1c was <8.0%.	4
Diabetes Care	Blood Pressure Control for Patients with Diabetes <140/90	Controlling Blood Pressure For People With Diabetes	The percentage of patients ages 18–75 with diabetes (type 1 and type 2) whose blood pressure was <140/90.	4
Diabetes Care	Statin Therapy for Patients with Diabetes	Prescribing Statins to People With Diabetes	The percentage of patients ages 40-75 with diabetes who were prescribed at least one statin medicine in the last year.	4
Heart Care	Controlling High Blood Pressure	Controlling High Blood Pressure	The percentage of patients ages 18-85 who are diagnosed with hypertension and whose blood pressure was controlled (<140/90) during the measurement year.	2
Heart Care	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 medicine during the last year.	2
Preventive Screenings	Breast Cancer Screening	Breast Cancer Screening	The percentage of adults ages 50–74 who had a mammogram to screen for breast cancer.	4

Topic	IHA Measure Name	CDII Measure Name	Definition	Number of Measures in Topic
Preventive Screenings	Cervical Cancer Screening	Cervical Cancer Screening	The percentage of adults ages 21-64 who were identified as having received the following testing: adults ages 21-64 who had cervical screening in the last 3 years; adults ages 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing in the last 5 years, or a cervical screening and hrHPV testing in the last 5 years.	4
Preventive Screenings	Chlamydia Screening in Women	Chlamydia Screening	The percentage of women ages 16–24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	4
Preventive Screenings	Colorectal Cancer Screening	Colorectal Cancer Screening	The percentage of patients ages 46–75 who had appropriate screening for colorectal cancer.	4
Treating Children	Childhood Immunization Status	Immunizations for Children	The percentage of enrolled children age two who were identified as having completed the following antigen series by their second birthday: four diphtheria, tetanus, acellular pertussis (DtaP) vaccinations; three polio (IPV) vaccinations; one measles, mumps, rubella (MMR) vaccination; three flu (HiB) vaccinations; three hepatitis B (HepB) vaccinations; one chicken pox (VZV) vaccination; and four pneumococcal conjugate (PCV) vaccinations, one hepatitis A (HepA) vaccination, two or three rotavirus vaccinations and at least two influenza vaccinations.	3
Treating Children	Immunizations for Adolescents	Immunizations for Early Teens	The percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), and completed the HPV vaccine series by their 13th birthday.	3

Topic	IHA Measure Name	CDII Measure Name	Definition	Number of Measures in Topic
Treating Children	Appropriate Testing for Pharyngitis	Treating Throat Infections	The percentage of patients age 3 and older, who were diagnosed with pharyngitis, given an antibiotic and received a group A streptococcus (strep) test for the episode.	3
Appropriate Use of Tests, Treatments and Procedures	Cervical Cancer Overscreening‡	Appropriate Use of Cervical Cancer Screening	The percentage of adults ages 21-64 who received more cervical cancer screenings than necessary according to evidence-based guidelines. This measure is inverted to show that a higher rate is better.	2
Appropriate Use of Tests, Treatments and Procedures	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	Treating Bronchitis: Getting the Right Care	The percentage of patients ages 18–64 with a diagnosis of acute bronchitis who were not given an antibiotic prescription.	2
Display Only Measures*	All-Cause Readmissions	Preventing Hospital Readmission After Discharge	For patients age 18 and older, the number of acute inpatient hospital stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	N/A
Display Only Measures*	Concurrent Use of Opioids and Benzodiazepines	Concurrent Use of Opioids and Benzodiazepines	The percentage of patients age 18 and older with prescriptions for both opioids and benzodiazepines.	N/A

*Display Only Measures are not included on the overall category performance score “Quality of Medical Care”.
‡*Cervical Cancer Overscreening* is a non-HEDIS measure.