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

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

Background

Representing the interests of health plan and medical groups, the 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 HMO health plans, PPO health plans, commercial HMO Medical Groups, and medical groups serving Medicare Advantage members. The current version (2024-25 Edition) of the online Health Care Quality Report Cards is available through https://www.cdii.ca.gov/consumer-reports/.

Of the 180 provider 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 provider organizations that contract with Medicare Advantage health plans 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 Report Card for Medicare Advantage members 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 ratings and scores addressed in this document is the IHA AMP Medicare Advantage program's medical group clinical performance data.

CDII also reports Medical Group scores for other populations, based on the following data sources (Methodology descriptions in separate documents).

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

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

Medical Group - Medicare Advantage Clinical Care Methodology Process

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.

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. IHA staff work in conjunction with the TMC to develop a subset of measures used for the Medicare Advantage health plan ratings.

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 or with the addition of new measures, 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 - 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. Outcome and intermediate outcome measures (e.g., Controlling Blood Sugar for People

with Diabetes) 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 Pressure	Intermediate Outcome	3
Controlling Blood Sugar for People with Diabetes	Intermediate Outcome	3
Eye Exam for People with Diabetes	Process	1
Number of Days Diabetes Medication Was Filled	Intermediate Outcome	3
Prescribing Statins to People with Diabetes	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
Plan All-Cause Readmissions	Outcome	3

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 People with Diabetes 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 cutpoints determined by CMS to rate Medicare Advantage health plans, which are displayed in Table 2.

Table 2. Clinical Care Performance Cutpoints for the 2024-25 Edition of the Medical Group – Medicare Advantage Report Card

Clinical Care Medicare Advantage Stars Measure	**Poor Cutpoint** **1 Star**	**Fair Cutpoint** **2 Stars**	**Good Cutpoint** **3 Stars**	**Very Good Cutpoint** **4 Stars**	**Excellent Cutpoint** **5 Stars**
Breast Cancer Screening	< 53%	≥ 53% to < 67%	≥ 67% to < 75%	≥ 75% to < 82%	≥ 82%
Colorectal Cancer Screening	< 53%	≥ 53% to < 65%	≥ 65% to < 75%	≥ 75% to < 83%	≥ 83%
Controlling Blood Pressure	< 69%	≥ 69% to < 74%	≥ 74% to < 80%	≥ 80% to < 85%	≥85%
Controlling Blood Sugar for People with Diabetes*	< 49%	≥ 49% to < 72%	≥ 72% to < 84%	≥ 84% to < 90%	≥ 90%
Eye Exam for People with Diabetes	< 57%	≥ 57% to < 70%	≥ 70% to < 77%	≥ 77% to < 83%	≥ 83%
Number of Days Diabetes Medication Was Filled	< 80%	≥ 80% to < 85%	≥ 85% to < 87%	≥ 87% to < 91%	≥ 91%
Prescribing Statins to People with Diabetes	< 81%	≥ 81% to < 86%	≥ 86% to < 89%	≥ 89% to < 93%	≥ 93%
Managing Osteoporosis in Women after a Fracture	< 27%	≥ 27% to < 39%	≥ 39% to < 52%	≥ 52% to < 71%	≥ 71%
Number of Days High Blood Pressure Medications Were Filled	< 83%	≥ 83% to < 87%	≥ 87% to < 90%	≥ 90% to < 92%	≥ 92%
Number of Days High Cholesterol Medications Were Filled	< 80%	≥ 80% to < 85%	≥ 85% to < 89%	≥ 89% to < 93%	≥ 93%
Prescribing Statins to People with Heart Disease	< 81%	≥ 81% to < 85%	≥ 85% to < 88%	≥ 88% to < 92%	≥ 92%

Clinical Care Medicare Advantage Stars Measure	Poor Cutpoint 1 Star	Fair Cutpoint 2 Stars	Good Cutpoint 3 Stars	Very Good Cutpoint 4 Stars	Excellent Cutpoint 5 Stars
Plan All-Cause Readmissions*	< 86%	≥ 86% to < 88%	≥ 88% to < 90%	≥ 90% to < 92%	≥92

* Results for the "Controlling Blood Sugar for People with Diabetes" and "Plan All-Cause Readmissions" measures 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 150 or more for the Plan All-Cause Readmissions (PCR) measure and 30 or more for all other measures. 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.

Changes for the 2024-25 Edition Medical Group Report Card for Medicare Advantage Members

- Per the 2025 Centers for Medicare and Medicaid Services' (CMS) Stars Rating Technical Notes, the measure weight for All-Cause Readmissions: Male and Female: All Ages 65-85+ (PCR65OV_IHS_RISK_ADJ) was increased to 3 to reflect the Outcome measure weighting. PCR65OV_IHS_RISK_ADJ is no longer a first-year measure for the CMS Medicare Advantage Star Rating system.
- In alignment with HEDIS, the age stratification for Colorectal Cancer Screening (COL5175) has been revised from 50-75 to 51-75. CDII will continue to display this measure as Colorectal Cancer Screening.

Appendix A. Mapping of Medical Group Clinical Measures to CDII Measure Names

IHA Measure ID	**AMP Measure** (measure steward)	**Medicare Advantage Stars Measure Name**	**CDII Measure Name**	**Definition**
BCSEOVR	Breast Cancer Screening (NCQA)	Breast Cancer Screening	Breast Cancer Screening	The percentage of adults ages 50–74 who had a mammogram to screen for breast cancer.
COL5175	Colorectal Cancer Screening (NCQA)	Colorectal Cancer Screening	Colorectal Cancer Screening	The percentage of patients ages 51–75 who had appropriate screening for colorectal cancer.
CBPTR	Controlling High Blood Pressure (NCQA)	Controlling Blood Pressure	Controlling High Blood Pressure	The percentage of patients ages 18-85 who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
HBD9TR	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Poor Control > 9.0% (NCQA)	Diabetes Care—Blood Sugar Controlled	Controlling Blood Sugar for People with Diabetes	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level was above 9.0% (or is missing a result), or if an HbA1c test was not done during the measurement year. Rates are inverted for the CDII Report Card such that a higher rate represents better performance.
EED	Eye Exam for Patients With Diabetes (NCQA)	Diabetes Care—Eye Exam	Eye Exam for People with Diabetes	The percentage of patients ages 18–75 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 patients age 18 and older who had enough medicine 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 given a medicine for diabetes that receive a statin medicine during the measurement year.

IHA Measure ID	**AMP Measure** (measure steward)	**Medicare Advantage Stars Measure Name**	**CDII Measure Name**	**Definition**
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 ages 67–85 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 patients age 18 and older who had enough medicine 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 patients age 18 and older who had enough medicine 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 medicine during the last year.
PCR65OV_IHS_RISK_ADJ	All-Cause Readmissions: Male and Female: Ages 65 and older (NCQA)	Plan All-Cause Readmissions	Preventing Hospital Readmission After Discharge	For patients 65 years of age and older, the risk-adjusted percentage of acute inpatient and observation stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days. Rates are inverted for the CDII Report Card such that a higher rate represents better performance.