

# 2022 Health Plan Ratings Methodology



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## NCQA 2022 HEALTH PLAN RATINGS METHODOLOGY

### How Are Plans Rated?

Health plans are rated in three categories: private/commercial plans in which people enroll through work or on their own; plans that serve Medicare<sup>1</sup> beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries.

NCQA ratings are based on three types of quality measures: measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS<sup>®2</sup>) and Health Outcomes Survey (HOS); measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®3</sup>); and results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.

#### Overall rating

The overall rating is the weighted average of a plan's HEDIS, HOS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars (see below for rounding rules).

The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 scale in half points (5 is highest). Performance includes three subcategories (also scored 0–5 in half points):

1. **Patient Experience:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).
2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
3. **NCQA Health Plan Accreditation:** For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displayed as stars. A plan with an Interim status receives 0.15 bonus points added to the overall rating before rounding to the nearest half point and displayed as stars.

**Note:** *If an Accredited plan that is not yet required to report HEDIS/CAHPS data for Accreditation chooses to publicly report its performance data, it is scored on the data submitted and receives the Accreditation bonus points.*

*If an Accredited plan that is not yet required to report HEDIS/CAHPS data chooses not to publicly report performance data, it will not have a rating.*

<sup>1</sup>Medicare ratings on approval from CMS.

<sup>2</sup>HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>3</sup>CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

**Rounding rules** The overall rating is calculated and truncated to 3 decimal places and rounded according to the rules below.

| Rounding Rules    |                   |
|-------------------|-------------------|
| 0.000–0.249 → 0.0 | 2.750–3.249 → 3.0 |
| 0.250–0.749 → 0.5 | 3.250–3.749 → 3.5 |
| 0.750–1.249 → 1.0 | 3.750–4.249 → 4.0 |
| 1.250–1.749 → 1.5 | 4.250–4.749 → 4.5 |
| 1.750–2.249 → 2.0 | ≥4.750 → 5.0      |
| 2.250–2.749 → 2.5 |                   |

**Measures included** All publicly reportable clinical and patient experience measures are eligible for inclusion. Selected measures have good differentiating properties, up-to-date evidence and high population impact.

Refer to <https://www.ncqa.org/hedis/reports-and-research/> for a full list of measures and indicators.

**HEDIS compliance audit results** NCQA Certified HEDIS Compliance Auditors must audit HEDIS results submitted by the organization. HEDIS Compliance Audits result in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. All measures selected for public reporting must have a final, audited result. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below.

- Audit results for HEDIS measures**
- *Reportable (R)*. A reportable rate was submitted for the measure.
  - *Small Denominator (NA)*. The organization followed the specifications, but the denominator was too small (e.g., <30 for Effectiveness of Care measures) to report a valid rate.
  - *No Benefit (NB)*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
  - *Not Reported (NR)*. The organization chose not to report the measure.
  - *Biased Rate (BR)*. The calculated rate was materially biased.
  - *Not Required (NQ)*. The organization was not required to report the measure.

- Audit results for survey frames**
- *Supports Reporting (SR)*. The survey sample frame was reviewed and approved.
  - *Not Reportable (NR)*. The survey sample frame was incomplete or materially biased.

**Handling missing values** Measures that are not reported (NR), not required (NQ) or have biased rates (BR) are given a rating of “0.”

Measures with missing values because of small denominators (NA) or because the plan did not offer the benefit (NB) are not used in the plan’s composite or overall rating. A plan must have scorable rates (a valid performance rate, NR, NQ, BR) for at least half of all measures by weight to receive an overall rating.

**Note:** Plans seeking Accreditation may not report NQ for performance measures included in the ratings methodology.

- Measure weights**
- Process measures (such as screenings) are given a weight of 1.
  - Outcome and intermediate outcome measures (e.g., HbA1c or blood pressure control and childhood immunizations) are given a weight of 3.
  - Patient experience measures are given a weight of 1.5.

*Note: New measures used for scoring are assigned a measure weight of 1.0, and then reassessed to determine their weight going into the second year.*

**Accreditation Status and Status Modifiers**

A plan’s Accreditation status is determined as of June 30. If a plan has an NCQA status modifier (e.g., Under Review, Under Corrective Action, Merger Review in Process, Appealed by Plan) as of June 30, it will be appended to the Accreditation status.

**Table 1. NCQA Accreditation Bonus Points**

| Accreditation Achieved    | Accreditation Bonus Points |
|---------------------------|----------------------------|
| Accredited or Provisional | 0.5                        |
| Interim                   | 0.15                       |
| In Process                | 0                          |
| Scheduled                 | 0                          |
| None                      | 0                          |

**Final Plan Rating**

**Measure and composite ratings**

NCQA combines and sorts measures into categories according to conceptually related services. Ratings are displayed at the composite, subcomposite and individual measure level.

A composite or subcomposite rating is the weighted average of a plan’s HEDIS and CAHPS measure ratings in those categories. The weight of any NR, NQ and BR measure is included. NCQA uses the following formula to score composites and subcomposites:

$$(\text{Sub}) \text{ Composite Rating} = \sum (\text{measure rating} * \text{measure weight}) / \sum \text{weights}$$

**Deriving ratings from individual results and national benchmarks**

The National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles are used for ratings, calculated as whole numbers on a 1–5 scale.

|   | <b>Rating</b> |
|---|---------------|
| A plan that is in the top decile of plans .....                           | <b>5</b>      |
| A plan that is in the top 3rd of plans, but not in the top 10th .....     | <b>4</b>      |
| A plan in the middle 3rd of all plans .....                               | <b>3</b>      |
| A plan that is in the bottom 3rd of plans, but not in the bottom 10%..... | <b>2</b>      |
| A plan that is in the bottom 10% of plans .....                           | <b>1</b>      |

*Note: Data from the prior reporting year are used to calculate the national benchmarks unless a measure has a trending concern. If a measure has a trending concern, results from the current reporting year are used in the rating calculation.*

**Scoring risk adjusted utilization measures**

To identify meaningful distinctions between plans, NCQA will distinguish between three levels of performance using statistical significance testing: better-than-expected performance, lower-than-expected performance and same-as-expected performance. Before evaluating the plan’s O/E thresholds as outlined below, the plan’s ratio and upper/lower confidence limits (CL) need to be calibrated to determine the percentage of the plan’s ratio above or below the national average. To calibrate the O/E ratio, divide the plan’s ratio and the upper and lower CL by the national average O/E ratio. This calibrated value is then compared to 1.0 for scoring.

- A calibrated O/E ratio >1.0 means the plan had a below average O/E ratio, based on its case mix.
- A calibrated O/E ratio <1.0 means the plan had an above average O/E ratio, based on its case mix.

Plans with fewer than 150 denominator events are scored NA. To help protect against trivial (but statistically significant) differences, we use an effect size threshold of 0.9 and 1.1.

Calibrated O/Es must be significantly different from 1.0 and exceed the upper and lower thresholds; therefore, these measures use a 3-point scale to determine low, medium and high levels of performance that we have mapped to HPR’s 5-point scale.

To calculate the upper and lower CL for scoring, we apply the formulas below using the reported values in the measure. Table 1 outlines the points earned for each group of plans.

$$(1) \text{ Upper CL} = \frac{\text{Observed Count} + 1.96\sqrt{\text{Variance}}}{\text{Expected Count}}$$

$$(2) \text{ Lower CL} = \frac{\text{Observed Count} - 1.96\sqrt{\text{Variance}}}{\text{Expected Count}}$$

$$(3) \text{ Calibrated Upper CL} = \frac{\text{Upper CL}}{\text{National Average O/E}}$$

$$(4) \text{ Calibrated Lower CL} = \frac{\text{Lower CL}}{\text{National Average O/E}}$$

**Table 2. Scoring Algorithm for Risk-Adjusted Utilization Measures**

| Scoring Rules   | HPR Scoring |
|---|-------------|
| Calibrated O/E <0.9 and Calibrated 95% upper CL <1.0  | 5           |
| Calibrated O/E not meaningfully and significantly different from 1.0 (0.9 ≤ Calibrated O/E ≤ 1.1 or Calibrated 95% CL includes 1.0) | 3           |
| Calibrated O/E >1.1 and Calibrated 95% lower CL >1.0  | 1           |
| Not Reported (NR), BR (Biased Rated), or NQ (Not Required) HEDIS audit result   | 0           |
| Plan’s denominator/eligible population <150   | NA          |

**Note:** NCQA will calculate the CLs for all organizations.

## How Are Plans Displayed?

|  |   |
|--|---|
| <b>What plans are rated or receive scores?</b> | Plans with complete data (both HEDIS and CAHPS) that have elected to publicly report data are rated; plans with partial or no data, or that do not publicly report, are listed but not rated.   |
| <b>Plans with partial data</b>                 | <p>Plans with partial data do not receive a rating, but NCQA lists them in the ratings and shows their scores on the measures they report. A plan is considered to have partial data if it:</p> <ul style="list-style-type: none"> <li>• Submits HEDIS and CAHPS measure data for public reporting, but has “missing values” NA or NB in more than 50% of the weight of measures used in the methodology. Plans that fall into this category receive an overall rating status of “Partial Data Reported” and their measure rates are displayed as “NC” (No Credit). Refer to <i>HEDIS Volume 2: Technical Specifications</i> for information about missing values.</li> <li>• Submits HEDIS data for public reporting but does not submit CAHPS data, or vice versa. Plans that fall into this category receive an overall rating status of “Partial Data Reported” and their measure rates for the dataset they did not submit are displayed as “NC.”</li> <li>• Earned NCQA Accreditation without HEDIS data (Health Plan Accreditation standards only) and did not submit HEDIS or CAHPS data for public reporting. Plans that fall into this category receive an overall rating status of “Partial Data Reported” and their measure rates are displayed as “NC.”</li> </ul> |
| <b>No data reported</b>                        | Plans that submit results but do not report data publicly, or that do not report HEDIS, CAHPS or Accreditation information to NCQA and are not “In-Process” or “Scheduled” for Accreditation Survey, receive a rating status of “No Data Reported” and their measure rates are displayed as “NC.” Plans that fall into this category <b>and</b> have fewer than 15,000 members are omitted—they are not rated and are not listed in displays related to ratings.  |

## Additional Rules

|  |   |
|--|---|
| <b>Medicaid CAHPS and benchmarks</b>             | <p>Medicaid plans may choose the version of the CAHPS survey (or “component”) they want scored: Adult CAHPS, Child CAHPS or Child With Chronic Conditions CAHPS (Child CCC).<sup>4</sup></p> <p>Plans designate the CAHPS component when completing the Healthcare Organization Questionnaire (HOQ). Designations may not be changed and are benchmarked by component selected:</p> <ul style="list-style-type: none"> <li>• Adult CAHPS benchmarks are based on adult rates only.</li> <li>• Child and Child CCC CAHPS benchmarks are based on the combined general population rates for both components.</li> </ul> |
| <b>Medicare CAHPS and Health Outcomes Survey</b> | Using Medicare CAHPS and Health Outcomes Survey (HOS) data in the ratings depends on yearly approval from the Centers for Medicare & Medicaid Services (CMS). Because the submission schedule for Medicare CAHPS and HOS measures differs from the HEDIS submission schedule, NCQA uses the previous year’s data for measures in the CAHPS and HOS domain in the  |

<sup>4</sup>CAHPS components are described in more detail in *HEDIS Volume 3: Specifications for Survey Measures*.

Medicare product line. For Medicare plans that were not required to submit CAHPS or HOS in the previous year, these measures are displayed as “NC” (No Credit).

**1876 cost plans** As of 2017, CMS no longer allows 1876 Cost Plans to submit data on measures that require inpatient data; therefore, submit “NQ” for these measures. “NQ” will be treated the same as “NA” and “NB,” and will not count against a Medicare plan’s Partial Data rule.

**Other display scenarios** To simplify the ratings display logic, NCQA developed the following display rules.

| APPLY FIRST   |   |
|---|---|
| Rate/Scenario   | Display   |
| Plan submits NR (Not Reported) for a measure indicator                  | NC (No Credit)                                      |
| Plan submits BR (Biased Rate) for a measure indicator                   | NC (No Credit)                                      |
| Plan submits NQ (Not Required) for a measure indicator                  | NC (No Credit)                                      |
| Plan submits NA (Not Applicable) for a measure indicator                | NA (Not Applicable)                                 |
| Plan submits NB (No Benefit) for a measure indicator                    | NA (Not Applicable)                                 |
| For Medicare, if “CAHPS Submitted = False” and “CAHPS Required = True”  | Display as NC, overall Rating=Partial Data Reported |
| For Medicare, if “CAHPS Submitted = False” and “CAHPS Required = FALSE” | Display as NA, overall Rating=Partial Data Reported |

| APPLY SECOND  |  |
|---|--|
| Rate/Scenario   | Display  |
| Plan is Accredited on HEDIS/CAHPS and did not elect to public report results on the IDSS Attestation. These plans will be rated assuming they submitted scorable data for more than 50% of measure weights. | <i>Plans that are NCQA Accredited with HEDIS and marked their submission “Not Publicly Reported” on the Attestation are eligible for ratings. All measures are used to calculate their overall rating and scores for all measures are displayed.</i> |
| Plan is Accredited on Standards only but submits HEDIS/CAHPS and did not elect to public report results on the IDSS Attestation. Plans will have an overall rating score of Partial Data Reported.          | NC (No Credit) for all measures.   |
| Plan is Accredited on Standards only and did not submit any data or submitted either HEDIS or CAHPS only. Plans will have an overall rating score of Partial Data Reported.                                 | NC (No Credit) for all measures the plan did not submit, except Medicare, which should follow the Medicare CAHPS rules above.  |
| Plan is not Accredited and submitted either HEDIS or CAHPS only and said Yes to public reporting on the IDSS Attestation. Plans will have an overall rating score of Partial Data Reported.                 | NC (No Credit) for all measures the plan did not submit, except for Medicare, which should follow the Medicare CAHPS rules above.  |

|   |                                  |
|---|----------------------------------|
| Plan is not Accredited or is “In-Process” or “Scheduled” for Accreditation Survey and did not submit any data.  | NC (No Credit) for all measures. |
| Plan is not Accredited or is “In-Process” or “Scheduled” for Accreditation Survey and submitted data but did not elect to public report results on the IDSS Attestation. Plans will have an overall rating score of No Data Reported. | NC (No Credit) for all measures. |

### Special Needs Plans

Special Needs Plans (SNP) with all members categorized as “special needs members” according to CMS, are flagged in the rating displays.

### Schedule, Advertising and Publicity Guidelines and Seals

Find the ratings schedule and the Advertising and Publicity Guidelines and Advertising and Publicity Seals at <https://www.ncqa.org/hedis/reports-and-research/>.

### Results

HPR results will be posted on the NCQA [Health Plan Report Card](#) in September 2022.

### Measure lists

Find the list of measures included in Health Plan Ratings at <https://www.ncqa.org/hedis/reports-and-research/>.

### Health Plan Ratings Benchmarks and Percentiles

The benchmarks and percentiles used for ratings will be available as an Excel workbook in the My Downloads section of My NCQA (<https://my.ncqa.org/Downloads>) in February 2022.

NCQA primary HEDIS and Accreditation contacts have access to the HPR Benchmarks and Percentiles in the Download section. Access is limited for all other customers to ensure that the benchmarks and percentiles are used solely for estimating an organization’s HEDIS performance for Ratings and not for general benchmarking or commercial purposes.

If you are a primary HEDIS or Accreditation contact and do not have access in the My Downloads section of My NCQA, submit a request at <https://my.ncqa.org/>.

### HEDIS Reporting for Accreditation

The following applies to organizations submitting HEDIS and CAHPS survey results for Interim, First or Renewal Surveys.

#### Reporting by product and product line

The organization reports HEDIS/CAHPS survey results:

- Separately for HMO, POS, PPO and EPO products, as applicable, **or**
- Combined for HMO and POS products or PPO and EPO, as applicable, **or**
- Combined for HMO and PPO, EPO or POS and PPO or EPO, as applicable, if 80% of the organization’s members are in a single practitioner and provider

network and the organization submits a written request for approval to PCS via My NCQA (<https://my.ncqa.org>).

The organization must collect and report HEDIS and CAHPS results separately, by product line, for the covered populations. Audited HEDIS results must reflect the exact product line/product combination for which the organization seeks Accreditation and must include all members covered by the product line/product (e.g., insured and self-insured), unless noted otherwise in the HEDIS specifications. NCQA combines the Accreditation standards score and the HEDIS and CAHPS score for each product line/product, and issues Accreditation decisions by product line/product (e.g., commercial HMO, Exchange PPO, Medicare HMO).

#### HEDIS/CAHPS reporting unit

NCQA evaluates an organization's HEDIS/CAHPS results at the time of its Accreditation Survey and annually, between surveys, based on its performance on the measures. NCQA uses the following criteria to define a HEDIS/CAHPS reporting unit:

- Product line and product (refer to General Guideline 1: Product-Line Reporting and General Guideline 2: Product-Specific Reporting in HEDIS *Volume 2 Technical Specifications for Health Plans*).
- Geographic unit.

**Note:** For Accreditation purposes, the HEDIS/CAHPS reporting unit is the same as the Accreditable entity.

#### Minimum enrollment threshold for HEDIS/CAHPS reporting

NCQA's goal is to maximize an organization's ability to produce HEDIS/CAHPS results. A HEDIS/CAHPS reporting unit must have enough members to calculate rates. Because producing HEDIS/CAHPS results can be resource intensive, NCQA established a minimum membership threshold for requiring HEDIS reporting:

- A geographic unit with 15,000 or more members in a product/product line submits audited HEDIS/CAHPS results to NCQA.

#### Reporting units with <15,000 members

A HEDIS/CAHPS reporting unit (Accreditable entity) with fewer than 15,000 members may choose one of the following options for reporting, which it selects before the Accreditation survey begins:

- Produce and submit a unique set of audited HEDIS/CAHPS results to NCQA to be scored as part of Accreditation. If the results submitted have too many audit results of Small Denominator (NA) or No Benefit (NB), the reporting unit may be scored on standards and CAHPS only or on Standards only.
- Combine its membership with another reporting unit in accordance with the policies described below, if applicable, to submit audited HEDIS/CAHPS results.
- Submit CAHPS only.
- Submit neither HEDIS nor CAHPS and be scored on Standards only.

**Note:** NCQA awards a status no higher than Accredited when Accrediting an organization on Standards and CAHPS only or Standards only.

#### Combining Accreditable entities and HEDIS/CAHPS reporting units

Organizations may combine two or more HEDIS/CAHPS reporting units (Accreditable entities) into a single unit in order to achieve the minimum reporting threshold if they meet the following criteria.

- Reporting units are part of a single legal entity.
- When combined, reporting units meet all other NCQA criteria for being defined as a single Accreditable entity (e.g., licensure, centralization, provider network).

- Reporting units share contiguous geographic borders (e.g., side-by-side or corner-to-corner states) and are within the same CMS region.

Organizations may not combine reporting for product lines (commercial, Exchange, Medicare, Medicaid), and must combine the fewest number of reporting units necessary to meet the threshold, allowing all reporting units to be able to report HEDIS/CAHPS for Accreditation. The organization must submit HEDIS/CAHPS results for all reporting units undergoing Accreditation within a CMS region when combining results.

**Combining across CMS regions in limited situations**

Membership for bordering states that cross CMS regions may be combined if all other conditions for combining are met, and the organization is not “licensed” or “selling” in the adjacent state but has members residing across the border.

**Approval process for HEDIS state combining requests**

All organizations that want to combine states for HEDIS reporting must submit a request to NCQA for review and approval before each Accreditation cycle. Requests should:

- Be submitted through PCS via My NCQA (<https://my.ncqa.org>).
- Be submitted annually by December 31 of the year prior to reporting.
- Include membership by state as of July 1 of the HEDIS measurement year and by applicable product or product line.
- Describe how policies for combining are met.

NCQA responds to requests within 30 business days.