California Health Care Quality Report Cards Medical Group - Commercial Report Card 2025-26 Edition Scoring Documentation for Public Reporting on Clinical Care (Reporting Year 2025)

Background

Representing the interests of health plan and medical group members, the Office of the Patient Advocate (OPA) publicly reports on health care quality data to help consumers make more informed decisions. 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 (2025-26 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 196 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 OPA 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 2025-26 Edition of the Medical Group Commercial Report Card is published in Spring 2026, using data reported in Reporting Year (RY) 2025, for performance in Measurement Year (MY) 2024. 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 the IHA AMP Commercial HMO

program's medical group total cost of care data for Total Cost of Care data. The Medicare Advantage Medical Group Report Card is based on the IHA AMP Medicare Advantage program's medical group clinical performance data. Other methodology descriptions can be found in separate documents via the About the Ratings webpage.

Methodology Decision Making Process

Through OPA'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 (2025)

Chair: Edward Yu, MD, Sutter Palo Alto Medical Foundation
Cheryl Damberg, PhD, RAND
Christine Nguyen, Blue Shield of California Promise Health Plan
Cristian Rico, MD, AltaMed
Eric Garthwaite, Health Net
Jeff Harrison, Anthem
Joy Dionisio, Covered California
Kathleen Gallagher, Sharp Community Medical Group
Kenneth Phenow, MD, Cigna
Kristina Petsas, MD, UnitedHealthcare
Michelle Best, Providence Medical Foundation
Nikki O'Dell, Aetna
Peter Robertson, California Quality Collaborative
Rachel Brodie, Independent Consultant
Ralph Vogel, PhD, Southern California Permanente Medical Group
Ranae Forbes, Dignity Health Medical Foundation
Sara Frampton, Kaiser Permanente Health Plan
Sherilyn Wheaton, MD, Primary Medical
Ting Pun, PhD, PFCC Partners' Patient Advisor Network
Tory Robinson, Blue Shield of California

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

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.

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 identified within the given time period, it is corrected prior to the public release of the OPA Report Cards.

Medical Group - Commercial Report Card Clinical Scoring Methodology

There are three levels of measurement:

1. **Clinical Measures**: IHA reports 15 clinical measures, all of which are also Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures.
2. **Topic**: The 15 total measures are grouped into seven topic areas.
3. **Category**: "Quality of Medical Care" is one aggregated all-clinical category performance score composed of 14 HEDIS® performance measures. *Preventing Hospital Readmission After Discharge* is not included in the category composite.

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

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS® is a source for data contained in the California Health Care Quality Report Cards obtained from Quality Compass® 2026 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass® 2026 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.

Performance Grading

Medical groups are graded on performance against national benchmarks for "Quality of Medical Care". Fourteen clinical measures are aggregated to create the All-Clinical category performance score: "Quality of Medical Care." Measures are expressed such that a higher score indicates better performance. One measure (*Controlling Blood Sugar for People with Diabetes: Poor Control (>9.0%)*) is a "lower is better" measure, where a lower rate in AMP results reflects stronger performance; therefore, this measure's rates are inverted for the OPA Report Card such that a higher score represents better performance. Groups are assigned star ratings for multi-level composites (category and topics) based on performance against cutpoints based on national benchmarks.

For the 2025-26 Edition Medical Group Report Card, RY 2025 (MY 2024), performance cutpoints for the clinical measures are based on NCQA's 2023 Quality Compass® national benchmarks for commercial health plans, all lines of business, using data that combines all plan types. Specifically, the star cutpoints correspond to the 10th, 33rd, 66th, and 90th percentiles. All benchmark values for individual measures are rounded to the nearest whole number for use in performance cutpoints

Composite Calculation for Category and Topic Scoring

Fourteen measures are aggregated to create the category-level composite score, while topic-level composites are calculated separately based on the measures within each topic. The scoring process involves the following calculations:

1. **To calculate the category level composite, "Quality of Medical Care":** The category-level composite for "Quality of Medical Care" is based on 14 of the 15 clinical measures (*Preventing Hospital Readmission After Discharge* is excluded). The composite score is calculated by taking the mean of the medical group's scores for all 14 included measures. Each of the 14 measures are equally weighted. 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 the "Buffer Zones" section).

   Category-level cutpoints are determined by averaging the corresponding national benchmark values (from the 2023 Quality Compass®), rounded to a whole number, for each of the 14 measures at each percentile threshold (10th, 33rd, 66th, and 90th). For example, the 5-star cutpoint for the category is calculated by averaging the 90th percentile benchmark values for all 14 measures. Category-level cutpoints are rounded to the 100th decimal point. A medical group's category score (rounded mean + 0.5 buffer) is then compared to these category-level cutpoints to determine the star rating.

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 the "Handling Missing Data" section).

2. **To calculate the topic level composites:** Measures are organized into seven topics. Medical groups receive a composite score for each topic based on the medical group's results across the measures in that topic, and star ratings are assigned by comparing the topic score to cutpoints based on national benchmarks for that topic. The measures are equally weighted within each of the seven 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 the "Buffer Zones" section).

   Topic-level cutpoints are determined by averaging the corresponding national benchmark values (from the 2023 Quality Compass®), rounded to a whole number, for all measures within a topic at each percentile threshold (10th, 33rd, 66th, and 90th). For example, if a topic includes four measures, the 5-star cutpoint is calculated by averaging the 90th percentile benchmark values for those four measures. Topic-level cutpoints are rounded to the 100th decimal point. A medical group's topic score (rounded mean + 0.5 buffer) is then compared to these topic-level cutpoints to determine the star rating.

   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 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 the "Handling Missing Data" section).

Individual Measure Scoring

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.

The measure results are converted to a score using the following formula:

$$Score = \left(\frac{Measure\ numerator}{Measure\ denominator}\right) \times 100$$

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 Willing to Report:** Medical group declined to report its results.

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 2024 AMP Technical Specifications.

Changes for the 2025-26 Edition Medical Group Commercial Report Card

- The following measures were **removed** from the Medical Group Commercial Report Card:
    - Controlling Blood Pressure for People with Diabetes
    - Prescribing Statins to People with Diabetes
    - Prescribing Statins to People with Heart Disease
    - Treating Throat Infections
    - Appropriate Use of Cervical Cancer Screening
    - Treating Bronchitis: Getting the Right Care
    - Concurrent Use of Opioids and Benzodiazepines
- The following measures were **added** to the Medical Group Commercial Report Card:
    - Controlling Blood Sugar for People with Diabetes: Poor Control (>9.0%)
    - Kidney Health Evaluation for People with Diabetes
    - Child and Teen Well-Care Visits
    - Prenatal Immunizations
- In alignment with HEDIS®, glucose management indicator (GMI) was added as an option to meet numerator criteria for the Controlling Blood Sugar for Diabetes Patients (GSD) measure.

Calculating Percentiles

One of five grades is assigned to each of the seven topics and to the “Quality of Medical Care” category based on national benchmarks from NCQA’s 2023 Quality Compass®. Percentile thresholds are predefined at the 10th, 33rd, 66th, and 90th percentiles for each measure. Topic-level and category-level cutpoint calculation methods are described in the “Composite Calculation for Category and Topic Scoring” section.

From Percentiles to Stars

There are four cutpoint thresholds (10th, 33rd, 66th, and 90th percentiles) corresponding to five-star scale rating assignments. After calculating a medical group’s composite rate and applying rounding and the +0.5 buffer as described in the “Composite Calculation for Category and Topic Scoring” section, the medical group’s

score is compared to the applicable topic- or category-level cutpoints:

Table 1. Star Ratings Cutpoints for the 2025-26 Edition of the Medical Group – Commercial Report Card

Star Rating	Rating Label	Description
★★★★★	Excellent	At or above the national Commercial 90th percentile
★★★★	Very Good	At or above the national Commercial 66th percentile but below the 90th percentile
★★★	Good	At or above the national Commercial 33rd percentile but below the 66th percentile
★★	Fair	At or above the national Commercial 10th percentile but below the 33rd percentile
★	Poor	Below the national Commercial 10th percentile

- 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”.

Table 2. Clinical Measure Performance Benchmarks for the 2025-26 Edition of the Medical Group – Commercial Report Card*

Measure	10th Percentile	33rd Percentile	66th Percentile	90th Percentile
Asthma Medication Ratio	77	82	87	91
Eye Exam for Patients with Diabetes	37	46	55	64
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	46	58	64	69
Glycemic Status Assessment for Patients with Diabetes (>9.0%)‡	54	69	75	80
Kidney Health Evaluation in Patients with Diabetes	30	40	46	56
Controlling High Blood Pressure	40	60	67	74
Breast Cancer Screening	66	71	76	80
Cervical Cancer Screening	66	71	76	81
Chlamydia Screening	35	42	49	62
Colorectal Cancer Screening	52	59	66	73
Immunizations for Children	36	50	62	71
Immunizations for Early Teens	21	29	36	46
Child and Adolescent Well Visits	43	53	61	72
Prenatal Immunizations	19	29	41	51
Preventing Hospital Readmission After Discharge^	6	5	4	3

*Source: NCQA's 2023 Quality Compass® national benchmarks for commercial health plans, all lines of business, using data that combines all plan types.

‡For this measure, a lower rate means better performance. Therefore, rates are inverted for the OPA Report Card such that a higher score represents better performance.

^Targets are established using NCQA Quality Compass O/E ratio and IHA Atlas Commercial, all lines of business, statewide observed rates.

Table 3. Clinical Topic and Category Performance Cutpoints for the 2025-26 Edition of the Medical Group – Commercial Report Card

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	< 77	77 to < 82	82 to < 87	≥ 87 to < 91	≥ 91
Preventative Care	4	< 54.75	54.75 to < 60.75	60.75 to < 66.75	≥ 66.75 to < 74	≥ 74
Diabetes Care	4	< 41.75	41.75 to < 53.25	53.25 to < 60	≥ 60 to < 67.25	≥ 67.25
Blood Pressure Management	1	< 40	40 to < 60	60 to < 67	≥ 67 to < 74	≥ 74
Child Care	3	< 33.33	33.33 to < 44	44 to < 53	≥ 53 to < 63	≥ 63
Prenatal Care	1	< 19	19 to < 29	29 to < 41	≥ 41 to < 51	≥ 51
Hospital Readmission	1	> 6	≤ 6 to < 5	≤ 5 to < 4	≤ 4 to < 3	< 3
All Clinical Category – Quality of Medical Care	14	< 44.43	44.43 to < 54.21	54.21 to < 61.5	≥ 61.5 to < 69.29	≥ 69.29

*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, Chlamydia Screening, Immunizations for Children, Immunizations for Early Teens, and Child and Adolescent Well Visits. 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 2024 (RY 2025) results. The Rady Children’s Health Network cutpoints for the 2025-26 Edition are 42.65, 50.95, 58.89, and 68.33 for the 10th, 33rd, 66th, and 90th percentiles, respectively (Table 4).

Table 4. Clinical Performance Cutpoints for the 2025-26 Edition of the Medical Group – Commercial Report Card, Rady Children's Health Network Subset

Subset	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
Rady Children's Health	5	< 42.4	≥ 42.4 to < 51.2	≥ 51.2 to < 59	≥ 59 to < 68.4	≥ 68.4

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."

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.

Reliability Testing/Minimum Number of Observations

IHA considers measurement error and reliability as follows. For 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	OPA Measure Name	Definition	Number of Measures in Topic
Asthma Care	Asthma Medication Ratio	Asthma Medication	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	Glycemic Status Assessment for Patients with Diabetes (<8.0%)	Controlling Blood Sugar for People with Diabetes: Controlled (<8.0%)	The percentage of patients ages 18–75 with diabetes (type 1 and type 2) whose most recent glycemic status (HbA1c or GMI) during the measurement year was less than 8.0%.	4
Diabetes Care	Glycemic Status Assessment for Patients with Diabetes (>9.0%)‡	Controlling Blood Sugar for People with Diabetes: Poor Control (>9.0%)	The percentage of patients ages 18-75 with diabetes (type 1 and type 2) whose most recent glycemic status (HbA1c or GMI) during the measurement year was greater than 9.0%. Rates are inverted for the OPA Report Card such that a higher score represents better performance.	4
Diabetes Care	Kidney Health Evaluation in Patients with Diabetes	Kidney Health Evaluation for People with Diabetes	The percentage of patients ages 18-75 with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) *and* a urine albumin-creatinine ration (uACR) during the measurement year.	4

Topic	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Blood Pressure Management	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.	1
Preventive Care	Breast Cancer Screening	Breast Cancer Screening	The percentage of adults ages 50–74 who had a mammogram to screen for breast cancer.	4
Preventive Care	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 Care	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 Care	Colorectal Cancer Screening: Ages 51-75	Colorectal Cancer Screening	The percentage of patients ages 51–75 who had appropriate screening for colorectal cancer.	4

Topic	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Child Care	Childhood Immunization Status	Immunizations for Children	The percentage of 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 (RV) vaccinations and at least two influenza (flu) vaccinations.	3
Child Care	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 (Tdap) vaccine, and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	3
Child Care	Child and Adolescent Well-Care Visits	Child and Teen Well-Care Visits	The percentage of patients age 3-21 who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	3
Prenatal Care	Prenatal Immunization Status	Prenatal Immunizations	The percentage of deliveries in the measurement year in which the delivering patient had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.	1

Topic	IHA Measure Name	OPA Measure Name	Definition	Number of Measures in Topic
Hospital Readmissions	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.	1

‡For this measure, a lower rate means better performance. Therefore, rates are inverted for the OPA Report Card such that a higher score represents better performance.

*This measure is not included on the overall category performance score “Quality of Medical Care”.