CDII Office of the Patient Advocate (OPA)
California Health Care Quality Health Plan Report Card, 2022-23 Edition
Scoring Documentation for Public Reporting on CAHPS [1]
(Reporting Year 2022)

Background

Representing the interests of health plan members, 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 on HMOs, PPOs and Medical Groups. The current version (2022-23 Edition) of the online Health Care Quality Report Cards is available at www.opa.ca.gov.

Performance results are reported at a health plan reporting unit level in the Health Plan Report Cards. Ten (10) participating health plans report HMO Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) results.

Aetna Health of California, Inc.
Anthem Blue Cross of California
Blue Shield of California
CIGNA HealthCare of California, Inc.
Health Net of California, Inc.
Kaiser Foundation Health Plan of Northern California, Inc.
Kaiser Foundation Health Plan of Southern California, Inc.
Sharp Health Plan
United Healthcare of California, Inc.
Western Health Advantage

Six (6) participating health plans report PPO Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results.

Aetna Health of California, Inc.
Anthem Blue Cross of California
Blue Shield of California
CIGNA HealthCare of California, Inc.
Health Net of California, Inc.
United Healthcare Insurance Co., Inc.

Sources of Data for California Health Care Quality Report Cards

The 2022-23 Edition of the Report Cards is published in October 2022, using data reported in Reporting Year (RY) 2022 for performance in Measurement Year (MY) 2021.

[1] Also see the Scoring Methodology for the HMO and PPO Report Cards HEDIS clinical care ratings: http://www.opa.ca.gov/Pages/AboutRatingsandMore.aspx

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Data sources are:

1. **The National Committee for Quality Assurance's (NCQA) publicly reported Consumer Assessment of Healthcare Providers and Systems (CAHPS) commercial measure data** and HMO and PPO Healthcare Effectiveness Data and Information Set (HEDIS [3])**.** (HEDIS Methodology Description in a separate document)
2. The Integrated Healthcare Association (IHA) Align. Measure. Perform. (AMP) Commercial HMO program's medical group clinical performance data. (Methodology Description in a separate document)
3. The Purchaser Business Group on Health (PBGH) Patient Assessment Survey's (PAS) patient experience data for medical groups. (Methodology Description in a separate document)

Health Plan CAHPS 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 program. IHA's Technical Measurement Committee (TMC) now serves as the primary advisory body to OPA regarding methodologies for the HMO and PPO Report Cards for both HEDIS clinical and CAHPS patient experience data and the Medical Group Report Card clinical data. 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. OPA's Health Care Quality Report Cards are a standing item at the TMC meetings.

   TMC Roster (2022)
   Chair: Christine Castano, MD, *Optum*
   Alice Gunderson, *PFCC Partners, Patient Advisor Network*
   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*
   Edward Yu, MD, *Sutter Palo Alto Medical Foundation*
   Eric Garthwaite, *Health Net*
   Fred Kuo, MD, MBA, *UnitedHealthcare*
   Kenneth Phenow, MD, *Cigna*
   Leticia Schumann, *Anthem*
   Marnie Baker, MD, MPH, *MemorialCare Medical Group*
   Pegah Mehdizadeh, DO, *Aetna*
   Peter Robinson, MPA, *Purchaser Business Group on Health*
   Rachel Brodie, *Purchaser Business Group on Health*
   Ralph Vogel, PhD, *Kaiser Permanente*
   Sherilyn Wheaton, MD, *Primary Medical*
   Sara Frampton, *Kaiser Permanente Health Plan*
   Ting Pun, *PFCC Partners, Patient Advisor Network*
   Tory Robinson, *Blue Shield of California*

[3] 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®2022 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2022 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

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.

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

Health Plan CAHPS Scoring Methodology

There are three levels of measurement:

1. **Stand Alone CAHPS Measures:** The one eligible measures consist of the CAHPS* 5.0H commercial measures for Reporting Year 2022, reported by the National Committee for Quality Assurance (NCQA).

2. **Topic:** There are three composite topic areas composed of nine (9) commercial CAHPS measures.

3. **Summary Performance**: There is one composite category, “Patients Rate Overall Experience,” which is the aggregated All-CAHPS summary performance score composed of nine (9) commercial CAHPS measures.

See Appendix A for mapping of CAHPS measures to performance topics and Appendix B for mapping of CAHPS measures to stand-alone patient experience ratings.

2-year Rolling Average

There are two specific measures that are calculated manually by multi-question composites, based on a 2-year rolling average; *Plan Customer Service,* and *Paying Claims.* Each question over two years is summed, and the total of each question over two years is averaged to create the rate of performance for each composite (e.g. Question 35 responses are summed from MY 2020 and MY 2021 and averaged with the same sum for Question 36 to create the rate of performance displayed for Customer Service in RY2022). The purpose for a 2-year rolling average is to amass a denominator large enough to report, given the difficulty most plans have in reaching the minimum reporting threshold in one measurement year across the entire composite.

Performance Grading

HMOs and PPOs are graded on performance relative to the nation for CAHPS for “Patients Rate Overall Experience” for HMO/PPOs. All of the performance results are expressed such that a higher score means better performance. Based on relative performance, plans are assigned star ratings for multi-level summary indicators.

Star rating performance grading is based on the NCQA RY 2022 Quality Compass® All Lines of Business (Health Maintenance Organization-HMO, Point of Service-POS and Preferred

Provider Organization-PPO) benchmarks. Quality Compass RY 2022 values are used to set performance cutpoints for new or revised measures.

1. **Summary Performance Indicator Scoring**

   One summary performance indicator result is reported: "Patients Rate Overall Experience." This summary rating is an aggregation of the measures within the three composites: 1) "Getting Care Easily", 2) "Satisfaction with Plan Services" and 3) "Satisfaction with Plan Doctors."

   a) Refer to HEDIS® 2022 Volume 3: Specifications for Survey Measures for a detailed description of the composite results scoring method.

2. **Composite Category and Topic Scoring**

   The NCQA CAHPS proportional scoring specifications are used to score both topic and category composites in Appendix A. Per NCQA scoring rules, CAHPS composite results are first rounded to the 100th decimal, and then to the 10th decimal, 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.

3. **Handling Missing Data**

   Not all health plans are able to report valid rates for all measures. In order to calculate summary performance indicator star ratings for as many health plans as possible, we impute missing data under specific conditions using an adjusted half-scale rule. This is accomplished by developing an actual measure level result for plans with missing data and using those for star calculations. Imputed results are not reported as an individual rate. If a plan is able to report valid rates for at least half of its measures in a topic, then missing values are replaced using this adjusted half-scale rule for all measures in the topic. Because eligibility for missing value re-assignment (imputation) is assessed independently at the summary indicator level, it is possible to have a summary indicator score even if topic scores are missing.

4. **Changes from the 2021-22 Edition Report Card to the 2022-23 Edition Report Card and Notes**

   Various methodology updates were made in effort to align with IHA's AMP program:

   a) <u>Benchmarks</u> – OPA has aligned the Health Plan Report Card with the Medical Group Report Card for Commercial HMO Members to utilize same-year benchmarks for MY 2021.
   b) <u>Rounding</u> – OPA has aligned the Health Plan and Medical Group Report Card for Commercial HMO Members with IHA's AMP program to adopt a 2-step rounding process for composite star ratings (topic and category ratings):
      i. First round to the 100th decimal point,
      ii. Then round to the 10th decimal point,
      iii. Then add a 0.5 point buffer before comparing to star rating benchmarks.
      iv. <u>Cutpoints</u> – OPA has aligned the Health Plan and Medical Group Report Card for Commercial HMO Members with IHA's AMP program to establish benchmarks for star ratings. First, instead of calculating the 90th, 65th, 35th and 10th percentiles and then calculating the composites (unweighted averages of each of the grouped measures at the topic and category level), these steps are reversed, described below in Section 5.

5. Calculate Percentiles

a) One of five grades are assigned to each of the three summary performance indicators using Table 1 cutpoints. Four cutpoints are used to calculate the performance grades. Cutpoints were calculated per the NCQA RY 2022 Quality Compass® All Lines of Business (Health Maintenance Organization-HMO, Point of Service-POS and Preferred Provider Organization-PPO).

b) Percentiles are established by first calculating the composites (unweighted averages of each of the grouped measures at the topic and category level) for National All Lines of Business. Then the 90th, 65th, 35th, and 10th percentiles of each topic and category composite are calculated across National All Lines of Business.

6. From Percentiles to Stars

a) Health plan performance in MY 2021 is graded against score thresholds derived from MY 2021 (RY 2022) data. There are four thresholds corresponding to five-star rating assignments. If a category performance indicator composite rate meets or exceeds the "Excellent" threshold, the plan is assigned a rating of five stars. If a summary performance indicator composite rate meets or exceeds the "Very Good" threshold (but is less than the "Excellent" threshold) then the plan is given a rating of four stars. If a summary performance indicator composite rate meets or exceeds the "Good" threshold (but is less than the "Very Good" threshold) then the plan is given a rating of three stars. If a summary performance indicator composite rate meets or exceeds the "Fair" threshold (but is less than the "Good" threshold) then the plan is given a rating of two stars. Summary performance indicator scores that are less than the two star "Fair" threshold result in a rating of one star "Poor".

b) The grade spans vary for each of the three summary performance indicator topics listed in Table 1:

Top cutpoint:	90th percentile nationwide
Middle-high cutpoint:	65th percentile nationwide
Middle-low cutpoint:	35th percentile nationwide
Low cutpoint:	10th percentile nationwide

Table 1. Health Plan CAHPS Performance Cutpoints for the 2022-23 Edition Report Card

Topic Ratings	Number of Measures Included	Excellent Cutpoint	Very Good Cutpoint	Good Cutpoint	Fair Cutpoint	Poor Cutpoint
Getting Care Easily	2	90	86	83	77	<77
Satisfaction with Plan Services	3	73	56	42	33	<33
Satisfaction with Plan Doctors	4	74	68	63	55	<55

Table 2. Health Plan CAHPS Summary Category Cutpoints for the 2022-23 Edition Report Card

Summary Category Rating	Number of Measures Included	Excellent Cutpoint	Very Good Cutpoint	Good Cutpoint	Fair Cutpoint	Poor Cutpoint
Patients Rate Overall Experience	9	79	70	63	55	<55

c) A buffer zone of a half-point (0.5) span is applied. Any HMO or PPO whose score is in the buffer zone that is 0.5 point below the grade cutpoint is assigned the next highest category grade. For example, a “Getting Care Easily” score of 82.5 would be assigned a grade of “Good”. A score of 82.4, which is outside of the buffer zone, would be assigned a grade of “Fair”.

Appendix A - Mapping of CAHPS Measures[i] to Topics

Summary Performance Indicator	Composite or Topic	Definition	Question #
Getting Care Easily	Getting Doctors and Care Easily	In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed? (never-always)	25
Getting Care Easily	Getting Doctors and Care Easily	In the last 12 months, how often was it easy to get the care, tests, or treatment you needed? (never-always)	14
Getting Care Easily	Getting Appointments and Care Quickly	In the last 12 months, when you needed care right away, how often did you get care as soon as you needed? (never-always)	4
Getting Care Easily	Getting Appointments and Care Quickly	In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? (never-always)	6
Satisfaction with Plan Services	Plan Customer Service	In the last 12 months, how often did your health plan's customer service give you the information or help you needed? (never-always)	35
Satisfaction with Plan Services	Plan Customer Service	In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? (never-always)	36
Satisfaction with Plan Services	Paying Claims	In the last 12 months, how often did your health plan handle your claims quickly? (never-always)	40
Satisfaction with Plan Services	Paying Claims	In the last 12 months, how often did your health plan handle your claims correctly? (never – always)	41
Satisfaction with Plan Services	Rate Their Plan	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan? (OPA uses the responses of 9 or 10 for this question).	42
Satisfaction with Plan Doctors	Rating of Doctor	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor? (OPA uses the responses of 9 or 10 for this question).	23
Satisfaction with Plan Doctors	Rating of Specialist	Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist? (OPA uses the responses of 9 or 10 for this question).	27
Satisfaction with Plan Doctors	Health Care Highly Rated	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months? (0-10)? (OPA uses the responses of 9 or 10 for this question	13
Satisfaction with Plan Doctors	Coordinated Care	In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	22

Appendix B - Stand-Alone Patient Experience Ratings (not included in star ratings)

Stand Alone Measure - Composite or Topic	Definition	Question #
Doctor Communication	In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand? (never-always)	17
Doctor Communication	In the last 12 months, how often did your personal doctor listen carefully to you? (never-always)	18
Doctor Communication	In the last 12 months, how often did your personal doctor show respect for what you had to say? (never-always)	19
Doctor Communication	In the last 12 months, how often did your personal doctor spend enough time with you? (never-always)	20

[i] The questions sampled in this table correspond with the CAHPS 5.0H survey