2025 Health Plan Ratings Methodology

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NCQA 2025 Health Plan Ratings Methodology

Summary of Changes

September 2025 Posting

- Added minor clarifications in the tables in the "Other display scenarios" section.

June 2025 Posting

- Revised the name of the "Prevention and Equity" composite to "Prevention and Population."

April 2025 Posting

- Revised the "Medicaid CAHPS and benchmarks" section to remove the bullet about the Medical Assistance With Smoking and Tobacco Use Cessation (MSC) measure.

December 2024 Posting

- Added a new sentence to the first paragraph under the "Measure, composite and subcomposite ratings" section to clarify that any subcomposite with one indicator or named "other" will not have a numerical rating.
- Revised the "Medicaid CAHPS and benchmarks" section to reflect the removal of the Child CAHPS with Chronic Conditions (Child CCC) as a CAHPS scoring component for Medicaid plans (only) in the HOQ.
- Revised the third paragraph of the "Reporting by reporting product and product line" section to clarify how organizations are scored.

September 2024 Posting

- Revised the second paragraph in the "Measures included" section to clarify when changes to the measure list may be made.
- Revised the "Scoring Language Diversity of Membership (LDM) measure" section to further clarify the scoring methodology.
- Added a note in the "Medicaid CAHPS and benchmarks" section to account for the expected removal of the Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit (MSC) measure from Health Plan Ratings (Medicaid).

August 2024 Posting

- Revised the "Scoring Language Diversity of Membership (LDM) measure" section to include the scoring methodology.

June 2024 Posting

- Added a new section titled "Scoring Language Diversity of Membership (LDM) 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 Medicare[1] 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's Health Plan 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

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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 and Population 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 ≥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 the last business day in June of the release year.

Note

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

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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	≥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 2025 Health Plan Ratings for a full list of measures and indicators.

Note: *After data are received, NCQA may remove any measure from Health Plan Ratings if <40% of the submitted rates are valid reported rates. There may also be other changes to measures in Health Plan Ratings, at NCQA's discretion.*

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 eligible population (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 on the Health Plan Rating 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 Health Plan Rating measure list.*

Audit results for CAHPS 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.
- *Small Denominator (NA).* The organization followed the specifications, but the eligible population (i.e., denominator) was too small. For measures in the CAHPS domain, organizations must achieve a denominator of at least 100 responses to obtain a reportable result. If the denominator for a particular survey result calculation is less than 100, NCQA assigns a measure result of *NA.*

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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 (per applicable product line) 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 and Population, 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 (per applicable product line) 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 1.
- The Language 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.*

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

A plan's Accreditation status is determined by its status as of the last business day in June of the release year. If a plan has an NCQA status modifier (Under Review by NCQA, Under Corrective Action, Merger Review in Process, Appealed by Organization) as of the last business day in June of the release year, 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

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

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subcomposite ratings

individual measure levels. Any subcomposite that only has one indicator or is named "other" will not have a numerical rating associated with it.

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. The weight of any NA or NB measure is not included in the sum of measure weights (per applicable product line). A plan must have scorable rates (valid performance rate, NR, NQ and BR) for at least 50% of measures by weight (per applicable product line) in order for NCQA to produce a numerical rating (1-5) for the subcomposite or composite. NCQA uses the following formula to score composites and subcomposites:

(Sub) Composite Rating = ∑ (measure rating * measure weight) / ∑ 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 third of plans, but not in the top 10th	**4**
Measure rating is in the middle third of all plans	**3**
Measure rating is in the bottom third 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) 2024 data and percentiles for commercial and Medicaid HEDIS/CAHPS and Medicare HEDIS. NCQA uses MY 2023 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 (RDM) measure

For scoring on this measure in Health Plan Rating 2025, NCQA will give organizations credit (an individual measure rating of "5") if the reported Direct Race ***and*** Direct Ethnicity is ≥20%.

Organizations that do not report Direct Race and Direct Ethnicity ≥20% will receive an individual measure rating of "0." The measure has a weight of 1.0.

Scoring Language Diversity of Membership (LDM) measure

For scoring on this measure in Health Plan Rating 2025, NCQA will give organizations credit (an individual measure rating of "5") if the reported "Unknown" Preferred Written Language **and** "Unknown" Preferred Spoken Language is <80%. Organizations that do not achieve an "Unknown" Preferred Written Language and "Unknown" Preferred Spoken Language of <80% will receive an individual measure rating of "0." The LDM measure has a weight of 0.5.

Note: *The <80% "Unknown" is equivalent to the previously announced target of ≥20% "Known" value for preferred written and spoken language, and better aligns with current measure reporting components in IDSS.*

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

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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/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 Health Plan Rating'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	Health Plan Ratings 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.*

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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 Health Plan Rating 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 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 the measures they submitted NA or NB are displayed as NA.
- The measures for which plans submitted a NR, NQ or BR display as "NC" (No Credit). Refer to *HEDIS Volume 2: Technical Specifications* for information about audit designations.
- 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 and Population, 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 (i.e., Accredited, Provisional or Interim status) without HEDIS and CAHPS data (Health Plan Accreditation standards only) or submitted data but said "No" to 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

A plan receives a rating of "No Data Reported" and measure rates are displayed as "NC" if it:

- Has ≥15,000 members and submits HEDIS or CAHPS data, but says "No" to public reporting and does not have an Accredited, Provisional or Interim status.
- Has ≥15,000 members, a status of In Process, Scheduled or None, and does not submit HEDIS or CAHPS data.
- Has <15,000 members, a status of In Process or Scheduled, and does not report HEDIS or CAHPS data.

Low enrollment

A plan receives a rating of "Low Enrollment" in Projected and Final Ratings (private), but is not listed on the NCQA Health Plan Report Card if it:

- Has <15,000 members and submits data, but says "No" to public reporting and does not have an Accredited, Provisional, Interim, In Process or Scheduled status.
- Has <15,000 members, does not submit data and does not have an Accredited, Provisional, Interim, In Process or Scheduled status.

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Additional Rules

Medicaid CAHPS and benchmarks

Medicaid plans may choose the version of the CAHPS survey (or "component") they want scored: Adult CAHPS or Child CAHPS.[4]

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 CAHPS benchmarks are based on the combined General Population of Child With CCC and Child Without CCC CAHPS rates.

Note

- *Medicaid plans select the CAHPS scoring component they wish to be scored on in the HOQ at the Product Line (Medicaid)/Reporting Product (HMO) level. This selection must align with the CAHPS Survey associated with the submission ID used for Health Plan Ratings.*

  For instance, if a Medicaid HMO plan (with submission ID 1234) selects the "Adult CAHPS" for the "CAHPS Component Scored" field, they must ensure that submission ID 1234 is fielding the Adult CAHPS survey. Misalignment will result in this submission receiving "NR" (Not Reported) values, which are given a score of 0 for the CAHPS measures used in Health Plan Ratings.

Medicare CAHPS and HOS

Using Medicare CAHPS and HOS data in Health Plan Rating 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 2023) 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 "NA." Refer to the "Other display scenarios" tables below for additional details.

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 Health Plan Rating 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.

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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 CAHPS measures as NC, overall Rating = Partial Data Reported
For Medicare, if "CAHPS Submitted = FALSE" and "CAHPS Required for previous year = FALSE"	Display CAHPS measures as NA, overall Rating = Partial Data Reported
For Medicare, if "HOS Submitted = FALSE" and "HOS Required for previous year = FALSE"	Display HOS measure as NA.

APPLY SECOND	
Rate/Scenario	**Display**
Plan is Accredited (i.e., Accredited, Provisional or Interim status) on HEDIS and CAHPS, and said No to public reporting on the IDSS Attestation.	NCQA-Accredited (i.e., Accredited, Provisional or Interim status) plans with HEDIS and CAHPS that said No to public reporting on the IDSS Attestation are eligible for Health Plan Ratings. All measures are used to calculate the overall rating, and scores are displayed for all measures.
Plan is Accredited (i.e., Accredited, Provisional or Interim status) on Standards only, but submits data and said No to public reporting on the IDSS Attestation. *Plan will have an overall rating score* of Partial Data Reported.	NC (No Credit) for all measures.
Plan is Accredited (i.e., Accredited, Provisional or Interim status) on Standards only, and did not submit data, *Plan will have an overall rating score* of Partial Data Reported.	NC (No Credit) for all measures.
Plan is Accredited (i.e., Accredited, Provisional or Interim status) on Standards only and submitted either HEDIS or CAHPS only and said Yes to public reporting on the IDSS Attestation. *Plan 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 and HOS rules above. All measures with valid performance rates are displayed.
Plan is not Accredited, and submitted either HEDIS or CAHPS only and said Yes to public reporting on the IDSS Attestation. *Plan 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 and HOS rules above. All measures with valid performance rates are displayed.
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.

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APPLY SECOND	
Rate/Scenario	**Display**
Plan is not Accredited, or is "In-Process" or "Scheduled" for Accreditation Survey, and submitted data and said No to public reporting on the IDSS Attestation. *Plan will have an overall rating score* of No Data Reported.	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. Special Project SNP submissions are not eligible for Health Plan Rating.

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 2025 Health Plan Ratings (for HEDIS MY 2024/Reporting Year 2025).

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 Health Plan Rating 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 Health Plan Rating and not for general benchmarking or commercial purposes.

To aid in plans' quality improvement efforts, NCQA created a Health Plan Ratings–Final Results website that grants access to the individuals listed above to past performance, including prior year percentiles/ benchmarks.

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.*

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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 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 ≥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.

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- 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.

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[1]Medicare ratings on approval from CMS.
[2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[4]CAHPS components are described in more detail in *HEDIS Volume 3: Specifications for Survey Measures.*

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