

2023 Health Plan Ratings Methodology



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NCQA 2023 Health Plan Ratings Methodology

Summary of Changes

December 2022 Posting

- Revised the following sections under “How Are Plans Rated?”:
 - “Overall rating”
 - “Audit results for HEDIS measures”
- Revised the following section under “Final Plan Rating”:
 - “Deriving measure ratings from national benchmarks”
- Revised the following sections under “How Are Plans Displayed?”:
 - “Plans with partial data”
 - “No data reported”
 - “Low enrollment”
- Revised the following sections under “Additional Rules”:
 - “Medicaid CAHPS and benchmarks”
 - “Other display scenarios”
- Revised the paragraph under “Health Plan Ratings Benchmarks and Percentiles.”
- Revised “Reporting units with <15,000 members” under “HEDIS Reporting for Accreditation.”

April 2022 Posting

- Added a section titled “Scoring Race/Ethnicity Diversity of Membership (RDM) measure.”

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 Medicare¹ beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries. NCQA rates health plans that choose to report measures publicly. NCQA does not rate Exchange plans.

NCQA ratings are based on three types of quality measures: measures of clinical quality from NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS^{®2}) and Health Outcomes Survey (HOS); measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS^{®3}); and results from NCQA’s review of a health plan’s health quality processes (NCQA Accreditation).

Overall rating

The overall rating is the weighted average of a plan’s HEDIS, CAHPS and HOS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), calculated on a 0–5 scale in half-points (5 is highest), displayed as Stars and rounded to the nearest half-point (refer to [Rounding Rules](#), below). The rating is based on the following:

1. **Patient Experience Measures (CAHPS):** Patient-reported experience of care, including experience with doctors, plan services and customer service (measures in the Patient Experience category).
2. **Clinical Measures (HEDIS):** The proportion of eligible members who received preventive services (measures in the Prevention composite) and

the proportion of eligible members who received recommended care for certain conditions (measures in the Treatment composite).

3. **Sufficient Data:** Plans must meet the following requirements to receive an overall rating:

- Scorable rates for $\geq 50\%$ of all measures by weight, per applicable product line.
- Numerical rating (1–5) on at least one subcomposite under all three composites.

Note: Refer to [Handling missing values](#) for additional information.

4. **NCQA Health Plan Accreditation:** For a plan with Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half-point. For a plan with Interim status, 0.15 bonus points are added to the overall rating before rounding to the nearest half-point. A plan's Accreditation status is determined as of June 30.

Note:

- *If an Accredited plan chooses to publicly report performance data but is not yet required to report HEDIS/CAHPS data for Accreditation and/or has <15,000 members, it is scored on the data submitted and receives Accreditation bonus points.*
- *If an Accredited plan chooses not to publicly report performance data but is not yet required to report HEDIS/CAHPS data, it does not have a rating.*

Rounding rules

The overall rating is 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	$\geq 4.750 \rightarrow 5.0$
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 [Health Plan Ratings 2023](#) a full list of measures and indicators.

HEDIS compliance audit results

All submitted HEDIS results selected for public reporting must be audited by NCQA Certified HEDIS Compliance Auditors. Audits result in rates or calculations at the measure level and indicate if the measures can be publicly reported.

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.
Note: Plans seeking Accreditation **may not** report NR for performance measures included in the ratings measure list.
- *Biased Rate (BR)*. The calculated rate was materially biased.
- *Not Required (NQ)*. The organization was not required to report the measure.
Note: Plans seeking Accreditation **may not** report NQ for performance measures included in the ratings measure list.

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

NR, NQ and BR measures 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 50% of all measures by weight, and must have a numerical rating (1–5) on at least one subcomposite (e.g., Getting Care, Cancer Screening) under all three composites (Patient Experience, Prevention, Treatment) to receive an overall rating.

A plan that does not have scorable rates in at least 50% of measures by weight in the composite or subcomposite is assigned a value of *Insufficient Data (I)* for display purposes in the Final Ratings summary results and in the Final Ratings public display on NCQA’s Health Plan Report Card.

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.
- The Race/Ethnicity Diversity of Membership measure is given a weight of 0.5.

Note: Typically, 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.

Inverted rates

NCQA inverts all final rates and percentiles where “a lower value represents better performance” to “a higher value represents better performance” scale in the Ratings scoresheets and then truncates to 3 decimals. For example, a raw rate of .2325 displays as .767 (1 – .2325 = .7675, truncated to 3 decimals).

Accreditation status and status modifiers

A plan’s Accreditation status is determined by its status as of June 30. If a plan has an NCQA status modifier (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, composite and subcomposite ratings

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

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:

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

Deriving measure ratings from national benchmarks

To calculate individual measure scores, NCQA truncates final raw rates and percentiles to 3 decimals and compares the rates submitted by plans to The National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles, and then assigns the individual measure rating (calculated as whole numbers on a 1–5 scale) that the plans receive for each measure as follows:

Measure Ratings

Measure rating is in the top decile of plans	5
Measure rating is in the top 3rd of plans, but not in the top 10th	4
Measure rating is in the middle 3rd of all plans	3
Measure rating is in the bottom 3rd of plans, but not in the bottom 10%	2
Measure rating is in the bottom 10% of plans	1

***Note:** NCQA uses measurement year (MY) 2022 data and percentiles for commercial and Medicaid HEDIS/CAHPS and Medicare HEDIS. NCQA uses MY 2021 data and percentiles for Medicare CAHPS and HOS. For details on the Medicare exception, refer to [Medicare CAHPS and HOS](#).*

Scoring Race/Ethnicity Diversity of Membership

For scoring on this measure in Health Plan Ratings 2023, NCQA will give organizations credit (an individual measure rating of 5) if the reported Direct Race **and** Direct Ethnicity is >0%. Organizations that do not report Direct Race and Direct Ethnicity >0% will receive an individual measure rating of “0.”

Scoring risk adjusted utilization measures

NCQA distinguishes 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, the plan’s ratio and upper/lower confidence limits (CL) need to be calibrated to determine the percentage of the ratio above/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 <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/E's 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 2 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?

What plans are rated or receive scores?

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.

Plans with partial data

Plans with partial data do not receive a rating, but NCQA lists them in the ratings and shows and shows scores of reported measures. A plan is considered to have partial data if it:

- Submits HEDIS and CAHPS measure data for public reporting but has "missing values" (NA or NB) in over 50% of the weight of measures. 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 *HEDIS Volume 2: Technical Specifications* for information about missing values.
- Does not have a numerical rating (1–5) on at least one subcomposite (e.g., Getting Care, Cancer Screening) under all three composites (Patient Experience, Prevention, Treatment).

- 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.” For Medicare, refer to [Other display scenarios](#).
- 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.”

No data reported	Plans with ≥15,000 members that submit results but do not report data publicly, or that do not report HEDIS or CAHPS information and do not have an Accredited, Interim, Provisional, In Process or Scheduled status, receive a rating of “No Data Reported” and their measure rates are displayed as “NC.”
Low enrollment	Plans with <15,000 members that submit results but do not report data publicly, or that do not report HEDIS or CAHPS information and do not have an Accredited, Interim, Provisional, In Process or Scheduled status are listed as “Low Enrollment” in Projected and Final Ratings (private), but are not listed on the NCQA Health Plan Report Card.

Additional Rules

Medicaid CAHPS and benchmarks 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).⁴

Note: When a plan chooses Child with CCC survey for scoring, only the results from the Child CCC Final GP Result Report are used for scoring. The Child CCC Final CCC Results Report is provided to plans for informational purposes only, and is not used for scoring.

Plans designate the CAHPS component when completing the Healthcare Organization Questionnaire (HOQ). Designations may not be changed and are benchmarked by component selected:

- Adult CAHPS benchmarks are based on adult rates only.
- Child and Child CCC CAHPS benchmarks are based on the combined general population rates for both components.

Medicare CAHPS and HOS Using Medicare CAHPS and HOS data in the ratings depends on yearly approval by the Centers for Medicare & Medicaid Services (CMS). Because the submission schedule for Medicare CAHPS and HOS measures differs from the HEDIS submission schedule, NCQA scores organizations using the previous year’s data and percentiles (MY 2021) for measures in the CAHPS and HOS domain.

For Medicare plans that were not required to submit CAHPS or HOS in the previous year, these measures are displayed as “NC.”

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

Note: The exception to this applies to non-CMS required measures in the Health Plan Rating measure list. A measure that is not required to be reported by CMS, but is

required for ratings and is reported as NQ, the plan receives a 0 on the measure, and the measure weight is included in the ratings calculation.

Non-CMS required measures

If a CMS-required measure list differs from the Health Plan Rating-required measure list, Medicare plans must also report the Health Plan Rating measures. Failure to do so will result in the plan receiving a “0” on the measure and the measure weight will be included in its Ratings calculation.

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 NQ (Not Required) for an inpatient data indicator (as specified by CMS) and is a Medicare 1876 Cost Plan	NA (Not Applicable)
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 publicly report results on the IDSS Attestation.	NCQA-Accredited plans with HEDIS that marked their submission “Not Publicly Reported” on the Attestation are eligible for ratings. All measures are used to calculate the overall rating, and scores are displayed for all measures.
Plan is Accredited on Standards only, but submits HEDIS/CAHPS and did not elect to publicly report results on the IDSS Attestation. <i>Plan will have an overall rating score of Partial Data Reported.</i>	NC (No Credit) for all measures.
Plan is Accredited on Standards only and did not submit data, or submitted either HEDIS or CAHPS only. <i>Plan will have an overall rating score of Partial Data Reported.</i>	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. <i>Plan will have an overall rating score of Partial Data Reported.</i>	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 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 publicly report results on the IDSS Attestation. <i>Plan will have an overall rating score of No Data Reported.</i>	NC (No Credit) for all measures.

Note: Rules listed in the “Handling Missing Values” section apply to all scenarios listed above.

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](#).

Results

Health Plan Rating results are posted on the NCQA [Health Plan Report Card](#) in September.

Measure List

Find the list of measures included in the [2023 Health Plan Ratings](#) (for HEDIS MY 2022/Reporting Year 2023).

Health Plan Ratings Benchmarks and Percentiles

During the Projected Ratings sign-off process in August, all eligible plans (numerically rated [1–5]) will be provided with Excel workbooks on the Review Ratings private website that displays all scoring information, used to help plans confirm the accuracy of their score. There are no scoresheets for Partial Data Reported, No Data Reported and Low Enrollment plans. NCQA primary HEDIS and Accreditation contacts have access to Projected Ratings. 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.

HEDIS Reporting for Accreditation

Accredited organizations must submit HEDIS/CAHPS annually. Organizations with First or Interim Accreditation must submit HEDIS/CAHPS by the HEDIS submission date deadline in the next calendar year following the effective date of the Accreditation status. For more information, refer to *Health Plan Ratings* and *Evaluation Options* in the *Standards and Guidelines for the Accreditation of Health Plans*.

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](#).

Organizations must collect and report HEDIS and CAHPS results separately, by product line, for covered populations. Audited HEDIS results must reflect the exact product line/product combination for which an 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 and 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 results. A HEDIS/CAHPS reporting unit (Accreditable entity) 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 $\geq 15,000$ members in a product/product line submits audited HEDIS/CAHPS results to NCQA.

Reporting units with <15,000 members

A HEDIS/CAHPS reporting unit with <15,000 members may choose one of the following options for reporting before the Accreditation Survey begins:

- Produce and submit audited HEDIS/CAHPS results for the required measures to NCQA to be scored as part of Health Plan Ratings.
Note: Organizations submitting audited results of Small Denominator (NA) or No Benefit (NB) in over 50% of the weight of measures will receive an overall rating status of "Partial Data Reported" and their measure rates are displayed as "NC" (No Credit).
- Combine its membership with another reporting unit in accordance with the policies described below, if applicable, to submit audited HEDIS/CAHPS results.
- Be scored on 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 in 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.

CHIP reporting

Because HEDIS reporting must match the product line for which an organization seeks Accreditation, an organization with a CHIP population must include its CHIP members in its Medicaid product line, using Medicaid measure specifications, even if it needs separate HEDIS submissions for other purposes (e.g., state reporting).

If the state requires the organization to report CHIP members separately, a second, state-specific, CHIP-only HEDIS/CAHPS submission is required. The organization must note this state-specific requirement in the HOQ.

The organization must exclude CHIP members from its commercial product line; including these members in commercial populations may affect organization-to-organization comparison.

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](#).
- 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.

¹Medicare ratings on approval from CMS.

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

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

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