Scoring Overview

Overview
Each health plan and medical group is scored on a range of health care quality and patient experience measures. Health plans and medical groups are assigned overall star ratings for quality of medical care and for patient experience. These overall star ratings are calculated from health care quality measure scores that show the percent of patients who got the right care at the right time, or patient experience scores that show the percent of patients who rated their experience highly. Although the patient experience scores for medical groups are not included in this dataset, the complete ratings are available in the Medical Group - Commercial Report Card on OPA’s website, at www.opa.ca.gov. Commercial medical groups are also rated based on their total cost of care.

For star ratings, more stars is better. For percentage scores, a higher score is better.

Scoring
For more detailed information on OPA’s scoring methods, see the methodology document or the individual Report Cards on OPA’s website.

For health plans and commercial medical groups, there are three levels of rating. First, each individual measure has a percentage score. Next, individual measures are grouped with similar measures into topics (called composites in the dataset), and each topic is assigned a star rating based on the individual measure scores. Finally, overall star ratings are calculated for clinical performance (Quality of Medical Care) and for patient experience (Patients Rate Overall Experience) from the topic ratings.

The ratings for Medicare Advantage medical groups consist of star ratings and percentages for individual measures, and an overall ‘Quality of Medical Care’ star rating.

Health Plan Clinical Performance Data (Quality of Medical Care)
Information from the health plan’s records were collected and scored based on standards for quality of care set by the HEDIS® (Healthcare Effectiveness Data and Information Set) performance measurement system to make sure that health plans were offering quality care and service to members. More than 43 HEDIS® quality care measures are sorted into nine health topics. All nine health topic scores are combined

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1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS is a registered trademark of NCQA.
into one summary rating using an equal weight and average score formula. This summary rating is presented as the ‘Quality of Medical Care’ star rating, with each health plan receiving one, two, three, or four stars.

**Health Plan Patient Experience Data**
A sample of HMO and PPO members completed a survey called CAHPS® (Consumer Assessment of Healthcare Providers and Systems) that asks members about their experience with the care and services offered by the health plan. Twelve patient experience percentage ratings are sorted into three patient experience topics with star ratings, and are presented in one overall star rating called ‘Patients Rate Their Experience.’ Ratings for the CAHPS® topics are based on the percentage of members who gave high scores or the most positive answers (“always” or “usually” for most questions) to the survey question measures. Each health plan receives one, two, three, or four stars.

**Commercial Medical Group Clinical Performance Data**
Participating medical groups who have commercial HMO/POS health plan members are measured by the Integrated Healthcare Association (IHA) to determine if the medical care provided meets national standards for using treatments proven to be effective. Twenty quality measures are reported with percentage scores; fifteen of the measures are combined into five health topics with star ratings. The summary ‘Quality of Medical Care’ star rating is calculated based on the 5 health topics. Each medical group with enough data to score reliably receives one, two, three, or four stars.

**Commercial Medical Group Total Cost of Care Data**
Integrated Healthcare Association (IHA) reviews all of the participating medical groups that have commercial HMO health plan members to determine the overall amount paid to care for the members of the medical group. The ‘Average Annual Payment for Care’ star rating is a summary rating developed by comparing medical groups’ costs. Each medical group’s costs are calculated by assessing actual payments from patients and health plans for the care provided to members of any age who belonged to that medical group during 2015.

Medical groups are assigned a star rating based on their average annual cost per patient. Four stars indicates $3,394 or less on average for each patient annually (lowest 10% of costs). Three stars indicates $3,395 - $4,061 on average for each patient annually. Two stars indicates $4,062 - $5,023 on average for each patient annually. One star indicates $5,024 or more on average for each patient annually (highest 10% of costs).

**Medical Group Medicare Clinical Performance Data**
Participating medical groups who have Medicare Advantage health plan members are reviewed by Integrated Healthcare Association (IHA) to determine if the medical care provided meets national standards for using treatments proven to be effective. Thirteen different health care quality measures are scored based on the percentage of Medicare Advantage patients who got the right care at the right time. IHA assigns a star rating for
each measure based on its percentage score. The overall Quality of Medical Care star rating is calculated by taking an average of the measure-level star ratings that are available for a medical group. Outcome measures such as Controlling Blood Sugar for Patients with Diabetes are given three times the weight of process measures such as Colon Cancer Screening. Each medical group with enough data to score reliably is assigned 0.5 through 5 stars.

The methods for determining the star ratings and scores for the Medical Group Medicare Report Card are based on requirements developed by the US Centers for Medicare and Medicaid Services (CMS). The scoring methodology to assign the star ratings for the summary rating uses the same cut-points and measure weightings that CMS uses to rate Medicare Advantage health plans.

Data Sources

HEDIS® and CAHPS® measures are important parts of a national system of accreditation of health plans and some medical groups. These measures are administered by the National Committee for Quality Assurance (NCQA). NCQA is “a private, not-for-profit organization dedicated to improving health care quality everywhere.” The NCQA-sponsored accreditation process is voluntary but many health plans participate. The scores and ratings for HEDIS® measures are based on randomly selected lists of members with a particular condition or need, like members who have had a heart attack or members who are children. The health plan gives information about whether or not the member got a particular service or the results of a test for that member. To get information about members’ experiences with their HMO or PPO, randomly selected members of the health plan are asked to complete the CAHPS® survey. A research firm collects the survey responses and independent researchers score the answers. HEDIS® and CAHPS® data is used in the Health Plan Clinical Performance ratings and the Health Plan Patient Experience ratings. For more information about HEDIS®, CAHPS®, or NCQA visit www.ncqa.org.

The Integrated Healthcare Association (IHA) is a non-profit, multi-stakeholder leadership group that promotes healthcare quality improvement, accountability, and affordability for the benefit of all Californians. As a regional healthcare improvement collaborative, IHA convenes diverse, cross-sector organizations to collaborate on challenging healthcare issues. IHA membership includes industry-leading health plans, physician groups, and hospital systems, plus academic, consumer, purchaser, pharmaceutical and technology representatives. Principal projects and activities include the California Value Based Pay for Performance (VBP4P) Program, performance measurement, payment innovation, administrative simplification, and promoting the use of health information technology and integrated care delivery. The VBP4P program generates the performance measures used in the Medicare Medical Group Clinical Performance ratings, the Commercial Medical Group Clinical Performance ratings, and the Commercial Medical Group Total Cost of Care ratings. For more information about VBP4P or IHA, visit www.iha.org.