Health Insurance Exchange℠

Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017

June 2017

Version 2.0

Document Change Log

Description	Date
Initial release of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017.* This guidance addresses requirements for 2017, which include data submission in the 2017 calendar year for quality rating information that will be publicly reported by the Exchanges, beginning during the open enrollment period for the 2018 plan year. Please see Section 1.1 for a summary of key differences between this document and the Technical Guidance for 2016, Version 2.0 of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016.*	9/20/2016
Version 2.0 is the final version of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017.* This version of the 2017 Guidance is the final Guidance to communicate 2017 QRS requirements and supersedes the initial version of the Guidance, which was published in September 2016. It includes the final QRS rating methodology, along with applicable refinements finalized in the 2017 QRS Call Letter and other applicable CMS guidance. Please see Section 1.1 for a summary of key differences between this document and Version 2.0 of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016.*	6/14/2017

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List of Exhibits

Technical Assistance

Please see the instructions below for submitting questions regarding this document or any requirements related to the *Quality Rating System (QRS) and the Qualified Health Plan (QHP) Enrollee Experience Survey* (QHP Enrollee Survey):

- **QHP issuers:** Please submit questions to the Exchange Operations Support Center (XOSC) Help Desk via email to CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Please reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.
- **Multi-state Plan (MSP) issuers:** Please submit questions via email to MSPPIssuer@OPM.gov and reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line. For MSP issuers that are also QHP issuers, please copy the QHP issuer contact (CMS_FEPS@cms.hhs.gov).
- **State-based Exchanges (SBEs):** Please submit questions to your respective State Officers.
- **Federally-facilitated Exchanges:** Please submit questions via email to CMS_FEPS@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.
- **Other stakeholders:** Please submit questions via email to Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.

Accompanying Documents

The accompanying document, the *2017 Quality Rating System Measure Technical Specifications*, details QRS clinical measure and QRS survey measure specifications and guidelines for data collection. The document can be found on the Centers for Medicare & Medicaid Services (CMS) Health Insurance MQI website (link in the table below). For questions on individual measures, please contact the appropriate measure stewards via the contact information listed in the technical specifications.

Website Links

The following resources provide additional details related to the QRS and QHP Enrollee Survey.

Website	Description	Link
CMS MQI website	This website provides resources related to CMS MQI activities, including the QRS, consumer experience surveys (e.g., the QHP Enrollee Survey), Quality Improvement Strategy (QIS) requirements, and patient safety standards. As the central site for QRS resources, this site contains instructional documents regarding QRS implementation and reporting, including this document, and the *2017 Quality Rating System Measure Technical Specifications*.	http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

Website	Description	Link
CMS QHP Enrollee Survey website	As the central website for the QHP Enrollee Survey, this website includes detailed information on the survey questionnaire, a list of the Department of Health & Human Services (HHS)-approved QHP Enrollee Survey vendors, and survey protocols for vendors (including the *2017 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications*).	http://qhpcahps.cms.gov
National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audit™ website	This website provides additional information related to data validation, including the data validator contracting process, as well as HEDIS® Compliance Audit standards, policies, and procedures.	http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx
Registration for Technical Assistance Portal (REGTAP)	This website serves as an information hub for CMS technical assistance related to Exchange and Premium Stabilization Program requirements. Registered users can access the library, frequently asked questions, training resources, and the inquiry tracking and management system. Use key word search "Quality Rating System" to identify any resources related to the QRS.	https://www.REGTAP.info
State Exchange Resource Virtual Information System (SERVIS)	This website serves as an information hub for CMS technical assistance related to SBE requirements. Registered State users can access relevant resources organized by the Center for Consumer Information and Insurance Oversight (CCIIO) State Exchange Group.	https://servis.cms.gov/resources/

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

1. Document Purpose and Scope

This *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017* (2017 Guidance) document provides technical guidance regarding the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) for 2017. It specifies QRS and QHP Enrollee Survey requirements for QHP issuers offering coverage through the Health Insurance Exchanges [SM] (Exchanges) (also known as Health Insurance Marketplaces).[1] Unless the context indicates otherwise, the term "Exchanges" refers to the Federally-facilitated Exchanges (FFEs) (inclusive of FFEs where the State performs plan management functions) and the State-based Exchanges (SBEs) (inclusive of State-based Exchanges on the Federal Platform [SBE-FPs]).

This updated version of the 2017 Guidance, version 2.0, communicates 2017 QRS requirements and supersedes the initial version of the Guidance that was published in September 2016. Specifically, version 2.0 includes the final rating methodology, based on the analysis of the 2016 data. Section 1.1 highlights all key updates made since the initial version of the 2017 Guidance. CMS anticipates issuing guidance at least annually in the fall before the year of data submission.

The primary audience for the 2017 Guidance is QHP issuers, but this document also includes information relevant to other stakeholders involved with QRS and QHP Enrollee Survey implementation (e.g., SBEs, data validators, Department of Health & Human Services [HHS]-approved survey vendors). The 2017 Guidance addresses requirements for 2017, which includes data submission in the 2017 calendar year for ratings for the 2018 plan year.[2]

The requirements outlined in this document are based on statute and Centers for Medicare & Medicaid Services (CMS) regulation, including the "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" Final Rule.[3]

The initial version of 2017 Guidance included QRS program refinements (including refinements to the QHP Enrollee Survey) described in the final 2016 QRS Call Letter published in September 2016,[4] as applicable.[5] This updated version of 2017 Guidance incorporates applicable

[1] Health Insurance Exchange[SM] and Exchange[SM] are service marks of the U.S. Department of Health & Human Services.
[2] All references to "coverage year" have been changed to "plan year" since the initial version of 2016 Guidance. The year referenced is the same year, but the term has been revised to reflect most common usage.
[3] "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" Final Rule, 79 FR 30240 at 30352 (May 27, 2014) (45 C.F.R. Parts 144, 146, 147, et al.).
[4] The final 2016 QRS Call Letter is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.
[5] This document does not reflect proposed revisions to the Information Collection Request (ICR) for the QHP Enrollee Survey (CMS-10488) outlined in the *Federal Register* notices at https://www.gpo.gov/fdsys/pkg/FR-2016-07-12/pdf/2016-16445.pdf or https://www.gpo.gov/fdsys/pkg/FR-2017-04-14/pdf/2017-07568.pdf.

refinements described in the 2017 QRS Call Letter[6] published in May 2017, as well as other previously announced[7] changes to the 2017 QRS.

1.1 Section Guide

In addition to the initial background sections, this document includes the information noted below. Where applicable, the section descriptions highlight key differences between the 2016 Guidance[8] and this 2017 Guidance.

- **Section 4. Implementation Schedule for the QRS and QHP Enrollee Survey:** This section provides a snapshot of the implementation process, key dates, and the stakeholder(s) with primary responsibility for critical action(s).
- **Section 5. Exchange Oversight Responsibilities:** This section describes Exchange responsibilities related to the QRS and QHP Enrollee Survey.
- **Section 6. QRS and QHP Enrollee Survey Requirements:** This section outlines the criteria for determining which QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS. This section also describes the QRS measure set and details the requirements for data collection, data validation, and data submission for the QRS and the QHP Enrollee Survey.

Key Differences in Requirements Between the 2016 Guidance and the 2017 Guidance
For the 2017 QRS and QHP Enrollee Survey, CMS added an additional minimum enrollment threshold to the participation criteria. Specifically, reporting units must have more than 500 enrollees as of July 1 of the prior year (e.g., 2016) *and more than 500 enrollees as of January 1 of the ratings year*[9] (e.g., 2017) to be eligible to participate in the QRS and QHP Enrollee Survey. In addition, QHP issuers will not be required to submit data for the Aspirin Use and Discussion (ASP) measure or the Relative Resource Use (RRU) measure for the 2017 QRS. CMS added language to address QHP issuers impacted by a change in ownership (e.g., merger, acquisition). CMS will not accept voluntary submissions (i.e., data from QHP issuers for reporting units that do not meet the participation criteria).

[6] The final 2017 QRS Call Letter is available at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/health-insurance-marketplace-quality-initiatives.html.

[7] In January 2017, CMS announced it was taking steps to align the 2017 QRS with changes made the measure steward. Specifically, neither the Aspirin Use and Discussion (ASP) nor the Relative Resource Use for People with Diabetes (Inpatient Facility) (RRU) measure would be used for scoring in the 2017 ratings year; and QHP issuers would not be required to submit data for the RRU measure in 2017. This guidance also announced that the ASP measure was being removed from the 2017 QRS. The January 6, 2017 FAQs are available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

[8] The term "2016 Guidance" refers to all CMS sub-regulatory guidance applicable to the 2016 ratings year, including Version 2.0 of the *QRS and QHP Enrollee Survey: Technical Guidance for 2016*, the *Quality Rating Information Bulletin*, and other CMS guidance (e.g., frequently asked questions available on REGTAP).

[9] See Appendix G for more information on the term "ratings year."

- **Section 7. QRS Rating Methodology:** This section provides an overview of the rating methodology used to produce the QRS scores and ratings from QRS measure data. The key differences outlined here reflect changes to the QRS rating methodology to align with technical specification changes by the applicable measure steward. The final 2017 QRS rating methodology is included in Appendix D.

Key Differences in Methodology Between the 2016 Guidance and the 2017 Guidance
For the 2016 QRS, CMS only scored those measures that required one year of data per the continuous enrollment criteria, with the exception of the *Relative Resource Use for People with Diabetes (Inpatient Facility Index)* (RRU) measure. For the 2017 QRS, CMS will score all measures in the QRS measure set as defined in the *2017 Quality Rating System Measure Technical Specifications*, with the exception of the RRU measure, the *Immunizations for Adolescents* (IMA) measure, and the *Aspirin Use and Discussion* (ASP) measures. In December 2016, the National Committee for Quality Assurance (NCQA) suspended collection of the RRU measure due to decreased usefulness and costs that exceed value. Therefore, the RRU measure will not be used in scoring for the 2017 ratings year, and QHP issuers will not be required to submit data for the RRU measure. For 2017, the *Human Papillomavirus Vaccination for Female Adolescents* (HPV) and IMA measures are combined into one IMA measure. CMS will not include the updated IMA measure in scoring for the 2017 ratings year, given the significant change to the technical specifications by the applicable measure steward. In December 2016, NCQA announced the retirement of the ASP measure due to misalignment with updated recommendations from the United States Preventive Services Task Force (USPSTF). Due to retirement of the ASP measure, it will not be used in scoring for the 2017 ratings year, and QHP issuers will not be required to submit data for the ASP measure.

- **Section 8. Quality Rating Information Results and Preview:** This section describes the process by which QHP issuers and Exchanges will be able to review QHP quality rating information (i.e., QRS ratings and QHP Enrollee Survey results) in advance of public display.

- **Section 9. Exchanges Display Guidelines for QHP Quality Rating Information:** This section provides an overview of the guidelines for display of QHP quality rating information on Exchange websites.

Key Differences in Display Between the 2016 Guidance and the 2017 Guidance
For the 2016 ratings year, CMS released the *Quality Rating Information Bulletin* announcing the limited display consumer pilot test beginning with the 2017 individual market open enrollment period.

Key Differences in Display Between the 2016 Guidance and the 2017 Guidance
On June 9, 2017, CMS released an *Updated Quality Ratings Information Bulletin* announcing the second year of consumer pilot testing of QHP quality ratings information. At this time, CMS anticipates that the second pilot year will be conducted in the same States that displayed QRS star ratings beginning during the 2017 individual market open enrollment period (i.e., Virginia and Wisconsin). Beginning with the 2018 individual market open enrollment period, CMS anticipates displaying the 2017 QRS global rating and three summary indicator ratings on the HealthCare.gov website for eligible QHPs operating in the pilot States. SBEs whose consumers do not use HealthCare.gov may choose to display QHP quality information beginning with the 2018 individual market open enrollment period.

- **Section 10. Marketing Guidelines for QHP Quality Rating Information:** This section describes guidelines for QHP issuers that elect to include QHP quality rating information in their marketing materials.

Key Differences in Marketing Guidelines Between the 2016 Guidance and the 2017 Guidance
Following the announcement of the limited display consumer pilot test beginning with the 2017 individual market open enrollment period, CMS released a frequently asked question (FAQ) document providing updated guidance related to inclusion of 2016 QHP quality rating information in QHP issuers' marketing materials.[10] This same guidance applies to QHP issuers in Exchanges that publicly display 2017 QHP quality rating information. The appropriate disclaimer language for the 2018 open enrollment period is provided in Section 10.

2. Background

Section 1311(c)(3) of the Patient Protection and Affordable Care Act[11] directs the Secretary of HHS to develop a quality rating for each QHP offered through an Exchange, based on quality and price. Section 1311(c)(4) of the Patient Protection and Affordable Care Act directs the Secretary to establish an enrollee satisfaction survey that will assess enrollee satisfaction with each QHP offered through the Exchanges with more than 500 enrollees in the prior year.

Based on this authority, CMS issued a regulation in May 2014 to establish standards and requirements related to QHP issuer data collection and public reporting of quality rating information in every Exchange.[12] As a condition of certification and participation in the Exchanges, CMS requires that QHP issuers submit QRS clinical measure data and QHP Enrollee

[10] CMS released FAQ 17068 on August 3, 2016 on the Registration for Technical Assistance Portal (REGTAP), available at: https://www.regtap.info/faq_viewu.php?id=17068.
[11] The Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively referred to as the Patient Protection and Affordable Care Act).
[12] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final Rule, 79 Fed. Reg. 30240 at 30352 (May 27, 2014), 45 C.F.R. §§ 156.1120 and 156.1125.

Survey response data for their respective QHPs offered through an Exchange in accordance with CMS guidelines.[13] Exchanges are also required to display QHP quality rating information on their respective websites.[14] Appendix A includes relevant statutory and regulatory citations for the QRS and QHP Enrollee Survey.

3. Overview

The goals of the QRS and QHP Enrollee Survey are to:

- Provide comparable and useful information to consumers about the quality of health care services and enrollee experience with QHPs offered through the Exchanges,
- Facilitate oversight of QHP issuer compliance with quality reporting standards set forth in the Patient Protection and Affordable Care Act and implementing regulations, and
- Provide actionable information that QHP issuers can use to improve quality and performance.

CMS aligned federal quality reporting standards for QHP issuers with other federal and State quality reporting program standards and the National Quality Strategy (NQS) priorities for improving the quality of health and health care.[15] States have the flexibility to build upon the federal quality reporting standards by setting additional standards for QHPs that reflect State priorities and population-based needs.

QHP issuers and Multi-state Plan (MSP) issuers that offered coverage through an Exchange in the prior year are required to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS as a condition of certification.[16] An MSP option, certified by and under contract with the Office of Personnel Management (OPM), is recognized as a QHP for purposes of 45 C.F.R. §155.1010. Therefore, the QHP issuer requirements described in 2017 Guidance also apply to QHP issuers offering MSP options. If necessary, additional MSP quality reporting requirements will be specified by OPM.

CMS will calculate the quality performance ratings for QHPs offered through all Exchanges, regardless of the Exchange model. CMS will apply the QRS rating methodology to validated QRS clinical measure data and a subset of the QHP Enrollee Survey response data (QRS survey measures) to produce quality ratings on a 5-star rating scale.[17] CMS will calculate quality ratings for each QHP issuer's product type (i.e., exclusive provider organization [EPO], health maintenance organization [HMO], point of service [POS], and preferred provider organization [PPO]) within each State and apply those ratings to each product type's eligible QHPs in that State. Beginning with the 2018 individual market open enrollment period, CMS anticipates

[13] 45 C.F.R. §§§ 156.200(b)(5),(h); 156.1120; and 156.1125.
[14] 45 C.F.R. §§ 155.1400 and 155.1405.
[15] The NQS was first published by the Agency for Healthcare Research and Quality (AHRQ) in March 2011 as the *National Strategy for Quality Improvement in Health Care*. It established a framework for coordinating quality improvement efforts of health care payers, purchasers, providers, and consumers. The NQS established a set of three broad aims, building on the Institute for Healthcare Improvement's Triple Aim®, supported by six priorities**.** See http://www.ahrq.gov/workingforquality/ for additional information.
[16] 45 C.F.R. §§§ 156.200(b)(5),(h); 156.1120; and 156.1125.
[17] The QHP Enrollee Survey includes a core question set that will be used to assess enrollee experience with health care services. Specific questions are grouped to form survey measures that will be used in the QRS.

displaying the 2017 QRS global rating and three summary indicator ratings on the HealthCare.gov website for eligible QHPs operating in pilot States. SBEs whose consumers do not use HealthCare.gov may choose to display QHP quality information beginning for the 2018 individual market open enrollment period.

CMS anticipates issuing guidance at least annually and expects to refine the QRS and QHP Enrollee Survey over time, based on experience with measuring and reporting quality performance for QHPs offered through the Exchanges. CMS will propose and communicate refinements to the QRS and QHP Enrollee Survey annually through a Call Letter process or through the information collection request process per the Paperwork Reduction Act requirements (as appropriate).

4. Implementation Schedule for the QRS and QHP Enrollee Survey

Exhibit 1 highlights key events and dates associated with 2017 QRS and QHP Enrollee Survey implementation. CMS expects QHP issuers to meet the following deadlines so data validators (Healthcare Effectiveness Data and Information Set [HEDIS®] Compliance Auditors) and survey vendors can effectively support QHP issuers in complying with the data collection and submission requirements. Details are addressed in the sections that follow.

Exhibit 1. Implementation Schedule for the 2017 QRS and QHP Enrollee Survey

Event	Date
QHP issuer contracts with a HEDIS® Compliance Organization (NCQA-licensed) for validation of the QHP Enrollee Survey sampling frame and the QRS clinical measure data.	**Deadline:** December 1, 2016
QHP issuer contracts with an HHS-approved QHP Enrollee Survey vendor and authorizes vendor to conduct the QHP Enrollee Survey and submit survey response data to CMS.	**Deadline:** January 5, 2017
QHP issuer and HEDIS® Compliance Auditor (employee of or contracted by the HEDIS® Compliance Organization) complete validation of QHP Enrollee Survey sampling frame.	**Deadline:** January 31, 2017
QHP issuer completes NCQA's Healthcare Organization Questionnaire (HOQ) to prepare for QRS clinical measure data submission.	**Deadline:** February 2017
QHP issuer and HEDIS® Compliance Auditor complete the HEDIS® Compliance Audit™.	January – June 2017[18]
HHS-approved QHP Enrollee Survey vendor conducts the QHP Enrollee Survey on the validated survey sampling frame.	February – May 2017
HHS-approved QHP Enrollee Survey vendor submits the QHP Enrollee Survey response data to CMS (on behalf of the QHP issuer) via a secure data submission function on the QHP Enrollee Survey website (http://qhpcahps.cms.gov).	**Deadline:** May 25, 2017

[18] Please see the general guidelines in the *2017 Quality Rating System Measure Technical Specifications* for a more detailed timeline for the HEDIS® Compliance Audit.

Event	Date
QHP issuer submits the validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS).[19] **Note:** Each QHP issuer must submit and plan-lock its QRS clinical measure data by June 8 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit-lock all submissions by the June 15 deadline.	**Deadline:** June 15, 2017
QHP issuers, Exchange administrators, and CMS preview the 2017 QHP quality rating information.	Anticipated August 2017
Pilot States and participating SBEs publicly display QHP quality rating information.	**Deadline:** Individual market open enrollment period for 2018 (that begins November 1, 2017)[20]

5. Exchange Oversight Responsibilities

Exchanges are responsible for QHP certification and oversight of compliance with certification standards by QHP issuers operating in their respective Exchanges. Included in this responsibility is oversight of QHP issuer compliance with QRS and QHP Enrollee Survey requirements.[21] Thus, CMS (on behalf of the FFEs) and the SBEs[22] will monitor and enforce compliance with QRS and QHP Enrollee Survey requirements with respect to QHP issuers operating in their respective Exchanges. Similarly, OPM is responsible for MSP certification and MSP issuer oversight and, therefore, will oversee MSP issuer compliance with these requirements. CMS will coordinate with the SBEs and OPM as needed to support their oversight efforts since CMS is responsible for calculating quality ratings for all eligible QHPs and MSP options in every Exchange.[23]

CMS will provide the SBEs with: (1) a list of QHP issuers that have eligible reporting units (as defined in Section 6.1) and are required to submit QRS clinical measure and QHP Enrollee Survey response data, and (2) a status update following the data submission deadline with a list of QHP issuers that submitted data for their eligible reporting units. The SBEs can use this information to support oversight of their respective QHP issuers' compliance with QRS and QHP Enrollee Survey requirements. CMS will also provide this information to OPM for MSP issuer oversight.

In addition to the federal requirements established by HHS, an SBE may choose to impose additional quality reporting requirements for QHPs offered through its Exchange. Additional State quality information can be used to supplement, but not replace or otherwise modify, the HHS-calculated QRS ratings. QHP issuers operating in an SBE should confirm any additional quality reporting requirements with that SBE.

6. QRS and QHP Enrollee Survey Requirements

This section outlines the participation criteria for compliance with QRS and QHP Enrollee Survey requirements (i.e., collection and submission of validated QRS clinical measure data and

[19] There are no fees for QHP issuers associated with accessing and using the IDSS.
[20] 45 C.F.R. § 155.410(e)(2).
[21] 45 C.F.R. § 155.200(d).
[22] SBEs, unless otherwise noted, include State-based Exchanges on the Federal Platform (SBE-FP) states (i.e., SBE states whose consumers use HealthCare.gov).
[23] 45 C.F.R. §§ 155.1010(a)(2) and 155.200(d).

QHP Enrollee Survey response data to CMS). Also described in this section is the QRS measure set, which includes both clinical measures and survey measures derived from a subset of questions in the QHP Enrollee Survey. Lastly, this section details the requirements for data collection, data validation, and data submission for the QRS and the QHP Enrollee Survey.

Not all reporting units that are eligible for compliance with QRS and QHP Enrollee Survey requirements will be eligible for QRS scoring. Section 7 includes information regarding scoring of eligible reporting units.

6.1 Participation Criteria for QHP Issuers

QRS and QHP Enrollee Survey requirements apply to QHP issuers offering QHPs through the Exchanges that meet participation criteria defined in this section.

QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data for each unique combination of product type and State.[24] QHP issuers may not combine product types or States. Therefore, the reporting unit for the QRS and QHP Enrollee Survey is defined by the unique State-product type for each QHP issuer. Product types subject to the QRS and QHP Enrollee Survey requirements include EPOs, HMOs, POSs, and PPOs. At this time, QRS and QHP Enrollee Survey requirements do not apply to indemnity plans (i.e., fee for service plans).

QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data for each reporting unit (defined above) that meets all of the below criteria:

- Offered through an Exchange in the prior year (i.e., 2016 calendar year);
- Offered through an Exchange in the ratings year (i.e., 2017 calendar year); and
- Meets the QRS minimum enrollment requirements[25, 26]:
  - Included more than 500 enrollees as of July 1 in the prior year (i.e., July 1, 2016); and
  - Included more than 500 enrollees as of January 1 of the ratings year (i.e., January 1, 2017).

Reporting units discontinued before June 15 of the ratings year (i.e., June 15, 2017) are exempt from these requirements. For an eligible reporting unit impacted by a QHP issuer change in ownership (e.g., merger, acquisition) effective as of January 1 of the ratings year, the QHP issuer that assumes the reporting unit is responsible for meeting these requirements.

CMS will *not* accept voluntary data submissions for reporting units that do not meet participation criteria as defined above.

When determining which enrollees to include in each reporting unit, QHP issuers must follow these guidelines:

[24] Pursuant to 45 C.F.R. §§ 156.1120(a)(3) and 156.1125(b)(3), QHP issuers participating in the Marketplaces must include information in their respective QRS and QHP Enrollee Survey data submissions only for those enrollees at the level specified by HHS.
[25] 45 C.F.R. §§ 156.1120(a) and 156.1125(b).
[26] The QHP Enrollee Survey minimum enrollment requirement aligns with standards set forth in 45 C.F.R. § 156.1125(b)(1). CMS established the minimum enrollment requirement for QRS to align with the QHP Enrollee Survey minimum enrollment requirement and to support a sufficient size for credible and reliable results.

- Include enrollees in QHPs offered through an Exchange in the 2017 QRS and QHP Enrollee Survey data submissions. For example, an eligible enrollee who does not have access to an Exchange website could enroll in an Exchange QHP directly with a QHP issuer; such an enrollee is to be included in 2017 QRS and QHP Enrollee Survey data submissions. These Exchange QHPs will be designated by Health Insurance Oversight System (HIOS) ID variants -01 through -06.
- Do not include enrollees in QHPs offered outside the Exchange (i.e., off-Exchange health plans) and non-QHPs in the 2017 QRS and QHP Enrollee Survey data submissions. Off-Exchange health plans include those that mirror QHPs offered through an Exchange due to guaranteed availability requirements (Section 147.104(a) of the Affordable Care Act), and are designated with a HIOS variant ID -00.
- Include enrollees in QHPs that provide family and/or adult-only medical coverage (unless noted otherwise in the *2017 Quality Rating System Measure Technical Specifications*). At this time, QRS and QHP Enrollee Survey requirements do not apply to child-only plans or stand-alone dental plans.[27]
- Include enrollees in a reporting unit that may be aligned to a different certified QHP issuer in the prior year, in cases where the QHP issuer has documented a change in ownership that is effective as of January 1 of the ratings year (e.g., the gaining QHP issuer should include enrollees previously aligned to the ceding QHP issuer in cases of merger or acquisition).
- Combine enrollees from both QHP and MSP products if the QHP issuer offers both a QHP and an MSP option of the same product type in the same State.
- Combine enrollees from both the individual market and Small Business Health Options Program (SHOP) if the QHP issuer offers the same product type in the individual market as well as the SHOP within a State.

CMS will *not* accept data submissions for reporting units that do not follow the guidelines as defined above for determining which enrollees should be included.

Example:

A fictional QHP issuer is certified to offer family medical coverage in two States: West Virginia (WV) and Maryland (MD). Exhibit 2 shows the characteristics of the issuer's reporting units. In accordance with the participation criteria defined above, this QHP issuer must collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS for only the following reporting unit: WV PPO. The other reporting units either did not have a sufficient number of enrollees as of July 1, 2016, did not have a sufficient number of enrollees as of January 1, 2017, or were discontinued before June 15, 2017.

[27] A limited number of child-only QHPs and enrollees may prohibit reliable child-only QRS rating calculations and QHP Enrollee Survey results. CMS will continue to monitor child-only plans and stand-alone dental plans, and will consider developing a quality rating system and QHP Enrollee Survey for these plan types in the future.

Exhibit 2. Example Reporting Units for a QHP Issuer Assessed Against 2017 QRS and QHP Enrollee Survey Participation Criteria

Reporting Unit	Enrollment as of July 1, 2016 (total and per individual market vs. SHOP	Enrollment as of January 1, 2017 (total and per individual market vs. SHOP)	Offered as of June 15, 2017	Meet participation criteria? (i.e., required to submit QRS and QHP Enrollee Survey measure data)?
WV PPO	505 (505 individual, 0 SHOP)	505 (505 individual, 0 SHOP)	Yes	Yes
WV HMO	601 (501 individual, 100 SHOP)	N/A	No – discontinued as of December 31, 2016	No – not operating in ratings year
MD PPO	100 (55 individual, 45 SHOP)	100 (55 individual, 45 SHOP)	Yes	No – insufficient enrollment size in both years
MD HMO	700 (700 individual, 0 SHOP)	300 (300 individual, 0 SHOP)	Yes	No – insufficient enrollment size as of January 1, 2017

QHP issuers with specific questions related to the application of the QRS and QHP Enrollee Survey participation criteria and/or determining reporting unit eligibility should seek guidance from CMS via the Exchange Operations Support Center (XOSC) Help Desk. Details on addressing membership changes in measure data collection are provided in the General Guidelines for Data Collection section of the *2017 Quality Rating System Measure Technical Specifications* under "Membership Changes."

6.2 QRS Measure Set

QHP issuers that meet the participation criteria as defined in Section 6.1 are required to collect and submit validated data for all measures as listed in Exhibit 3. The QRS measure set consists of measures that address the areas of: clinical quality management; enrollee experience; and plan efficiency, affordability, and management.

Some measures have multiple indicators (or rates), including additional sub-levels (e.g., age bands). QHP issuers are required to submit validated data for all elements within a measure, unless a specific indicator is shown in parentheses next to the measure. In the latter case, only that indicator must be reported (e.g., for Childhood Immunization Status [Combination 3], only Combination 3 must be reported).

The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which draws heavily from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[28] surveys. Note that the QRS survey measures (except for the three clinical measures captured in the QHP Enrollee Survey) and the QRS clinical measures Plan All-Cause Readmissions are case-mix adjusted. See Section 6.2.1 for details on the QHP Enrollee Survey.

[28] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The CAHPS® surveys are available at https://cahps.ahrq.gov.

Exhibit 3. QRS Measure Set[29]

Measure Title	National Quality Forum (NQF) ID[30]	QRS Measure Type
Access to Care	Not Endorsed[31]	Survey
Access to Information	Not Endorsed	Survey
Adult BMI Assessment	Not Endorsed	Clinical
Annual Dental Visit	Not Endorsed	Clinical
Annual Monitoring for Patients on Persistent Medications	2371	Clinical
Antidepressant Medication Management	0105	Clinical
Appropriate Testing for Children With Pharyngitis	0002	Clinical
Appropriate Treatment for Children With Upper Respiratory Infection	0069	Clinical
Aspirin Use and Discussion	Not Endorsed	Survey
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Clinical
Breast Cancer Screening	2372	Clinical
Care Coordination	Not Endorsed	Survey
Cervical Cancer Screening	0032	Clinical
Childhood Immunization Status (Combination 3)	0038	Clinical
Chlamydia Screening in Women	0033	Clinical
Colorectal Cancer Screening	0034	Clinical
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055	Clinical
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575	Clinical
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057	Clinical
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	Clinical
Controlling High Blood Pressure	0018	Clinical
Cultural Competence	Not Endorsed	Survey
Flu Vaccinations for Adults Ages 18-64	0039	Survey
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	0576	Clinical
Follow-Up Care for Children Prescribed ADHD Medication	0108	Clinical
Immunizations for Adolescents (Combination 2)	1407	Clinical
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	Clinical
Medical Assistance With Smoking and Tobacco Use Cessation	0027	Survey
Medication Management for People With Asthma (75% of Treatment Period)	1799	Clinical
Plan Administration	Not Endorsed	Survey
Plan All-Cause Readmissions	1768	Clinical
Prenatal and Postpartum Care	1517	Clinical
Proportion of Days Covered	0541	Clinical
Rating of All Health Care	0006	Survey

[29] For the 2017 ratings year, the ASP, IMA (Combination 2), and RRU measures will not be used in scoring. Additionally, issuers will not be required to submit data for the ASP and RRU measures.
[30] Definitions of NQF-endorsed measures can be found here: http://www.qualityforum.org/Home.aspx.
[31] The QRS Access to Care measure includes two separate NQF-endorsed measures (Getting Needed Care and Getting Care Quickly), along with an additional CAHPS® Health Plan Supplemental question regarding getting after-hours care.

Measure Title	National Quality Forum (NQF) ID[30]	QRS Measure Type
Rating of Health Plan	0006	Survey
Rating of Personal Doctor	0006	Survey
Rating of Specialist	0006	Survey
Relative Resource Use for People with Diabetes (Inpatient Facility Index)	1557	Clinical
Use of Imaging Studies for Low Back Pain	0052	Clinical
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024	Clinical
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	1392	Clinical
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516	Clinical

Appendix B includes summaries of each QRS measure. For detailed measure specifications, QHP issuers should refer to each measure's technical specifications (in the *2017 Quality Rating System Measure Technical Specifications*), which specify criteria for determining the eligible population.

For additional information on how measures are used for scoring, please see Section 7.1.

6.2.1 QHP Enrollee Survey

The QHP Enrollee Survey draws heavily from the CAHPS® Health Plan Surveys, which are used widely to assess Medicare, Medicaid, and other commercial health plan performance. The survey assesses enrollee experience with a QHP offered through an Exchange on the topics presented in Exhibit 4. Measures derived from a subset of survey questions are included in the QRS measure set and accompanying ratings. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), please see Appendix C.

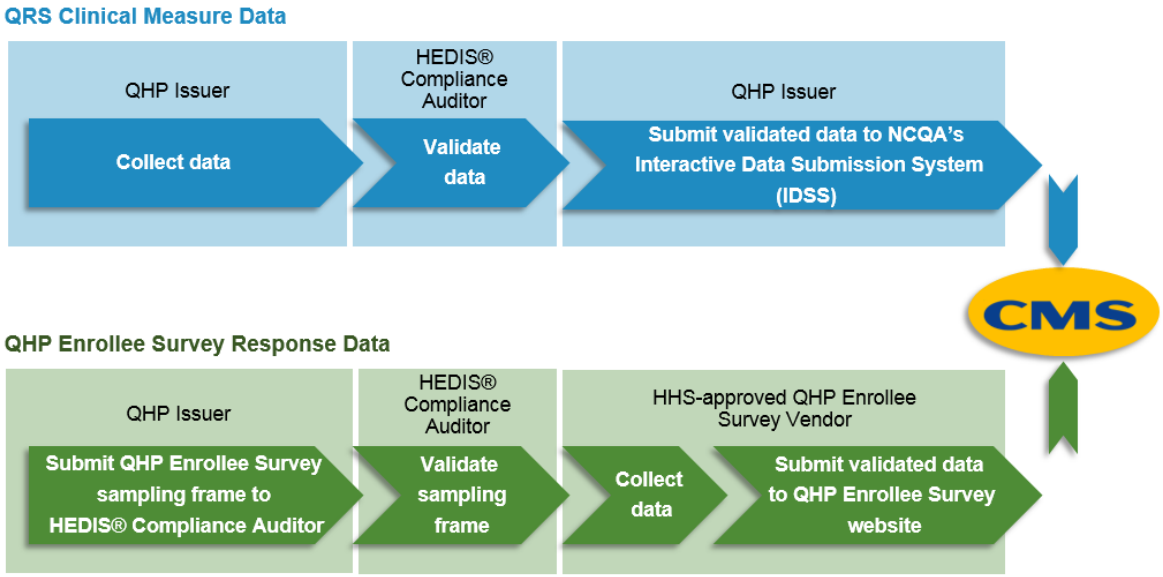
Exhibit 4. QHP Enrollee Survey Topics

QHP Enrollee Survey Topics *(Asterisk [*] indicates survey questions within this topic are not included in QRS survey measures)*
Access to Care
Access to Information
Care Coordination
Cultural Competence
Doctor Communication*
Enrollee Experience with Cost*
Plan Administration
Prevention

6.3 Data Collection, Validation, and Submission

The following sections address the protocols for data collection, data validation, and data submission of the QRS clinical measure and QHP Enrollee Survey response data. Exhibit 5 illustrates the process and stakeholders with primary responsibility for the associated steps. The steps are detailed in subsequent sections.

Exhibit 5. QRS Clinical Measure and QHP Enrollee Survey Response Data Process Flow



6.3.1 Data Collection

Details related to the data collection protocols for QRS clinical measure data and QHP Enrollee Survey response data are summarized below. For additional data collection instructions for the QRS clinical measures, including the required data elements, refer to the *2017 Quality Rating System Measure Technical Specifications*. For additional data collection procedures related to the QHP Enrollee Survey, refer to the *2017 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications.*

6.3.1.1 QRS Clinical Measure Data Collection

QHP issuers will collect data for QRS clinical measures using administrative sources or a hybrid of administrative and medical record sources. The data collection methods are described below.

- **Administrative Method:** Uses data obtained from administrative sources (e.g., claims data) to identify the eligible population (denominator) and numerator compliance.
- **Hybrid Method:** Uses data obtained from both administrative and medical record/electronic medical record sources to identify the eligible population and numerator compliance. The denominator consists of a systematic sample of enrollees drawn from the measure's eligible population. QHP issuers then: a) review administrative data to determine numerator compliance, and b) review medical record data for enrollees who do not meet numerator criteria based on administrative data to identify additional numerator compliance for the measure.

QHP issuers must refer to the *2017 Quality Rating System Measure Technical Specifications* to determine which data collection method is allowed for each clinical measure. If more than one method is allowed, the QHP issuer may choose its preferred method.

6.3.1.2 QHP Enrollee Survey Data Collection

Prior to survey administration, each QHP issuer will develop a sampling frame of enrollees for each of its eligible reporting units (per criteria detailed in Section 6.1). QHP issuers must contract with an HHS-approved QHP Enrollee Survey vendor to administer the QHP Enrollee Survey to a sample of the QHP issuer's eligible enrollees, using a standardized data collection protocol specified by CMS. These vendors will collect enrollee responses to the survey questions on behalf of the QHP issuer.

Each QHP issuer must formally authorize its chosen survey vendor to collect and submit QHP Enrollee Survey response data to CMS on its behalf.[32] In the fall of 2016, QHP issuers received instructions on the survey vendor authorization process. These instructions included the step-by-step process for authorizing a survey vendor, including login information for the QHP Enrollee Survey website and the timeline for authorizing a survey vendor.

The QHP Enrollee Survey website (http://qhpcahps.cms.gov) includes a list of HHS-approved survey vendors and general instructions for QHP issuers about the survey vendor contracting process and the QHP Enrollee Survey data collection process. Additionally, QHP issuers can register via the QHP Enrollee Survey website to receive periodic email updates about the QHP Enrollee Survey.

6.3.2 Data Validation

Each QHP issuer must have its clinical measure data and the QHP Enrollee Survey sampling frame validated by a data validator, in accordance with the measure stewards' protocols, prior to data submission.[33] For 2017, CMS requires that QHP issuers use a HEDIS® Compliance Auditor and follow the HEDIS® Compliance Audit standards to validate all QRS measures, including the QHP Enrollee Survey sampling frame.[34] The sections below contain details related to these data validation requirements.

6.3.2.1 Data Validators

QHP issuers must use a HEDIS® Compliance Auditor (validator) to perform the HEDIS® Compliance Audit (i.e., validation of QRS measure data) for all clinical measures and the survey sampling frame. Each QHP issuer is responsible for selecting the HEDIS® Compliance Organization, determining fees, and entering into a data validation contract (if necessary).

The HEDIS® Compliance Auditor should work with the QHP issuer throughout the data collection process, engaging in ongoing communications and a series of offsite and onsite reviews to confirm compliance with standards and protocols, including effective and sound data collection. This process is intended to be collaborative and iterative; it should occur continually until all data are submitted. The process is designed to give QHP issuers the maximum opportunity to have valid and publicly reportable results.

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[32] 45 C.F.R. § 156.1125(a).
[33] 45 C.F.R. §§ 156.1120(a)(2) and 156.1125(b)(2).
[34] The Pharmacy Quality Alliance (PQA) does not have a defined measure validation strategy for the Proportion of Days Covered measure. CMS requires this measure to be validated using the HEDIS® Compliance Audit standards, policies, and procedures.

QHP issuers should refer to the following website to access the list of NCQA-certified HEDIS® Compliance Auditors: http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx.

6.3.2.2 Data Validation Standards

The data validation standards are specified in the *HEDIS® Compliance Audit: Standards, Policies, and Procedures*. Auditors will use this uniform set of data validation standards to assess each QHP issuer's information system characteristics and capabilities, as well as its compliance with the *2017 Quality Rating System Measure Technical Specifications*. HEDIS® Compliance Auditors will also use the standards to assess the QHP issuer's sampling frame for the QHP Enrollee Survey.

QHP issuers should refer to the *HEDIS® Compliance Audit: Standards, Policies, and Procedures*, which is available for purchase on the following website: http://store.ncqa.org/index.php/performance-measurement.html.

6.3.2.3 Data Validation Results

All QRS measures must have a final, validated result that indicates data are complete, accurate, and comparable. The HEDIS® Compliance Auditor will determine if the QHP issuer's clinical measure rates are reportable and if the QHP Enrollee Survey sampling frame is accurate, using the HEDIS® Compliance Audit standards described above.

The HEDIS® Compliance Auditor will document one of the following results for each clinical measure once the QHP issuer submits its data:

- **A rate:** The QHP issuer followed the specifications and produced a reportable rate (numeric result) for the measure.
- **Benefit Not Offered (NB):** The QHP issuer did not offer the health benefit required by the measure.
- **Biased Rate (BR):** The QHP issuer's calculated rate was materially biased.
- **Not Reported (NR):** The QHP issuer chose not to report the measure.
- **Not Applicable (NA):** The QHP issuer followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. The QHP issuer did not have sufficient data to fulfill the continuous enrollment criteria for the measure. For example, a QHP issuer that has operated for only one year may be unable to meet the continuous enrollment criteria for Breast Cancer Screening, which requires multi-year continuous enrollment as outlined in the *2017 Quality Rating System Measure Set Technical Specifications*.

For QRS survey measures, the QHP issuer is responsible for sending the validated QHP Enrollee Survey sampling frame and validator's approval notice to the survey vendor before the QHP Enrollee Survey is administered. Survey vendors are not permitted to proceed with fielding the survey until they receive the validator's approval notice.

6.3.2.3.1 Compliance Reviews

CMS may conduct targeted compliance reviews under 45 C.F.R. § 156.715 to examine QHP issuer compliance with the federal data submission and reporting requirements for the QRS and

QHP Enrollee Survey (subsequent to data validation of QRS clinical measure and QHP Enrollee Survey response data). These reviews could occur in cases where CMS suspects that a QHP issuer's mishandling of data, inappropriate processing, or implementation of incorrect practices has resulted in erroneous data, scores, or ratings. Examples include, but are not limited to: a QHP issuer's failure to adhere to QRS and QHP Enrollee Survey reporting requirements, and a QHP issuer's failure to pass data validation directly related to data reported for specific measures. Based on the findings of this compliance review or other evidence received by CMS, CMS may take enforcement action, such as civil money penalties and/or decertification of the affected QHPs.[35]

In addition, CMS may include compliance with the QRS and QHP Enrollee Survey data submission and reporting requirements as part of a more general compliance review of a QHP issuer participating in an FFE. CMS intends to coordinate with State regulators, when appropriate, to avoid duplication of efforts for these compliance reviews.

6.3.3 Data Submission

Each QHP issuer will work with its HEDIS® Compliance Auditor and its HHS-approved QHP Enrollee Survey vendor to submit the required QRS clinical measure data and the QHP Enrollee Survey response data to CMS. Details related to the data submission process (based on data type) are provided below.

6.3.3.1 QRS Clinical Measure Data Submission

All QHP issuers submitting QRS clinical measure data must complete the Healthcare Organization Questionnaire (HOQ) to gain access to NCQA's web-based tool, the Interactive Data Submission System (IDSS). There are no fees for QHP issuers associated with accessing and using the IDSS. Upon completion of the HOQ, a QRS-specific submission ID will be created in the IDSS.

NCQA opened the annual HOQ completion process in early January 2017 and closed access in February 2017. When opened by NCQA, the HOQ can be accessed at: http://CustomerCenter.ncqa.org. For more information regarding the HOQ, visit: http://www.ncqa.org/tabid/219/Default.aspx. QHP issuers should submit questions about the HOQ to the NCQA portal at: https://my.ncqa.org/.

QHP issuers must submit only summary-level QRS clinical measure data (for each reporting unit) via NCQA's IDSS, once the data have been validated by a HEDIS® Compliance Auditor. Summary-level data are specific to each clinical measure and include such elements as eligible population or denominator, numerator, and the reported rate. Patient-level data are not required to be submitted via the IDSS for QRS clinical measures.

QHP issuers must work with their HEDIS® Compliance Auditors to submit the validated QRS clinical measure data and signed attestations (i.e., confirm data are accurate and reflect plan performance) by 11:59 p.m. Eastern Time (ET), June 15, 2017. QHP issuers should submit questions regarding the IDSS to the NCQA portal at: https://my.ncqa.org/.

[35] 45 C.F.R. § 156.800.

6.3.3.2 QHP Enrollee Survey Data Submission

On behalf of the QHP issuer, the HHS-approved QHP Enrollee Survey vendor will submit de-identified enrollee response data directly to the QHP Enrollee Survey website. Instructions for survey vendors on how to submit the response data are available on the QHP Enrollee Survey website and in the *2017 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications.*

QHP Enrollee Survey vendors must submit the QHP Enrollee Survey response data by 11:59 p.m. ET, May 25, 2017.

7. QRS Rating Methodology

This section describes how CMS will calculate 2017 QRS quality ratings based on the QRS clinical measure and QHP Enrollee Survey response data submitted in 2017. CMS made refinements to this section to improve clarity after receiving stakeholder feedback.

Appendix D provides the final 2017 QRS rating methodology.

7.1 Measures and Scoring

For 2017, QHP issuers are required to collect and submit validated data for 40 measures in the QRS measure set. The total measure count changed between the 2016 QRS and the 2017 QRS as the HPV and IMA measures were combined into one updated IMA measure for the 2017 QRS. Additionally, QHP issuers are not required to collect and submit data for the RRU and ASP measures. CMS will include 39 measures in scoring, as the RRU, ASP, and updated IMA measures will not be scored in 2017.

In December 2016, NCQA suspended collection of the RRU measure due to decreased usefulness and costs that exceed value, and announced retirement of the ASP measure due to misalignment with updated recommendations from the USPSTF. Therefore, the RRU and ASP measures will not be used for scoring in the 2017 ratings year, and QHP issuers are not required to submit data for these measures. In addition, CMS will not include the updated IMA measure in scoring for the 2017 ratings year, given the change to the technical specifications by the applicable measure steward.

Exhibit 6 offers a comparative summary of the QRS measures and scoring approach for the 2016 and 2017 ratings years.

Exhibit 6. QRS Measures and Scoring[36]

	2016	2017 (current year)
Number of measures required for QRS data submission	43	40*
Number of measures to be used for QRS scoring	28**	39***

* QHP issuers should refer to each measure's technical specifications, which specify criteria for determining the eligible population and ability to submit data for the measure (e.g., a measure may require multiple years of continuous enrollment and, therefore, a new QHP issuer or reporting unit may be unable to report a numeric rate for this measure).

** For the complete list of measures used for scoring in 2016, please see the 2016 Guidance.

*** For the 2017 QRS, the updated IMA measure, the RRU measure, and the ASP measure will not be used in scoring.

While QHP issuers are required to submit QRS measure data for eligible reporting units beginning with the reporting unit's second year of operation, eligible reporting units will not receive QRS scores and ratings until their *third* consecutive year of operation in the Exchange. Therefore, a reporting unit that is eligible to be scored must meet the criteria for data submission (as defined by Section 6.1) *and have been in operation for at least three consecutive years.* For example, as shown in Exhibit 7, to receive QRS scores and ratings in 2017, a reporting unit must be in operation in 2015, 2016, and 2017.

Exhibit 7. Reporting Unit Data Submission and Scoring Example

Criteria	Required to submit data?	Eligible to be scored?
Reporting unit operates in ratings year only (2017)	No, does not meet the QRS participation criteria	No
Reporting unit operates in ratings year and prior year (2017 and 2016) and meets the QRS participation criteria (as defined in Section 6.1)	Yes	No
Reporting unit operates for at least three consecutive years (2017, 2016, and 2015) and meets the QRS participation criteria (as defined in Section 6.1)	Yes	Yes

If a reporting unit is eligible for scoring, the data submitted for this reporting unit are included in ratings calculation. Specifically, the data are included with all other submitted data for reporting units eligible for scoring to create the national all-product reference group, and QRS scores and ratings are calculated for that reporting unit.

7.2 QRS Hierarchy

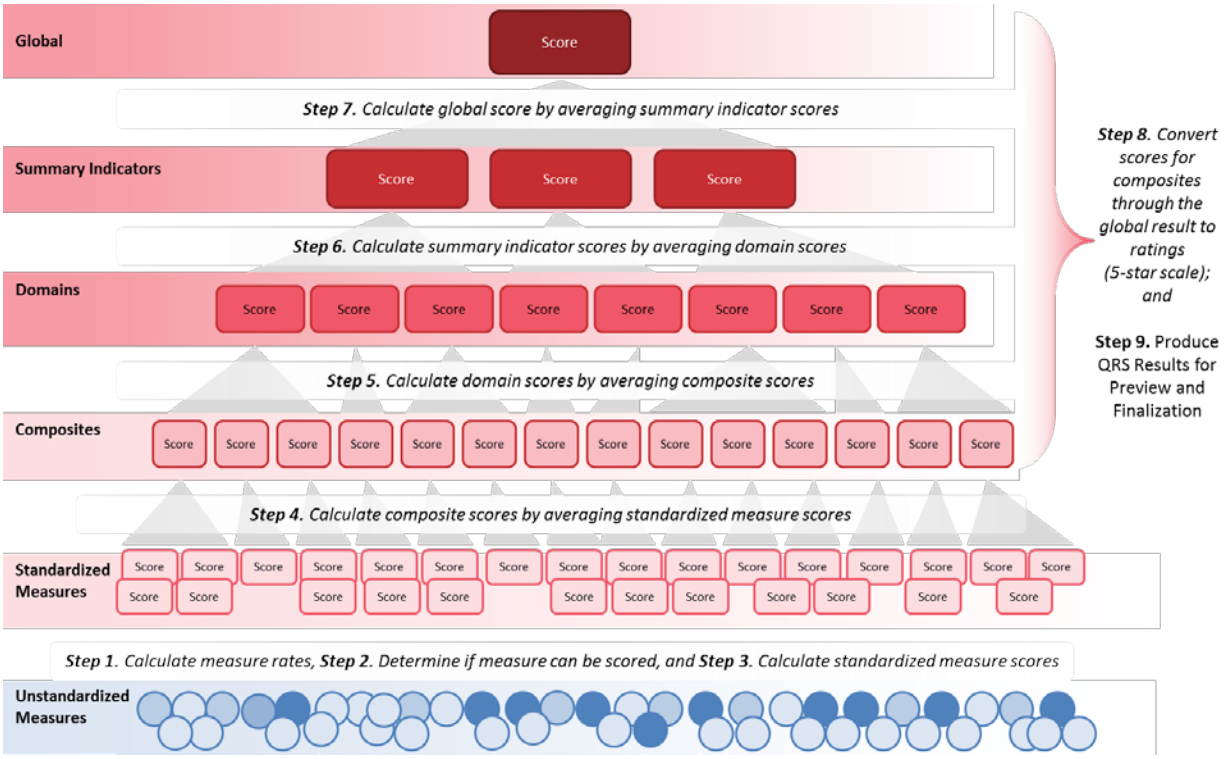
The QRS measures are organized into a hierarchical structure that serves as a foundation of the QRS rating methodology (Appendix E). The measures are grouped into hierarchy components (composites, domains, and summary indicators) to form a single global rating.

[36] In communicating total measure counts, the totals presented here represent the perspective of the measure steward, rather than the perspective of the QRS scoring methodology. If counting based on the perspective of the scoring methodology, there are 45 measures in total (rather than 42). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care (NQF #1517) is split into two distinct measures for the QRS hierarchy: Timeliness of Prenatal Care and Postpartum Care. Similarly, Proportion of Days Covered (NQF #0541) is split into three distinct measures: Diabetes All Class, Renin Angiotensin System (RAS) Antagonists, and Statins.

7.3 Overview of Process for Calculating QRS Scores and Ratings

Exhibit 8 below is a visual overview of the QRS rating methodology, which shows how CMS calculates QRS scores and ratings from submitted QRS measure data. This overview shows how CMS converts submitted measure data into higher-level QRS hierarchy component scores and ratings. Component scores are calculated by averaging scores of components in a lower level of the hierarchy. Thus, the global score is an average of summary indicator scores, summary indicator scores are averages of associated domain scores, and domain scores are averages of associated composite scores.

Exhibit 8. Overview of QRS Rating Methodology



Appendix D further describes the process for calculating 2017 QRS scores and ratings. CMS conducts quality assurance (QA) activities throughout the data scoring process, beginning upon receipt of QRS clinical measure data and QHP Enrollee Survey response data. These QA activities include verification of submitted data file attributes and data content quality checks to validate the accuracy, completeness, consistency, and validity of output files and reports.

8. Quality Rating Information Results and Preview

QHP issuers and State Exchange administrators will receive QHP quality rating information and will be able to preview their respective QRS results via the CMS Health Insurance Oversight System-Marketplace Quality Module (HIOS-MQM) website during a two-week preview period (anticipated August 2017). CMS will also provide OPM with the QRS results for the MSP options. QHP issuers and State Exchange administrators will receive an email notification via the HIOS-MQM prior to the start of preview.

8.1 QRS Preview via CMS' HIOS-MQM

During the QRS preview period, QHP issuers in all Exchanges will be able to preview their respective QRS quality ratings via CMS' HIOS-MQM website and submit any related inquiries to CMS. Exhibit 9 provides descriptions of the documents available for preview on the HIOS-MQM website. The QRS Preview Reports and QRS Proof Sheets for the applicable ratings year will be available for preview on CMS' HIOS-MQM website concurrently.

Exhibit 9. QRS Documents Available for Preview on the HIOS-MQM Website

Document Title	Description
QRS Preview Report	The QRS Preview Report provides the QRS ratings for each QHP issuer's eligible reporting unit(s). The ratings are provided on a 5-star scale for all QRS hierarchy components (i.e., composites, domains, summary indicators, and the global result). The QRS Preview Report will be available online and for download as a PDF file on CMS' HIOS-MQM website.
QRS Proof Sheet	The QRS Proof Sheet provides additional detail behind the ratings shown in the QRS Preview Report. The QRS Proof Sheet will be available for download on CMS' HIOS-MQM website as a PDF file and comma separated values (CSV) file. The PDF file displays outputs for each step of the QRS rating methodology, from the submitted raw measure values through the global score and rating. Specifically, the PDF file includes the following: • Scores and ratings for all QRS hierarchy components. • Results for all QRS measures, including measures not included in scoring. For all measures, the file will include the raw rate and total denominator size. • Cut points used to convert numeric scores to star ratings for each QRS hierarchy component. The CSV file provides additional information, specifically: • Measure indicator values and sub-measure indicator values (age stratifications). • Benchmark information (percentile values) for raw measure rates, allowing a QHP issuer to compare its reporting unit's results to all other reporting units nationally. CMS includes benchmark values that show the standardized 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentile values of the numerical rates (raw values) across all reporting units. To create these benchmark values, CMS uses only raw measure rates that have met the minimum denominator size criteria for scoring.
QRS Proof Sheet User Guide	A PDF that describes the contents of the QRS proof sheet and provides detail regarding the QRS rating methodology used to produce the QRS scores and ratings shown in the QRS proof sheet.

8.1.1 Instructions for Accessing QRS Results

Access to HIOS-MQM is required to view QRS results during the QRS preview period. For QHP issuers looking to access the results for their reporting units during the QRS preview period, please see the following instructions:

1) Log in to the HIOS-MQM website;
   – Users new to HIOS need to request access to HIOS and the MQM through the CMS Enterprise Portal. Existing HIOS users who are new to the MQM need to request a new role: Ratings/Reports Viewer. The Ratings/Reports Viewer role authorizes the user to perform predetermined functions and access certain data sets. Detailed instructions for registering for access to HIOS and the MQM can be found in the HIOS-MQM Quick Reference Guide located on the CMS MQI website.

2) Navigate to the "Preview Ratings" webpage and search for the corresponding QHP issuer. To access the QRS Preview Report and QRS Proof Sheet, click the appropriate links at the bottom of the page.

8.2 Additional Ratings Preview by SBEs

An SBE may choose to conduct an additional ratings preview for QHP issuers operating in that Exchange. CMS encourages the SBEs to do so, particularly in States that require QHP issuers to report additional quality measures beyond the federal QRS and QHP Enrollee Survey requirements.

8.3 Preview Period Inquiries

CMS intends to work with QHP issuers and Exchange administrators to address any inquiries about the QRS results or QHP Enrollee Survey Quality Improvement (QI) reports (described in Section 8.4) and to resolve potential discrepancies. All ratings submitted by CMS during the preview period are considered final ratings, unless otherwise noted after the preview period ends.

8.4 QHP Enrollee Survey QI Reports

QHP issuers and State Exchange administrators will also receive a QHP Enrollee Survey QI report for each respective reporting unit in late summer 2017. These reports communicate the full results of the QHP Enrollee Survey, including questions not included as part of the QRS measure set. Each QHP Enrollee Survey QI report will include the reporting unit's results for all QHP Enrollee Survey composite measures and their component questions.

For more information regarding the information provided in the QHP Enrollee Survey QI Report, see Appendix F.

9. Exchange Display Guidelines for QHP Quality Rating Information

CMS will conduct a second year of consumer pilot testing of the display of QHP quality rating information beginning with the 2018 individual market open enrollment period.[37] CMS' goals with the second pilot expand upon the goals from the consumer pilot testing, beginning with the 2017 individual market open enrollment period, and include:

- Gathering information regarding the impact of the revised open enrollment period of November 1, 2017 to December 15, 2017 on consumer experience with QRS star ratings;
- Obtaining further details about consumer access and use of QHP quality rating information, so as to inform display of QRS star ratings; and
- Informing the development of comprehensive technical assistance and education related to the QRS star ratings for consumers, assisters, Navigators, agents, brokers, and consumer groups prior to nationwide QRS public display.

[37] See the June 9, 2017, Quality Rating Information Bulletin, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017-Quality-Rating-Information-Bulletin.pdf.

CMS intends to use the same criteria for identifying States to participate in the second year of the consumer pilot testing.[38] At this time, we anticipate that the second pilot will be conducted in the same States that displayed QRS star ratings beginning with the 2017 individual market open enrollment period (i.e., Virginia and Wisconsin). SBEs whose consumers do not use HealthCare.gov may choose to display QHP quality rating information on their websites beginning with the 2018 individual market open enrollment period.

In future years, CMS will require the FFEs, including FFEs where the State performs plan management functions, and SBE-FPs to publicly display QHP quality ratings information. Additionally, CMS will require SBEs whose consumers do not use HealthCare.gov to display the quality rating information assigned to each eligible QHP as calculated by CMS on their respective websites.

The QRS ratings reflect QHP performance by product type, which includes QHPs in both the SHOP and individual market. CMS will require Exchanges to display the ratings for all QHPs in the product type, including QHPs in the SHOP and individual market, as applicable.

OPM reserves the authority to display QHP quality rating information for MSP options, and may issue further details about display to MSP issuers.

9.1 Display on HealthCare.gov

CMS intends to display the 2017 QRS global rating and the three summary indicator ratings on the HealthCare.gov website for eligible QHPs available in pilot States. Pilot States that include 2017 quality rating information must prominently display the following disclaimer language:

> *Plan quality ratings and enrollee survey results are calculated by the Marketplace using data provided by health plans in 2017. The ratings will be displayed for health plans for the 2018 plan year. We're testing the use of star ratings this year and will use this test to improve the program. Learn more about these ratings. [Link to appropriate explanatory/Help text on HealthCare.gov.]*

CMS will release additional details specifying the form and manner in which CMS will display QHP quality rating information on HealthCare.gov. For example, CMS anticipates referring to the QRS global rating as the "Overall Quality Rating."

9.2 Display Guidance for SBEs

SBEs that do *not* rely on the federal eligibility and enrollment platform (i.e., SBEs whose consumers do not use Healthcare.gov) may choose to display QHP quality ratings information on their respective websites beginning with the 2018 individual market open enrollment period. CMS will continue to provide the QHP quality rating information to SBEs via the Quality Ratings Application Program Interface (API) and the State Ratings Data File for the States' respective issuers. States that choose to display the 2017 QHP quality rating information should

[38] See the April 29, 2016, Quality Rating Information Bulletin, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/QRS-Bulletin-4292016.pdf. Also see FAQ 17068 (August 3, 2016), available at: https://www.regtap.info/faq_viewu.php?id=17068.

display at least the QRS global rating on their websites by the start of the 2018 individual market open enrollment period.

SBEs choosing to display 2017 quality ratings information on their websites must prominently display the following disclaimer language:

> *Plan quality ratings and enrollee survey results are calculated by the federal government, using data provided by health plans in 2017. The ratings will be displayed for health plans for the 2018 plan year. We're testing the use of star ratings this year and will use this test to improve the program. Learn more about these ratings. [Link to appropriate explanatory page on SBM's site.]*

10. Marketing Guidelines for QHP Quality Rating Information

QHP issuers in Exchanges that display QHP quality rating information beginning during the 2018 individual market open enrollment period may reference the 2017 QRS quality ratings and QHP Enrollee Survey results for their QHPs in marketing materials in a manner specified by CMS.[39] Any QHP issuer that elects to include its 2017 QHP quality rating information, specifically QRS scores and ratings and QHP Enrollee Survey results, in its marketing materials (whether paper, electronic, or other media) must do so in accordance with the CMS instructions below.[40]

The 2017 marketing guidelines are generally based on CMS guidance related to marketing QHPs as communicated in the *Final 2017 Letter to Issuers in the Federally-facilitated Exchanges* (2017 Letter to Issuers).[41] A QHP issuer that elects to include QRS and QHP Enrollee Survey information in its marketing materials must do so in a manner that does not mislead consumers. The instructions that follow provide details as to the manner in which QRS and QHP Enrollee Survey information must be communicated in marketing materials:

- **Disclaimers:** QHP issuers must include the following disclaimers on all marketing materials referencing QRS or QHP Enrollee Survey information. All disclaimers must be clear and conspicuous.
  - QHP issuers participating in a consumer display pilot State, or issuers in an SBE that choose to display 2017 QRS star ratings for the 2018 open enrollment period must prominently display the following disclaimer language to inform consumers that CMS is conducting additional consumer testing regarding the public display of this quality rating information:
    - *Plan quality ratings and enrollee survey results are calculated by CMS using data provided by health plans in 2017. The ratings will be displayed for health plans for the 2018 plan year. CMS is testing the use of star ratings this year*

[39] 45 C.F.R. §§156.1120(c) and 156.1125(c).
[40] The scope of the definition for "marketing" extends beyond the public's general concept of advertising materials. CMS interprets the definition of marketing materials, as referenced here, as equivalent to the definitions for the Medicare Advantage program in 42 C.F.R. § 422.2260.
[41] See Chapter 5, Section 5, "Oversight of Marketing Activities," in the *Final 2017 Letter to Issuers in the Federally-facilitated Marketplaces*, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf. See also 45 C.F.R. §§§ 156. 225 (Marketing and Benefit Design of QHPs), 155.260 (Privacy and Security), and 156.200(e) (Non-discrimination).

and will use this test to improve the program. Learn more about these ratings. [Link to appropriate explanatory page on respective Exchange's site.]

- If marketing materials reference only QRS information, QHP issuers must include the following disclaimer on all materials:
  - *CMS rates qualified health plans (QHPs) offered through the Exchanges using the Quality Rating System (QRS), which is based on third-party validated clinical measure data and QHP Enrollee Survey response data. CMS calculates ratings annually on a 5-star scale, and ratings may change from one year to the next. For more information, please see CMS' Health Insurance Marketplace℠ Quality Initiatives website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.*
- If marketing materials reference only QHP Enrollee Survey information, QHP issuers must include the following disclaimer on all materials:
  - *CMS evaluates qualified health plans (QHPs) offered through the Exchanges using QHP Enrollee Survey response data. QHP issuers contract with HHS-approved survey vendors that independently conduct the survey each year. QHP Enrollee Survey results may change from one year to the next. For more information, please see CMS' Health Insurance Marketplace℠ Quality Initiatives website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.*
- If marketing materials reference QRS and QHP Enrollee Survey information, QHP issuers must include the following disclaimer on all materials:
  - *CMS rates qualified health plans (QHPs) offered through the Exchanges using the Quality Rating System (QRS), which is based on third-party validated clinical measure data and QHP Enrollee Survey response data. CMS calculates QRS ratings annually using a 5-star scale. QHP issuers contract with HHS-approved survey vendors that independently conduct the QHP Enrollee Survey each year. QRS ratings and QHP Enrollee Survey results may change from one year to the next. For more information, please see CMS' Health Insurance Marketplace℠ Quality Initiatives website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.*

- **Up-to-date information:** QHP issuers that choose to include QHP quality rating information in marketing materials must use the most up-to-date information. Changes must be made within 30 days of finalizing the current year's QHP quality rating information,[42] and QHP issuers must discontinue marketing based on the previous year's information. CMS

[42] As detailed in Section 8, all ratings displayed by CMS during the QRS preview period will be considered final at the conclusion of the QRS preview period, unless otherwise noted.

anticipates issuing the final QRS ratings to QHP issuers and Exchange administrators annually, prior to the start of the individual market open enrollment period.

- **Specificity of content:** Materials should reference specific QHPs or product types and their CMS-assigned quality rating information. QHP issuers may advertise a product type's quality rating information (e.g., a "5-star HMO"), as QRS scores and ratings and QHP Enrollee Survey results are calculated for each product type (i.e., EPO, HMO, POS, PPO) and assigned to each QHP within the product type.
  - Materials should be specific as to the State to which the information applies.
  - QHP issuers with one or more QHPs (or product types) that were assigned a specific QRS global rating (e.g., 5 stars) should not create or disseminate marketing materials in a way that implies that all of their QHPs (or product types) achieved this rating.
  - QHP issuers are encouraged to advertise QRS ratings (i.e., stars) rather than scores (i.e., numerical value), which are less meaningful to consumers.
  - QHP issuers are encouraged to advertise the QRS global rating rather than the rating for other QRS components (i.e., summary indicators, domains, or composites). If QHP issuers choose to advertise ratings for QRS components, the QHP issuer may use only the component titles assigned by CMS without variation (e.g., Clinical Quality Management). Additionally, the QHP issuer must always include the QRS global rating alongside the QRS component rating.
  - The use of a general label in reference to the rating of a specific QHP (e.g., "a 5-star plan") can only be used to reference the QRS global rating, unless the component is specified (e.g., "a 5-star plan for [insert component name]"). QHP issuers may not use the rating for another QRS component (i.e., summary indicator, domain, composite, or measure) to imply a higher global rating than actually received. For example, a QHP issuer may not promote a QHP that received a global rating of three stars and a summary indicator rating of five stars as a "5-star plan."
  - QHP issuers should not use superlatives (e.g., "highest ranked," "one of the best") without additional context. For example, a QHP that received a 5-star rating for a specific QRS component, but received a 3-star global rating, may not be promoted as the highest ranked QHP in the State when other QHPs have a higher global rating.
  - QHP issuers may not claim that any of their product types or QHPs are recommended or endorsed by the Federal Government, HHS, CMS, CCIIO, or the Exchanges. This includes, but is not limited to, use of the Department's name or logo; any HHS agency's name and marks; or the Exchanges' names, logos, and marks in a manner that would convey the false impression that any product type is recommended or endorsed by the Federal Government, HHS or its Agencies, or the Exchanges.
- **Compliance with State law and regulations:** QHP issuers must comply with all applicable State laws and regulations on health plan marketing, and must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[43]

[43] 45 C.F.R. § 156.225.

Pursuant to 45 C.F.R. § 156.340(a)(1), a QHP issuer participating in an FFE or an SBE-FP maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, including affiliated agents and brokers, with the QRS and QHP Enrollee Survey marketing standards.[44]

As noted in the 2017 Letter to Issuers, States generally regulate health plan marketing practices and materials and related documents under State law, and CMS does not intend to review QHP marketing materials for compliance with State standards as described at 45 C.F.R. § 156.225(a). In the FFEs, CMS may review QHP marketing materials for compliance with applicable federal regulations.[45] CMS will work with States to determine where additional monitoring and review of marketing activities may be needed.

Complaints about a QHP issuer's marketing activities related to QHP quality rating information are generally overseen by the State. CMS will send such complaints to State regulators or federal entities, as appropriate, for investigation. Following investigation by the State or another federal agency investigation, CMS may take further enforcement action, if necessary or appropriate.

OPM reserves the authority to supplement these marketing guidelines and review marketing materials for MSP options, and may issue further guidance regarding marketing.

[44] This includes, but is not limited to, compliance by delegated and downstream entities with the marketing standards at 45 C.F.R. §§§ 156.225, 156.1120(c), and 156.1125(c).
[45] See, for example, 45 C.F.R. §§§ 156.200(e), 156.225(b), 156.1120(c), and 156.1125(c).

Appendix A. Relevant Statutory and Regulatory Citations

Exhibit 10 through Exhibit 13 include excerpts from the Patient Protection and Affordable Care Act and supporting regulations that are relevant to QRS and the QHP Enrollee Survey (referred to in the statute as the enrollee satisfaction survey system). The exhibits in this appendix are intended for reference only, and do not comprise an exhaustive list of QHP issuer and/or Exchange requirements.

Exhibit 10. Patient Protection and Affordable Care Act, 42 U.S.C. Sec. 18031 (March 23, 2010)

Topic	Provisions	Citation
QHP certification standards: Public reporting of quality information	(c) RESPONSIBILITIES OF THE SECRETARY.— (1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum— (H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable. (I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act. [*As added by section 10203(a)*]"	Section 1311 (c)(1)(H),(I)
Exchange standards: Public reporting of QRS and QHP Enrollee Survey information	(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).	Section 1311 (c)(3)
	(4) ENROLLEE SATISFACTION SYSTEM.—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.	Section 1311 (c)(4)
	(5) INTERNET PORTALS.—The Secretary shall — (B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices. Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.	Section 1311 (c)(5)(B)

Topic	Provisions	Citation
	(d) REQUIREMENTS.— (4) FUNCTIONS.—An Exchange shall, at a minimum— (D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3); (E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;	Section 1311 (d)(4)(D),(E)

Exhibit 11. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, 77 Fed. Reg. 18310-18475 (March 27, 2012)

Topic	Provisions	Citation
Exchange standards for quality activities	(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.	45 C.F.R. § 155.200(d) Functions of an Exchange
Exchange standards for public display of QHP quality rating information	(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and: (1) Provides standardized comparative information on each available QHP, including at a minimum: (iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act; (v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act.	45 C.F.R. § 155.205(b)(1)(iv),(v) Consumer assistance tools and programs of an Exchange

Exhibit 12. Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rule, 78 Fed. Reg. 65046-65105 (October 30, 2013)

Topic	Provisions	Citation
Application & standards for QHP Enrollee Survey vendors; List of HHS-approved vendors	(a) *Application for approval.* An enrollee satisfaction survey vendor must be approved by HHS, in a form and manner to be determined by HHS, to administer, on behalf of a QHP issuer, enrollee satisfaction surveys to QHP enrollees. HHS will approve enrollee satisfaction survey vendors on an annual basis, and each enrollee satisfaction survey vendor must submit an application for each year that approval is sought. (b) *Standards.* To be approved by HHS, an enrollee satisfaction survey vendor must meet each of the following standards: (1) Sign and submit an application form for approval in accordance with paragraph (a) of this section; (2) Ensure, on an annual basis, that appropriate staff participate in enrollee satisfaction survey vendor training and successfully complete a post-training certification exercise as established by HHS; (3) Ensure the accuracy of their data collection, calculation and submission processes and attest to HHS the veracity of the data and these processes;	45 C.F.R. § 156.1105(a)-(c) Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges

Topic	Provisions	Citation
	(4) Sign and execute a standard HHS data use agreement, in a form and manner to be determined by HHS, that establishes protocols related to the disclosure, use and reuse of HHS data; (5) Adhere to the enrollee satisfaction survey protocols and technical specifications in a manner and form required by HHS; (6) Develop and submit to HHS a quality assurance plan and any supporting documentation as determined to be relevant by HHS. The plan must describe in adequate detail the implementation of and compliance with all required protocols and technical specifications described in paragraph (b)(5) of this section; (7) Adhere to privacy and security standards established and implemented under § 155.260 of this subchapter by the Exchange with which they are associated; (8) Comply with all applicable state and federal laws; (9) Become a registered user of the enrollee satisfaction survey data warehouse to submit files to HHS on behalf of its authorized QHP contracts; (10) Participate in and cooperate with HHS oversight for quality-related activities, including, but not limited to: review of the enrollee satisfaction survey vendor's quality assurance plan and other supporting documentation; analysis of the vendor's submitted data and sampling procedures; and site visits and conference calls; and, (11) Comply with minimum business criteria as established by HHS. (c) *Approved list.* A list of approved enrollee satisfaction survey vendors will be published on an HHS Web site.	

Exhibit 13. Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final Rule, 79 Fed. Reg. 30240-30353 (May 27, 2014)

Topic	Provisions	Citation
Exchange standards for public display of QRS ratings	The Exchange must prominently display the quality rating information assigned to each QHP on its Web site, in accordance with § 155.205(b)(1)(v), as calculated by HHS and in a form and manner specified by HHS.	45 C.F.R. § 155.1400 Quality rating system
Exchange standards for public display of QHP Enrollee Survey information	The Exchange must prominently display results from the Enrollee Satisfaction Survey for each QHP on its Web site, in accordance with § 155.205(b)(1)(iv), as calculated by HHS and in a form and manner specified by HHS.	45 C.F.R. § 155.1405 Enrollee satisfaction survey system

Topic	Provisions	Citation
QHP certification standards: public reporting of QHP quality rating information[46]	(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. (b) *QHP issuer requirement.* A QHP issuer must— (5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Affordable Care Act consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act; (h) As a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements described in subparts D, E, H, K, L, and M of this part.	45 C.F.R. § 156.200(a),(b)(5),(h) QHP issuer participation standards
Monitoring of QHP Enrollee Survey vendors and vendor appeals	(d) *Monitoring.* HHS will periodically monitor HHS-approved enrollee satisfaction survey vendors to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS determines that an HHS-approved enrollee satisfaction survey vendor is non-compliant with the standards required in paragraph (b) of this section, the survey vendor may be removed from the approved list described in paragraph (c) of this section and/or the submitted survey results may be ineligible to be included for ESS results. (e) *Appeals.* An enrollee satisfaction survey vendor that is not approved by HHS after submitting the application described in paragraph (a) of this section may appeal HHS's decision by notifying HHS in writing within 15 days from receipt of the notification of not being approved and submitting additional documentation demonstrating how the vendor meets the standards in paragraph (b) of this section. HHS will review the submitted documentation and make a final approval determination within 30 days from receipt of the additional documentation.	45 C.F.R. § 156.1105(d),(e) Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges

[46] The QHP participation standards at 45 C.F.R. § 156.200 were first codified as part of the "Establishment of Exchange and QHP Standards; Exchange Standards for Employers" Final Rule (March 27, 2012). This citation is included here because of the technical amendments that were made as part of the "Exchange and Insurance Market Standards for the 2015 and Beyond" Final Rule (May 27, 2014) to cross-reference the QRS statutory provisions and correctly align it with the other quality standards originally listed in the regulation as part of the QHP certification standards.

Topic	Provisions	Citation
Standards for QRS data submission, data validation, implementation timeline, and marketing of QRS ratings; Multi-State Plan requirements	(a) *Data submission requirement.* (1) A QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP that has been offered in an Exchange for at least one year. (2) In order to ensure the integrity of the data required to calculate the QRS, a QHP issuer must submit data that has been validated in a form and manner specified by HHS. (3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS. (b) *Timeline.* A QHP issuer must annually submit data necessary to calculate the QHP's quality ratings to HHS and Exchanges, on a timeline and in a standardized form and manner specified by HHS. (c) *Marketing requirement.* A QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS. (d) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (a) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.	45 C.F.R. § 156.1120 (a)–(d) Quality rating system
Standards for administering the QHP Enrollee Survey and marketing survey results; Multi-State Plan requirements	(a) *General requirement.* A QHP issuer must contract with an HHS-approved enrollee satisfaction survey (ESS) vendor, as identified by § 156.1105, in order to administer the Enrollee Satisfaction Survey of the QHP's enrollees. A QHP issuer must authorize its contracted ESS vendor to report survey results to HHS and the Exchange on the issuer's behalf. (b) *Data requirement.* (1) A QHP issuer must collect data for each QHP, with more than 500 enrollees in the previous year that has been offered in an Exchange for at least one year and following a survey sampling methodology provided by HHS. (2) In order to ensure the integrity of the data required to conduct the survey, a QHP issuer must submit data that has been validated in a form and manner specified by HHS, and submit this data to its contracted ESS vendor. (3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS. (c) *Marketing requirement.* A QHP issuer may reference the survey results for its QHPs in its marketing materials, in a manner specified by HHS. (d) *Timeline.* A QHP issuer must annually submit data necessary to conduct the survey to its contracted ESS vendor on a timeline and in a standardized form and manner specified by HHS. (e) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (b) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.	45 C.F.R. § 156.1125 (a)–(e) Enrollee satisfaction survey system

Appendix B. QRS Measure Summaries

Exhibit 14 includes measure summaries for the final 2017 QRS measure set, organized alphabetically. For detailed QRS clinical measure specifications, refer to the *2017 Quality Rating System Measure Technical Specifications* at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), see: https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system. Measures highlighted in grey will not be included in scoring in 2017.

Exhibit 14. QRS Measure Summaries

Measure Name:	**Access to Care**
Measure Steward:	Agency for Healthcare Research and Quality (AHRQ), CMS
NQF Endorsement ID:	Not Endorsed[47]
Description:	Enrollee experience related to the following: • Got care for illness/injury as soon as needed • Got non-urgent appointment as soon as needed • Easy to get care after regular office hours • How often it was easy to get necessary care, tests, or treatment • Got appointment with specialists as soon as needed
Data Source(s):	QHP Enrollee Survey

Measure Name:	**Access to Information**
Measure Steward:	AHRQ, CMS
NQF Endorsement ID:	Not endorsed
Description:	Enrollee experience related to the following: • Written materials or Internet provided information needed about how plan works • Found out from health plan about cost for health care service or equipment • Found out from health plan about cost for specific prescriptions
Data Source(s):	QHP Enrollee Survey

Measure Name:	**Adult BMI Assessment**
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
Description:	The percentage of members 18–74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.
Data Source(s):	Administrative and Hybrid

[47] The QRS Access to Care measure includes two separate NQF-endorsed measures (Getting Needed Care and Getting Care Quickly), along with an additional CAHPS® Health Plan Supplemental question regarding getting after-hours care.

Measure Name:	Annual Dental Visit
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
Description:	The percentage of members 2-20 years of age who had at least one dental visit during the measurement year.
Data Source(s):	Administrative Data

Measure Name:	Annual Monitoring for Patients on Persistent Medications
Measure Steward:	NCQA
NQF Endorsement ID:	2371
Description:	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the three rates separately and as a total rate. • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) • Annual monitoring for members on digoxin • Annual monitoring for members on diuretics • Total rate (the sum of the three numerators divided by the sum of the three denominators)[48]
Data Source(s):	Administrative Data

Measure Name:	Antidepressant Medication Management
Measure Steward:	NCQA
NQF Endorsement ID:	0105
Description:	The percentage of members 18 years of age and older who had a diagnosis of major depression, and were treated with antidepressant medication and remained on an antidepressant medication treatment. Two rates are reported: 1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks) 2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)
Data Source(s):	Administrative Data

Measure Name:	Appropriate Testing for Children with Pharyngitis
Measure Steward:	NCQA
NQF Endorsement ID:	0002
Description:	The percentage of children 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).
Data Source(s):	Administrative Data

[48] The total rate for Annual Monitoring for Patients on Persistent Medications will not be used for QRS scoring.

Measure Name:	Appropriate Treatment for Children With Upper Respiratory Infection
Measure Steward:	NCQA
NQF Endorsement ID:	0069
Description:	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics *were not* prescribed).
Data Source(s):	Administrative Data

Measure Name:	Aspirin Use and Discussion
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
Description:	The two components of this measure assess different facets of aspirin use management. • *Aspirin Use.* A rolling average represents the percentage of members who are currently taking aspirin. A single rate is reported for which the denominator includes: – Women 56–79 years of age with at least two risk factors for cardiovascular disease – Men 46–65 years of age with at least one risk factor for cardiovascular disease – Men 66–79 years of age, regardless of risk factors • *Discussing Aspirin Risks and Benefits.* A rolling average represents the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. A single rate is reported for which the denominator includes: – Women 56–79 years of age – Men 46–79 years of age
Data Source(s):	QHP Enrollee Survey

Measure Name:	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
Measure Steward:	NCQA
NQF Endorsement ID:	0058
Description:	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were *not* prescribed).
Data Source(s):	Administrative Data

Measure Name:	Breast Cancer Screening
Measure Steward:	NCQA
NQF Endorsement ID:	2372
Description:	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
Data Source(s):	Administrative Data

Measure Name:	Care Coordination
Measure Steward:	AHRQ, CMS
NQF Endorsement ID:	Not Endorsed
Description:	Enrollee experience related to the following: • Doctor seemed informed and up-to-date about care from other health providers • Doctor had your medical records • Doctor followed up about blood test, x-ray results • Got blood test, x-ray results as soon as you needed them • Doctor talked about prescription drugs you are taking • Got help you needed from doctor's office manage your care among different providers
Data Source(s):	QHP Enrollee Survey

Measure Name:	Cervical Cancer Screening
Measure Steward:	NCQA
NQF Endorsement ID:	0032
Description:	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years • Women age 30–64 who had cervical cytology/HPV co-testing performed every 5 years
Data Source(s):	Administrative and Hybrid

Measure Name:	Childhood Immunization Status (Combination 3)
Measure Steward:	NCQA
NQF Endorsement ID:	0038
Description:	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox Varicella Zoster Virus (VZV); and four pneumococcal conjugate vaccines (PCV) by their second birthday. The measure calculates a rate for each vaccine and a combination rate ("Combination 3").
Data Source(s):	Administrative and Hybrid

Measure Name:	Chlamydia Screening in Women
Measure Steward:	NCQA
NQF Endorsement ID:	0033
Description:	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Data Source(s):	Administrative Data

Measure Name:	Colorectal Cancer Screening
Measure Steward:	NCQA
NQF Endorsement ID:	0034
Description:	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.
Data Source(s):	Administrative and Hybrid

Measure Name:	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
Measure Steward:	NCQA
NQF Endorsement ID:	0055
Description:	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
Data Source(s):	Administrative Data and Hybrid

Measure Name:	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Measure Steward:	NCQA
NQF Endorsement ID:	0575
Description:	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.
Data Source(s):	Administrative and Hybrid

Measure Name:	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
Measure Steward:	NCQA
NQF Endorsement ID:	0057
Description:	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.
Data Source(s):	Administrative and Hybrid

Measure Name:	Comprehensive Diabetes Care: Medical Attention for Nephropathy
Measure Steward:	NCQA
NQF Endorsement ID:	0062
Description:	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or monitoring test or had evidence of nephropathy during the measurement year.
Data Source(s):	Administrative Data and Hybrid

Measure Name:	Controlling High Blood Pressure
Measure Steward:	NCQA
NQF Endorsement ID:	0018
Description:	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg **Note:** A single rate is reported and is the sum of all three groups.
Data Source(s):	Hybrid Method must be used

Measure Name:	Cultural Competence
Measure Steward:	AHRQ, CMS
NQF Endorsement ID:	Not Endorsed
Description:	Enrollee experience related to the following: • How often got an interpreter • Forms available in preferred language • Forms available in preferred format, such as large print or braille **Note:** "How often got an interpreter" includes American Sign Language.
Data Source(s):	QHP Enrollee Survey

Measure Name:	Follow-Up Care for Children Prescribed ADHD Medication
Measure Steward:	NCQA
NQF Endorsement ID:	0108
Description:	The percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: • *Initiation Phase*. The percentage of members 6–12 years of age as of the Index Prescription Start Date with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase • *Continuation and Maintenance (C&M) Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended
Data Source(s):	Administrative Data

Measure Name:	Flu Vaccinations for Adults Ages 18-64
Measure Steward:	NCQA
NQF Endorsement ID:	0039
Description:	The percentage of members 18–64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the QHP Enrollee Survey was completed.
Data Source(s):	QHP Enrollee Survey

Measure Name:	Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up)
Measure Steward:	NCQA
NQF Endorsement ID:	0576
Description:	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.
Data Source(s):	Administrative Data

Measure Name:	Immunizations for Adolescents (Combination 2)
Measure Steward:	NCQA
NQF Endorsement ID:	1407
Description:	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Data Source(s):	Administrative and Hybrid

Measure Name:	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Steward:	NCQA
NQF Endorsement ID:	0004
Description:	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: • *Initiation of AOD Treatment*. The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • *Engagement of AOD Treatment*. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Data Source(s):	Administrative Data

Measure Name:	Medical Assistance With Smoking and Tobacco Use Cessation
Measure Steward:	NCQA
NQF Endorsement ID:	0027
Description:	The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: • *Advising Smokers and Tobacco Users to Quit*: A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year. • *Discussing Cessation Medications*: A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. • *Discussing Cessation Strategies*: A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.
Data Source(s):	QHP Enrollee Survey

Measure Name:	Medication Management for People With Asthma (75% of Treatment Period)
Measure Steward:	NCQA
NQF Endorsement ID:	1799
Description:	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. One rate is reported: • The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period
Data Source(s):	Administrative Data

Measure Name:	Plan Administration
Measure Steward:	AHRQ, CMS (Measure consists of CAHPS® survey items and a survey item developed for purposes of the QHP Enrollee Survey)
NQF Endorsement ID:	Not Endorsed
Description:	Enrollee experience related to the following: • Customer service gave necessary information/help • Customer service staff courteous and respectful • Wait-time to talk to customer service took longer than expected • Forms were easy to fill out • Health plan explained purpose of forms
Data Source(s):	QHP Enrollee Survey

Measure Name:	Plan All-Cause Readmissions
Measure Steward:	NCQA
NQF Endorsement ID:	1768
Description:	For members 18-64 years of age, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) (denominator) • Count of 30-Day Readmissions (numerator) • Average Adjusted Probability of Readmission
Data Source(s):	Administrative Data

Measure Name:	Prenatal and Postpartum Care
Measure Steward:	NCQA
NQF Endorsement ID:	1517
Description:	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care: • *Timeliness of Prenatal Care*. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date *or* within 42 days of enrollment in the organization. • *Postpartum Care*. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
Data Source(s):	Administrative and Hybrid

Measure Name:	Proportion of Days Covered
Measure Steward:	PQA
NQF Endorsement ID:	0541
Description:	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement period. Report a rate for the following: Diabetes All Class, Renin Angiotensin System (RAS) Antagonists, and Statins.
Data Source(s):	Administrative Data

Measure Name:	Rating of All Health Care
Measure Steward:	AHRQ
NQF Endorsement ID:	0006
Description:	Enrollee experience related to the following: • Rating of all health care
Data Source(s):	QHP Enrollee Survey

Measure Name:	Rating of Health Plan
Measure Steward:	AHRQ
NQF Endorsement ID:	0006
Description:	Enrollee experience related to the following: • Rating of health plan
Data Source(s):	QHP Enrollee Survey

Measure Name:	Rating of Personal Doctor
Measure Steward:	AHRQ
NQF Endorsement ID:	0006
Description:	Enrollee experience related to the following: • Rating of personal doctor
Data Source(s):	QHP Enrollee Survey

Measure Name:	Rating of Specialist
Measure Steward:	AHRQ
NQF Endorsement ID:	0006
Description:	Enrollee experience related to the following: • Rating of specialist
Data Source(s):	QHP Enrollee Survey

Measure Name:	Relative Resource Use for People with Diabetes (Inpatient Facility)
Measure Steward:	NCQA
NQF Endorsement ID:	1557
Description:	The relative resource use by members with diabetes during the measurement year.
Data Source(s):	Administrative Data

Measure Name:	Use of Imaging Studies for Low Back Pain
Measure Steward:	NCQA
NQF Endorsement ID:	0052
Description:	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).
Data Source(s):	Administrative Data

Measure Name:	Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents
Measure Steward:	NCQA
NQF Endorsement ID:	0024
Description:	The percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity
Data Source(s):	Administrative and Hybrid

Measure Name:	Well-Child Visits in the First 15 Months of Life (6 or More Visits)
Measure Steward:	NCQA
NQF Endorsement ID:	1392
Description:	The percentage of patients who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.
Data Source(s):	Administrative Data

Measure Name:	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Measure Steward:	NCQA
NQF Endorsement ID:	1516
Description:	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.
Data Source(s):	Administrative Data

Appendix C. Crosswalk of 2017 QHP Enrollee Survey Questions Included in the QRS

Exhibit 15. Crosswalk of 2017 QHP Enrollee Survey Questions Included in the QRS

This crosswalk maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), see: https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system. Measures highlighted in grey will not be included in scoring in 2017.

2017 QRS Survey Measure	2017 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Access to Care	Getting Care Quickly	4	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	CAHPS® Health Plan 5.0
		6	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	CAHPS® Health Plan 5.0
	Getting Needed Care	11	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	CAHPS® Health Plan 5.0
		33	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	CAHPS® Health Plan 5.0
	Single Item Measure	8	In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic after regular office hours?	CAHPS® Health Plan 5.0 — Supplemental Items
Access to Information	Access to Information[49]	37	In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?	CAHPS® Health Plan 4.0 — Supplemental Items (HEDIS®)
		39	In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?	CAHPS® Health Plan 4.0 — Supplemental Items (HEDIS®)
		41	In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?	CAHPS® Health Plan 4.0 — Supplemental Items (HEDIS®)
Care Coordination	Care Coordination	20	When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?	CAHPS Health Plan 5.0 — Supplemental Items
		22	In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?	CAHPS Health Plan 5.0 — Supplemental Items
		23	In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?	CAHPS Health Plan 5.0 — Supplemental Items

[49] These items come from the National Committee for Quality Assurance (NCQA) HEDIS® CAHPS Survey.

2017 QRS Survey Measure	2017 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
		25	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	CAHPS Health Plan 5.0 — Supplemental Items
Care Coordination (continued)	Care Coordination (continued)	28	In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?	CAHPS Health Plan 5.0 — Supplemental Items
		31	In the last 6 months, did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?	CAHPS Health Plan 5.0 — Supplemental Items
Cultural Competence	Cultural Competence	13	In the last 6 months, when you needed an interpreter at your doctor's office or clinic, how often did you get one?	CAHPS Health Plan 5.0— Supplemental Items
		49	In the last 6 months, how often were the forms that you had to fill out available in the language you prefer?	Modified from CG CAHPS 2.0, Adult Supplemental Items
		51	In the last 6 months, how often were the forms that you had to fill out available in the format you needed, such as large print or braille?	Modified from CG CAHPS 2.0, Adult Supplemental Items
Plan Administration	Plan Administration	43	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	CAHPS Health Plan 5.0
		44	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	CAHPS Health Plan 5.0
	Single Item Measure (Plan Administration)	45	In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected?	New Question developed for QHP Enrollee Survey
		47	In the last 6 months, how often were the forms from your health plan easy to fill out?	CAHPS Health Plan 5.0
		48	In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?	CAHPS Health Plan 5.0— Supplemental Items
Rating of all Health Care	Single Item Measure	10	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	CAHPS Health Plan 5.0
Rating of Health Plan	Single Item Measure	52	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months?	CAHPS Health Plan 5.0

2017 QRS Survey Measure	2017 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Rating of Personal Doctor	Single Item Measure	26	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	CAHPS Health Plan 5.0
Rating of Specialist	Single Item Measure	35	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?	CAHPS Health Plan 5.0
Flu Vaccinations for Adults Ages 18–64	Single Item Measure (Preventive Services)	60	Have you had either a flu shot or flu spray in the nose since July 1, 2015?	CAHPS 5.0H[50] Survey
Aspirin Use and Discussion	Single Item Measure (Preventive Services)	65	Do you take aspirin daily or every other day?	CAHPS 5.0H Survey
		66	Do you have a health problem or take medication that makes taking aspirin unsafe for you?	CAHPS 5.0H Survey
		67	Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?	CAHPS 5.0H Survey
		68	Are you aware that you have any of the following conditions? *Mark one or more*. High cholesterol, High blood pressure, Parent or sibling with heart attack before the age of 60	CAHPS 5.0H Survey
		69	Has a doctor ever told you that you have any of the following conditions? Mark one or more. Heart attack, Angina or coronary heart disease, Stroke, Any kind of diabetes or high blood sugar.	CAHPS 5.0H Survey
Medical Assistance With Smoking and Tobacco Use Cessation	Single Item Measure (Preventive Services)	62	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	CAHPS 5.0H Survey
		63	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	CAHPS 5.0H Survey

[50] National Committee for Quality Assurance (NCQA) HEDIS® CAHPS® Survey.

2017 QRS Survey Measure	2017 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
		64	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	CAHPS® 5.0H Survey

Appendix D. 2017 QRS Rating Methodology

The following steps outline the 2017 QRS rating methodology. The 2017 ratings methodology reflects applicable refinements finalized in the 2017 QRS Call Letter. Section 8 (Exhibit 9) provides a description of the QRS Preview Report and the QRS Proof Sheet. Both documents are available during the QRS preview period on the HIOS-MQM website.

STEP 1: CALCULATE MEASURE RATES

If a QHP issuer **submitted a valid** measure rate for the reporting unit, then a numeric result will appear in the Raw Value field for the measure in the QRS Proof sheet.

If a QHP issuer **did not submit a valid** measure rate for the reporting unit, then an invalid code will appear in the Raw Value field for the measure in the QRS Proof Sheet (and a null value [a dash, "-"] will be shown in the Denominator Size field). A measure rate is considered invalid if the reporting unit received one of the audit designations provided in Exhibit 16:

Exhibit 16. Audit Designations

Audit Designation	Meaning
Benefit Not Offered (NB)	The QHP issuer did not offer the health benefit required by the measure.
Biased Rate (BR)	The QHP issuer's calculated rate was materially biased.
Not Reported (NR)	The QHP issuer chose not to report the measure.

Invalid measure data is not used in scoring, meaning not used in Step 3 or beyond, and is assigned an invalid code, **NC (Not Calculated)**, for the measure score (i.e., shown in the Standardized score/Ranking field).

Measures not used in scoring: Not all measures are used for scoring in 2017. For measures not included in scoring, the QRS Proof Sheet includes an invalid code, **M-NS (Measure – Not Scored)**, for the measure score (i.e., shown in the Standardized score/Ranking field). Note that if a composite score cannot be calculated due to inability to pass the half-scale rule, then the reporting unit receives the invalid code, **Component Score or Rating – Not Scored (CSR-NS)**.

For all measures used in scoring, CMS calculates measure rates (raw values) for QRS clinical and survey measures as described in detail below.

QRS Clinical Measures

For QRS clinical measures composed of multiple indicators, CMS uses various aggregation methods to calculate a measure rate per the measure's technical specifications. See Exhibit 17 for a summary of each method; further detail can be found in the *2017 Quality Rating System Measure Technical Specifications*.

Exhibit 17. Aggregation Methods for QRS Clinical Measures with Multiple Indicators

Measure (M)	Measure Indicator (MI) Asterisk (*) indicates sub-measure indicator (sub-MI)	Method for Calculating Measure Rate	Method for Calculating Total Measure Denominator Size
Annual Dental Visit	• Annual Dental Visit (2-3 Years) • Annual Dental Visit (4-6 Years) • Annual Dental Visit (7-10 Years) • Annual Dental Visit (11-14 Years) • Annual Dental Visit (15-18 Years) • Annual Dental Visit (19-20 Years)	$\frac{\sum Numerator}{\sum Denominator}$ [51]	Sum of MI denominators
Annual Monitoring for Patients on Persistent Medications	• Annual Monitoring for Patients on Persistent Medications Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs) • Annual Monitoring for Patients on Persistent Medications (Digoxin) • Annual Monitoring for Patients on Persistent Medications (Diuretics)	$\frac{\sum Numerator}{\sum Denominator}$	Sum of MI denominators
Antidepressant Medication Management	• Antidepressant Medication Management: Acute • Antidepressant Medication Management : Continuation	Average of MI rates	Average of MI denominators
Chlamydia Screening in Women	- Chlamydia Screening (16-20 Years) - Chlamydia Screening (21-24 Years)	$\frac{\sum Numerator}{\sum Denominator}$	Sum of MI denominators
Follow-Up Care for Children Prescribed ADHD Medication	- Follow-Up Care for Children Prescribed ADHD Medication: Initiation - Follow-Up Care for Children Prescribed ADHD Medication: Continuation	Average of MI rates	Average of MI denominators
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence	• Initiation of Alcohol and Other Drug Dependence Treatment (Total) – Treatment (13-17)*[52] – Treatment (18+)* • Engagement of Alcohol and Other Drug Dependence Treatment (Total) – Treatment (13-17) * – Treatment (18+)*	Two Steps: 1. MI rate = $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 2. Average of MI rates	Two Steps: 1. $\sum Denominator_{sub-MI}$ 2. Average of MI denominators
Medication Management for People With Asthma	• Medication Management for People With Asthma (75%; 5-11) • Medication Management for People With Asthma (75%; 12-18) • Medication Management for People With Asthma (75%; 19-50) • Medication Management for People With Asthma (75%; 51-64)	$\frac{\sum Numerator}{\sum Denominator}$	Sum of MI denominators

[51] The measure rate is calculated via a sum of MI numerators divided by the sum of MI denominators. The numerator of a given MI rate can be calculated by multiplying the MI rate by the denominator for the MI

[52] Sub-measure indicators (sub-MIs) are combined via an average (sum of numerators divided by sum of denominators) to create the rate for a measure indicator (MI).

Measure (M)	Measure Indicator (MI) Asterisk (*) indicates sub-measure indicator (sub-MI)	Method for Calculating Measure Rate	Method for Calculating Total Measure Denominator Size
Plan All-Cause Readmissions	• Observed Readmission (Numerator/Denominator) Total • Average Adjusted Probability Total	Observed Readmission divided by Average Adjusted Probability	Sum of MI denominators
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	• Body Mass Index (BMI) Percentile Documentation – BMI Percentile – 3-11 Years* – BMI Percentile – 12-17 Years* • Counseling for Nutrition – Counseling for nutrition – 3-11 Years* – Counseling for nutrition – 12-17 Years* • Counseling for Physical Activity – Counseling for Physical Activity – 3-11 Years* – Counseling for Physical Activity – 12-17 Years*	Two Steps: 1. MI rate = $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 2. Average of MI rates	Two Steps: 1. $\sum Denominator_{sub-MI}$ 2. Average of MI denominators
Medical Assistance with Smoking and Tobacco Use Cessation[53]	• How Often Advised to Quit Smoking or Using Tobacco • How Often Advised to Quit Smoking or Using Tobacco (Previous Year) • How Often Medication Recommended or Discussed • How Often Medication Recommended or Discussed (Previous Year) • How Often Provided Strategies to Quit • How Often Provided Strategies to Quit (Previous Year)	Two Steps: 1. MI rate = $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 2. Average of MI rates	Two Steps: 1. $\sum Denominator_{sub-MI}$ 2. Average of MI denominators

QRS Survey Measures

For QRS survey measures, CMS calculates measure rates from QHP Enrollee Survey questions.

Appendix C shows which QHP Enrollee Survey questions are used for each QRS survey measure.

QRS survey measures are grouped into two categories:

(1) **CAHPS®-based:** Consumers' experience of care measures based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and

[53] The Medical Assistance with Smoking and Tobacco Use Cessation (Tobacco) measure is calculated as a two-year rolling average based on sub-MI data reported in the prior year (i.e., 2016) and the ratings year (i.e., 2017). CMS merges information for a given reporting unit from the prior year onto the data from the ratings year to calculate the measure score. The Tobacco sub-MIs are reported in the QRS Proof Sheets as M25a1-M25c1 and M25a2-M25c2, respectively. For reporting units that were ineligible to receive a QRS rating in the prior year, CMS uses the reported rates from the prior year and current year to calculate the Tobacco measure score, even though the reporting unit was not ratings-eligible in the prior year. For example, if a reporting unit is newly eligible to receive a QRS rating in 2017, CMS will use the reporting unit's reported data for 2016 and 2017 to calculate the Tobacco measure score.

(2) **Clinical measures captured in QHP Enrollee Survey:** Selected clinical measures based on the Healthcare Effectiveness Data and Information Set (HEDIS®).

CMS calculates QRS survey measure rates according to the scoring specifications described below.

CAHPS®-Based QRS Survey Measures

CMS calculates CAHPS®-based QRS survey measures with an approach similar to the one CMS uses in the Medicare Advantage-Prescription Drug Program (MA-PDP) quality measurement initiative for data collected through the MA-PDP CAHPS® survey.[54]

CMS calculates QRS survey measures rates from the QHP Enrollee Survey using the CAHPS® Analysis Program ("CAHPS® Macro"), which was developed by the CAHPS® Consortium under the auspices of the Agency for Healthcare Research and Quality (AHRQ). A comprehensive description of the calculations performed by the CAHPS® Macro, including additional information on weighting and case-mix adjustment, can be found in *Instructions for Analyzing Data from CAHPS Surveys*.

To adjust for any systematic biases with the enrollee response data, CMS applies a case-mix adjustment to the QHP Enrollee Survey response data and uses the adjusted data when calculating the QRS survey measures. It is common in survey-based applications to case-mix adjust for such factors as overall health status, age, and education to account for biases due to survey response tendencies. The QHP Enrollee Survey variables used in the case-mix adjustment include the following: general health rating, mental health rating, chronic conditions/medications, age, education, survey language, help with the survey, and survey mode. The final variables to be included in the case-mix adjustment will be determined based on additional analysis of the 2017 QHP Enrollee Survey data.

All CAHPS®-based measures are based on weighted, case-mix adjusted means. CMS uses person-level sampling weights to account for the different probabilities of selection across reporting units. The weights are calculated as follows:

$$Final\ Weight = \left(\frac{M}{n\_s}\right) * k$$

Where:
n_s = Total number of sampled enrollees in the sampling unit;
M = Total number of records in the sampling unit after-de-duplication;
k = Number of eligible enrollees covered by the Subscriber or Family ID (SFID) that covers the sampled enrollee.

As shown below, all CAHPS®-based questions should be coded so higher values represent more positive responses.

[54] General background information about the scoring of CAHPS®-based measures in the MA-PDP program is presented in the *MA-PDP CAHPS® Survey: Quality Assurance Protocols and Technical Specifications* (http://www.ma-pdpcahps.org/).

Rating of Health Plan

Question 52 in the 2017 QHP Enrollee Survey asks, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months?" Use the following steps to calculate the QRS measure rate for Rating of Health Plan:

1. Calculate the weighted, case-mix adjusted mean for question 52.
2. Transform to a 0 – 100 scale as follows: score = [(x – a)/(b – a)]*100, where x = the weighted, case-mix adjusted mean from step 1; a = minimum possible value of x; and b = maximum possible value of x. This is the QRS measure rate for Rating of Health Plan.
    - **Note:** This rescaling allows the presentation of different measures on a common metric; the transformation to a 0 – 100 scale applies to all QRS survey measures that are CAHPS®-based.

Rating of All Health Care

Question 10 in the 2017 QHP Enrollee Survey asks, "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?" To calculate the QRS measure rate for Rating of All Health Care measure, use the same steps that were used to calculate the rate for Rating of Health Plan.

Rating of Personal Doctor

Question 26 in the 2017 QHP Enrollee Survey asks, "Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?" To calculate the QRS measure rate for Rating of Personal Doctor, use the same steps that were used to calculate the rate for Rating of Health Plan.

Rating of Specialist

Question 35 in the 2017 QHP Enrollee Survey asks, "We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?" To calculate the QRS measure rate for Rating of Specialist, use the same steps that were used to calculate the score for Rating of Health Plan.

Access to Care

The QRS Access to Care measure is made up of five questions, all of which are coded on a 1 – 4 scale in the 2017 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS measure rate for Access to Care:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Access to Care measure:
    - Question 4: In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
    - Question 6: In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- Question 8: In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic after regular office hours?
- Question 11: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
- Question 33: In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

2. Calculate the average of the weighted, case-mix adjusted means across the five survey questions; use equal weighing of the questions.
3. Transform the average from Step 2 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the QRS measure rate for Access to Care.

Cultural Competence

The QRS Cultural Competence measure is made up of three questions, all of which are coded on a 1 – 4 scale in the 2017 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS measure rate for Cultural Competence:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Cultural Competence measure:
   - Question 13: In the last 6 months, when you needed an interpreter at your doctor's office or clinic, how often did you get one?
   - Question 49: In the last 6 months, how often were the forms that you had to fill out available in the language you prefer?
   - Question 51: In the last 6 months, how often were the forms that you had to fill out available in the format you needed, such as large print or braille?
2. Calculate the average of the weighted, case-mix adjusted means across the three survey questions; use equal weighing of the questions.
3. Transform the average from Step 2 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the QRS measure rate for Cultural Competence.

Care Coordination

The QRS Care Coordination measure is made up of six questions, all of which are coded on a 1 – 4 scale in the 2017 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS measure rate for the Care Coordination measure:

1. Questions 22 and 23 are combined into a single measure to assess getting results after a blood test, x-ray, or other test. Calculate the average of the weighted, case-mix adjusted means for Questions 22 and 23 using equal weighting of the two questions. Use this average in Step 3.
2. Calculate the weighted, case-mix adjusted mean separately for each question included in the Care Coordination measure:
   - Question 20: When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?

- Question 22: In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- Question 23: In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?
- Question 25: In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
- Question 28: In the last 6 months, how often did you and your personal doctor talk about all the prescriptions you were taking?
- Question 31: In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?

3. Calculate the average of the weighted, case-mix adjusted means across the five survey questions (i.e., Questions 20, 25, 28, and 31, and the average of Questions 22 and 23 from Step 2); use equal weighting of the questions.
4. Transform the average from Step 3 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the QRS measure rate for Care Coordination.

Access to Information

The QRS Access to Information measure is made up of three questions, all of which are coded on a 1 – 4 scale in the 2017 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS measure rate for Access to Information:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Access to Information measure:
   - Question 37: In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?
   - Question 39: In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?
   - Question 41: In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?
2. Calculate the average of the weighted, case-mix adjusted means across the three survey questions; use equal weighing of the questions.
3. Transform the average from Step 2 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the QRS measure rate for Access to Information.

Plan Administration

The QRS Plan Administration measure is made up of five questions, all of which are coded on a 1 – 4 scale in the 2017 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS score for the Plan Administration measure:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Plan Administration measure:

- Question 43: In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
- Question 44: In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
- Question 45: In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected?
  - **Note:** To make the direction of coding of Question 45 consistent with the other questions, Question 45 needs to be recoded so higher values represent a more positive response, as follows:

Category	Original code	Recode
Never	1	4
Sometimes	2	3
Usually	3	2
Always	4	1

- Question 47: In the last 6 months, how often were the forms from your health plan easy to fill out?
- Question 48: In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?

2. Calculate the average of the weighted, case-mix adjusted means across the five survey questions; use equal weighing of the questions.
3. Transform the average from Step 2 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the QRS measure rate for Plan Administration.

QRS Clinical Measures Captured in QHP Enrollee Survey

The following QRS survey measures are clinical in nature:

- Flu Vaccinations for Adults Ages 18-64
- Medical Assistance with Smoking and Tobacco Use Cessation
- Aspirin Use and Discussion

Scoring specifications for the clinical measures collected through the 2017 QHP Enrollee Survey follow the HEDIS® specifications as defined by NCQA. Beginning in the 2017 ratings year and beyond, CMS will apply the QRS clinical measure denominator criterion of 30 to all clinical measures captured in the QHP Enrollee survey. For the 2017 ratings year, this includes Flu Vaccinations for Adults Ages 18-64 and Medical Assistance with Smoking and Tobacco Use Cessation. The Aspirin Use and Discussion measure will neither be collected nor used in scoring for the 2017 ratings year. The scoring procedures are described below. These specifications are also presented in the *2017 Quality Rating System Measure Technical Specifications*.

Flu Vaccinations for Adults Ages 18-64

The QRS survey measure captures the proportion of eligible plan enrollees who received a flu vaccination. The following steps are used for calculating the QRS survey measure (flu_shot):

1. Select eligible enrollees:
   - Include:
     - Enrollees age 18-64 (to determine eligibility use flu_flag from the sampling frame, which indicates eligibility for the flu shot based on the person's age as of July 1, 2016).
   - Exclude:
     - Respondents with a missing value code on flu_shot (i.e., respondents coded as -1, -3, or 3 on flu_shot).
2. Calculate the proportion of eligible enrollees for whom flu_shot=1 to create the final QRS survey measure rate for Flu Vaccinations for Adults Ages 18-64.
   - Note: the proportion is not weighted and is not case-mix adjusted.

Medical Assistance with Smoking and Tobacco Use Cessation

The QRS survey measure is made up of three items/indicators, all of which are coded on a 1-4 scale in the questionnaire. All items require two years of data collection.

The inclusion/exclusion criteria for the measure includes the following steps:

1. Select eligible enrollees (the criteria for each of the three indicators follow separately):

Advising Smokers and Tobacco Users to Quit (advised_quit_tob):

- Include:
  - Current smokers or tobacco user (i.e., respondents coded as 1 or 2 on use_tobacco).
- Exclude:
  - Respondents with a missing value code on advised_quit_tob (i.e., respondents coded as -1, -2, -3, or -7 on advised_quit_tob).

Discussing Cessation Medications (recommend_tob_meds):

- Include:
  - Current smokers or tobacco user (i.e., respondents coded as 1 or 2 on use_tobacco).
- Exclude:
  - Respondents with a missing value code on recommend_tob_meds (i.e., respondents coded as -1, -2, -3, or -7 on recommend_tob_meds).

Discussing Cessation Strategies (dicuss_tob_non_meds):

- Include:
  - Current smokers or tobacco user (i.e., respondents coded as 1 or 2 on use_tobacco).
- Exclude:
  - Respondents with a missing value code on discuss_tob_non_meds (i.e., respondents coded as -1, -2, -3, or -7 on discuss_tob_non_meds).

2. Calculate the unadjusted proportion of respondents who indicated on each item included in the measure that they received some level of advice/discussion (i.e., proportion on each item with codes of sometimes, usually, or always).
   - **Note:** The proportion is not weighted and not case-mix adjusted. These are the indicators used in the calculation of the QRS survey measure rate for Medical Assistance with Smoking and Tobacco Use Cessation:

- advised_quit_tob (i.e., proportion of respondents coded as 2, 3, or 4),
- recommend_tob_meds (i.e., proportion of respondents coded as 2, 3, or 4),
- discuss_tob_non-meds (i.e., proportion of respondent coded as 2, 3, or 4).

Aspirin Use and Discussion

In December 2016, NCQA announced the retirement of the Aspirin Use and Discussion (ASP) measure due to misalignment with updated recommendations from the USPSTF. CMS then announced through an FAQ[55] that it would take steps to align the 2017 QRS with these changes made by the measure steward. Specifically, the ASP measure will not be used for scoring in the 2017 ratings year, QHP issuers are not required to submit data for the measure, and CMS will remove the ASP Measure from the 2018 QRS measure set.

STEP 2: DETERMINE IF MEASURE DENOMINATOR SIZES ARE SUFFICIENT FOR STEP 2: DETERMINE SCORING STATUS AND APPLICATION OF DENOMINATOR CRITERIA

For each reporting unit, CMS assesses whether measure data can be included in QRS scoring based on the reporting unit's ratings eligibility status, and each measure's denominator size. A reporting unit is considered ratings-eligible if it has operated in an Exchange for three consecutive years and meets the minimum enrollment criteria (i.e., more than 500 enrollees as of July 1 of the prior year [i.e., 2016] and the ratings year [i.e., 2017]). Reporting units that do not meet the ratings eligibility criteria are removed from scoring. Similarly, while QHP issuers submit measure data to CMS regardless of denominator size, measures that do not meet the minimum denominator criteria for scoring (see Exhibit 18) are excluded from QRS scoring.

Exhibit 18. Minimum Denominator Size Required for Inclusion in QRS Scoring

Measure	Minimum Denominator Criteria for Inclusion in QRS Scoring
QRS Clinical Measure	30
QRS Clinical Measures Captured in QHP Enrollee Survey	30
QRS Survey Measure	100

The minimum denominator size of 100 applies to all QRS CAHPS®-based survey measures, regardless of the number of survey questions associated with the measure. The minimum denominator size of 30 applies to all QRS clinical measures, including those clinical measures captured in the 2017 QHP Enrollee Survey.

For measures with an insufficient denominator size, CMS assigns the measure an invalid code (i.e., **NC/Not Calculated**) and excludes the measure from scoring.

QRS Clinical Measures

For QRS clinical measures, CMS determines if the minimum denominator size is met based on the measure's total denominator size. Different measures have different aggregation methods, as shown in Exhibit 6.

[55] See the January 6, 2017, FAQs available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

As shown in the illustrative example in Exhibit 19, the measure Annual Monitoring for Patients on Persistent Medications has three indicators. For this example reporting unit, the measure's denominator size of 2985 meets the minimum denominator size criteria of 30. Therefore, CMS will use this measure data in QRS scoring (i.e., proceed to use this measure data in the standardization procedures described in Step 3).

Exhibit 19. Example Denominator Size for QRS Clinical Measure Indicators

Name	Denominator Size
ACE Inhibitors or ARBs (Indicator)	1641
Digoxin (Indicator)	17
Diuretics (Indicator)	1327
Annual Monitoring for Patients on Persistent Medications (Measure)	**2985**

QRS Survey Measures

For CAHPS®-based QRS survey measures, CMS determines if the minimum denominator size is met based on the measure's total denominator size. The denominator size for the measure is equal to the total number of unique respondents who provided a response to at least one of the questions.

Exhibit 20 shows an example (using mock data) of denominator size calculation for the CAHPS®-based QRS survey measure, Access to Care. Access to Care is composed of five questions. As shown, there can be valid denominator observations for each of the five questions that are *lower* than 100 and yet the measure denominator size can still be *greater* than 100. Enrollees are not required to respond to all survey questions to be included in a given measure's denominator or rate. The total measure denominator size (161) is greater than the minimum denominator size needed for QRS scoring (100). Therefore, CMS calculates the average of the case-mix adjusted mean across the five survey questions to obtain the Access to Care measure score.

Exhibit 20. Example of Total Denominator Size Calculation for QRS Survey Measure

QRS Component	Name	Question Details	Denominator Size
Indicator	CAHPS® Getting Care Quickly: Non-Urgent Care	Question 6: In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	136
Indicator	CAHPS® Getting Care Quickly: Urgent Care	Question 4: In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	77
Indicator	CAHPS® Getting Needed Care: Easy Care, Tests, or Treatment	Question 11: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	146
Indicator	CAHPS® Getting Needed Care: Easy to See Specialist	Question 33: In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	70

QRS Component	Name	Question Details	Denominator Size
Indicator	CAHPS® Getting Needed Care: After Hours	Question 8: In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic after regular office hours?	20
Measure	**Access to Care**		**161**

STEP 3: CALCULATE STANDARDIZED MEASURE SCORES

CMS calculates standardized measure scores by calculating national percentile ranks across all reporting units using valid observations of a given measure (meaning those that meet minimum denominator size criteria). Percentile ranks are based on one national, all-product reference group (i.e., not stratified by any characteristics, such as product type or Exchange). The rankings reflect how well a reporting unit did as compared to the other reporting units in a given measure. For example, across all products (i.e., EPOs, HMOs, POSs, and PPOs) and all Exchanges, CMS ranks the valid rates for the Cervical Cancer screening measure. A QHP issuer's HMO product with a measure rate (raw value) that corresponds to the 50th percentile rank among all reporting units receives a Cervical Cancer Screening measure score of 50.

If reporting units have tied measure rates, the reporting unit is assigned the value of the average rank, as highlighted in Exhibit 21.

Exhibit 21. Handling Tied Measure Rates

Observation	Measure Rate	Standardized Score/ Ranking
1	0.04	10
2	0.18	20
3	0.27	30
4	0.36	40
5	0.53	55
6	0.53	55
7	0.71	70
8	0.89	80
9	0.97	95
10	0.97	95

CMS uses the PROC RANK procedure in SAS to rank an individual measure across all available reporting units at a national level. All measures go through the ranking process independently, and percentile ranks range from 0 to 100. The procedure allows for as many percentile ranks as there are reporting units (e.g., a percentile rank of 1.5 is valid). CMS excludes reporting units that do not meet the minimum denominator criterion from percentile ranking for each measure. This approach calculates the rank as n/ (N+1), where n is the reporting unit's position in the rank order (breaking ties using the mean rank) and N is the number of reporting units with a valid measure rate and a denominator meeting the criteria defined above.

For example, as shown in Exhibit 22, for a given measure, the score is the valid measure rate (raw value) post-standardization.

Exhibit 22. Example Score after Standardization

Measure Name	Raw Value	Standardized Score/Ranking
Annual Monitoring for Patients on Persistent Medications	0.82	99.6516

STEP 4: CALCULATE COMPOSITE SCORES

CMS calculates composite scores, like other QRS component scores (i.e., domains, summary indicators, and global), by averaging (unweighted) scores.

CMS calculates composite scores based on averages of standardized QRS measure scores. The steps are as follows:

1. **Determine if the composite score can be calculated.** CMS uses a *half-scale rule* to determine if the composite score can be calculated. The half-scale rule allows calculation of the score only if at least half (>50%) of the associated measures in the composite have a valid score (i.e., measure results met the minimum denominator criteria as defined in Step 2 and therefore received a score). Otherwise, the composite cannot be calculated and does not receive a score. When applying the half-scale rule for composite score calculation, CMS only considers measures that are included in scoring.

   If the composite score cannot be calculated due to inability to pass the half-scale rule, then the reporting unit receives the following invalid code:

   - **CSR – I:** Insufficient data to calculate a score according to the QRS rating methodology.

2. **Calculate the composite score.** If the composite score can be calculated according to the half-scale rule, CMS averages the available measure scores.

   Exhibit 23 shows how a composite is calculated from measure scores using mock data.

Exhibit 23. Example Composite Score Calculation

Measure	Type of QRS Component	Score
Adult BMI Assessment	Measure	NC (Invalid code NC assigned due to invalid measure rate [NR audit designation])
Chlamydia Screening in Women	Measure	99.5169
Aspirin Use and Discussion	Measure	M-NS (Measure Not Scored)
Flu Vaccinations for Adults Ages 18-64	Measure	10.4982
Medical Assistance With Smoking and Tobacco Use Cessation	Measure	NC (Invalid code NC assigned due to invalid measure rate [NR audit designation])
Staying Healthy Adult	**Composite**	**55.0076** Note, the composite score can be calculated because two of the four available measures (Chlamydia Screening and Flu Vaccinations) received valid scores (equal to 50%).

Composite scores are averages of standardized measure scores/percentile ranks. Therefore, a composite score of 55 means "this QHP has an average percentile rank of 55 based on the

measure scores for this composite." It does not mean "this QHP is at the 55th percentile rank for this composite."

STEP 5: CALCULATE DOMAIN SCORES

CMS calculates domain scores based on averages of composite scores. The steps are as follows:

1. **Determine if the domain score can be calculated.** To calculate the domain score, CMS uses the *half-scale rule* to determine if at least half (>50%) of the associated composites have a valid score. If the domain score cannot be calculated, it will not reflect a score (i.e., will receive an invalid result of CSR-I).
2. **Calculate the domain score.** If the domain score can be calculated, CMS averages the available composite scores. An example using mock data is shown in Exhibit 24.

Exhibit 24. Example Domain Score Calculation

Name	Type of QRS Component	Score
Checking for Cancer	Composite	99.6599
Maternal Health	Composite	99.4186
Staying Healthy Adult	Composite	55.0076
Staying Healthy Child	Composite	80.3985
Prevention	**Domain**	**83.6211 (Average of available composite scores)**

STEP 6: CALCULATE SUMMARY INDICATOR SCORES

CMS calculates summary indicator scores based on averages of domain scores. The steps are as follows:

1. **Determine if the summary indicator score can be calculated.** To calculate the summary indicator score, CMS uses the *half-scale rule* to determine if at least half (>50%) of the associated domains have a valid score. If the summary indicator score cannot be calculated, it will not receive a score (i.e., receives an invalid result of CSR-I).
2. **Calculate the summary indicator score.** If the summary indicator score can be calculated, CMS averages the available domain scores. An example using mock data is shown in Exhibit 25.

Exhibit 25. Example Summary Indicator Score Calculation

Name	Type of QRS Component	Score
Clinical Effectiveness	Domain	71.1757
Patient Safety	Domain	99.6516
Prevention	Domain	83.6211
Clinical Quality Management	**Summary Indicator**	**84.8161 (Average of available domain scores)**

STEP 7: CALCULATE GLOBAL SCORE

CMS calculates the global score based on averages of summary indicator scores. The steps are as follows:

1. **Determine if the global score can be calculated.** CMS calculates the global score for the reporting unit only if the *Clinical Quality Management summary indicator* has a score and *at least one of the other two summary indicators* has a score. If the global score cannot be calculated due to inability to pass this scoring rule, then the reporting unit receives the following invalid code:

   - **Not Global (NG):** Insufficient data to calculate a global rating.

2. **Calculate the global score.** If the global score can be calculated according to the scoring rule described above, CMS averages the available summary indicator scores. An example using mock data is shown in Exhibit 26.

Exhibit 26. Example Global Score Calculation

Name	Type of QRS Component	Example Score
Clinical Quality Management	Summary Indicator	84.8161
Enrollee Experience	Summary Indicator	59.9472
Plan Efficiency, Affordability, and Management	Summary Indicator	57.8032
Global	**Global**	**67.5222 (Average of available summary indicator scores)**

STEP 8: CONVERT SCORES TO RATINGS

1. **Identify cut point values.** After calculating scores for composites through the global result, CMS uses cluster analysis of the component scores to create cut points for each composite, domain, summary indicator, and global component. Cut points are numeric values that delineate the 5-star categories. These values are used to convert numeric scores into star ratings for each QRS hierarchy component. There are no cut points for measures; measures are uniformly distributed due to standardization and therefore it would be difficult to cluster and assign star ratings.

   To identify the cut point values, CMS uses a clustering analysis to take valid scores from each reporting unit and group them together based on distance into five clusters. The cluster analysis is conducted for each component of the hierarchy from composites through the global scores (i.e., 26 independent clustering runs). The resulting data-driven cut points are different at each level of the hierarchy. Therefore, each QRS hierarchy component has its own set of four cut point values (to create five rating categories). In the QRS Proof Sheet, the cut point values are labeled 1 through 4, (e.g., Cut Point 1, reporting the threshold between 1-star rating and 2-star rating).

   Cut points will likely change from year to year due to differences in submitted QRS measure data each year. CMS publishes the cut point values with the QRS scores and ratings during the QRS preview period.

2. **Convert scores to ratings.** CMS converts each component score (for composites, domains, summary indicators, and global score) into a rating using their respective cut points that delineates the rating categories of 1, 2, 3, 4, and 5 stars. Scores fall into one of the five categories created by the cut points. CMS does not use decimal points when applying cut points (i.e., only the two-digit integer cut point is used when applying a cut point to the score). Ratings are assigned on a 5-star scale and only whole stars (1, 2, 3, 4 or 5) are assigned.

   Exhibit 27 shows how a global score is converted to a global rating using mock global score cut points (example cut points of 31, 45, 56, and 69). A reporting unit that received a global score of 67.5222 would receive a 4-star rating as the score lies within the limits of the fourth category (56 ≤ Score < 69).

Exhibit 27. Global Rating Calculation with Example Cut Points

Example Cut Points	Rating
0 < Score < 31	1 ★
31≤ Score < 45	2 ★★
45 ≤ Score < 56	3 ★★★
56 ≤ Score < 69	4 ★★★★ **For example, a global score of 67.5222 would be assigned a 4-star global rating**
69 ≤ Score	5 ★★★★★

STEP 9: PRODUCE QRS RESULTS FOR PREVIEW AND FINALIZATION

The last step in applying the QRS rating methodology, is production of the Ratings Output File (ROF). The ROF contains all the QRS results for all participating reporting units. Using the ROF, CMS produces a QRS Preview Report and QRS Proof Sheet for each reporting unit for QHP issuers to preview the results during the QRS preview period and reports for Exchange administrators (e.g., CCIIO, SBE administrators, FFE State contacts, and OPM).

Appendix E. QRS Hierarchy

The QRS measures are organized into a hierarchical structure that serves as a foundation of the QRS rating methodology (the QRS hierarchy). The measures are grouped into hierarchy components (composites, domains, summary indicators) to form a single global rating.[56]

Exhibit 28 illustrates the 2017 QRS hierarchy, which is the organization of measures into composites, domains, and summary indicators and, ultimately, a single global rating. The survey measures in the QRS measure set are noted with an asterisk (*). Shown in grey are the measures that will not be included in 2017 QRS scoring. Please note, QHP issuers are not required to submit data for the ASP and RRU measures.

Exhibit 28. QRS Hierarchy

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
Clinical Quality Management	Clinical Effective-ness	Asthma Care	Medication Management for People With Asthma (75% of Treatment Period)	1799
		Behavioral Health	Antidepressant Medication Management	0105
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	0576
			Follow-Up Care for Children Prescribed ADHD Medication	0108
			Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004
		Cardiovascular Care	Controlling High Blood Pressure	0018
			Proportion of Days Covered (RAS Antagonists)	0541
			Proportion of Days Covered (Statins)	0541
		Diabetes Care	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062
			Proportion of Days Covered (Diabetes All Class)	0541
	Patient Safety	Patient Safety	Annual Monitoring for Patients on Persistent Medications	2371
			Plan All-Cause Readmissions	1768
	Prevention	Checking for Cancer	Breast Cancer Screening	2372
			Cervical Cancer Screening	0032
			Colorectal Cancer Screening	0034

[56] In communicating total measure counts, the totals presented here represent the perspective of the scoring methodology, rather than the perspective of the measure steward. If counting based the perspective of the scoring methodology, there are 42 measures used in scoring (rather than 39) and 45 measures collected in total (rather than 42). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care (NQF #1517) is split into two distinct measures for the QRS hierarchy: Timeliness of Prenatal Care and Postpartum Care. Similarly, Proportion of Days Covered (NQF #0541) is split into three distinct measures: Diabetes All Class, Renin Angiotensin System (RAS) Antagonists, and Statins.

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
		Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	1517
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517
		Staying Healthy Adult	Adult BMI Assessment	Not Endorsed
			Chlamydia Screening in Women	0033
			Aspirin Use and Discussion*	Not Endorsed
			Flu Vaccinations for Adults Ages 18-64*	0039
			Medical Assistance With Smoking and Tobacco Use Cessation*	0027
		Staying Healthy Child	Annual Dental Visit	Not Endorsed
			Childhood Immunization Status (Combination 3)	0038
			Immunizations for Adolescents (Combination 2)	1407
			Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024
			Well-Child Visits in the First 15 Months of Life (Six or More Visits)	1392
			Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516
Enrollee Experience	Access	Access to Care	Access to Care*	Not Endorsed
	Care Coordination	Care Coordination	Care Coordination*	Not Endorsed
	Doctor and Care	Doctor and Care	Cultural Competence*	Not Endorsed
			Rating of All Health Care*	0006
			Rating of Personal Doctor*	0006
			Rating of Specialist*	0006
Plan Efficiency, Affordability, & Management	Efficiency & Affordability	Efficient Care	Appropriate Testing for Children With Pharyngitis	0002
			Appropriate Treatment for Children With Upper Respiratory Infection	0069
			Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058
			Use of Imaging Studies for Low Back Pain	0052
	Plan Service	Enrollee Experience with Health Plan	Access to Information*	Not Endorsed
			Plan Administration*	Not Endorsed
			Rating of Health Plan*	0006
Not included in QRS hierarchy for purposes of QRS scores and ratings				
N/A	N/A	N/A	Relative Resource Use for People with Diabetes (Inpatient Facility)	1557

Appendix F. Overview of QHP Enrollee Survey Results

Exhibit 29 provides an overview of different resources through which QHP Enrollee Survey results are communicated to QHP issuers.

Exhibit 29. QHP Issuer Resources for Reviewing QHP Enrollee Survey Results

Resource	Description
QHP Enrollee Survey Quality Improvement (QI) reports	These reports communicate the full results of the QHP Enrollee Survey, including questions not included as part of the QRS measure set. The raw frequencies for all QHP Enrollee Survey questions are included in the QHP Enrollee Survey QI reports. CMS intends to release the QHP Enrollee Survey QI reports shortly after the QRS preview period ends. Note that some response categories may be missing due to CMS' policies regarding minimum cell sizes. CMS' standard practice is to not publically report cell sizes smaller than 11 in order to protect confidentiality. The results shown in QHP Enrollee Survey QI reports are produced after data cleaning and scoring procedures. First, the data used for these reports are cleaned according to standard CAHPS® rules. Second, the scores are weighted and case-mix adjusted. Lastly, the scores are calculated using the CAHPS® Analysis Program (CAHPS® Macro) and the full national QHP Enrollee Survey database. This program, along with instructions for using it, are available at no cost at *Instructions for Analyzing Data from CAHPS Surveys*. Please reference https://qhpcahps.cms.gov/ for additional information about the methodology behind the QHP Enrollee Survey QI reports.
QRS survey measures (e.g., via QRS preview)	CMS-calculated results for the QRS include survey measures derived from a subset of questions in the QHP Enrollee Survey. The results in the QHP Enrollee Survey QI reports differ from those reported for QRS survey measures as additional scoring specifications are used to calculate QRS survey measure results. QRS survey measure results are calculated via additional post-survey processing including case-mix adjustment, removal of invalid responses, and including appropriate respondents in the denominator totals.
Raw results provided by the QHP Enrollee Survey vendors upon data submission	The estimates provided by survey vendors are preliminary and are intended to provide QHP issuers with an early estimate of their survey scores. Survey vendors may not perform the same type of data cleaning performed by CMS. Additionally, survey vendors are unable to implement the identical case-mix adjustment that is performed by CMS because they do not have access to the full national dataset. A survey vendor may analyze the survey data in order to provide QHP issuers with aggregated results and may conduct additional analyses. These survey vendor analyses are not official survey results and should only be used for quality improvement purposes.

Detailed below is additional information regarding differences between QHP Enrollee Survey results communicated via the QHP Enrollee Survey QI reports and QRS results communicated via the QRS Proof Sheet.

QHP Enrollee Survey Composite versus QRS Survey Measure Construction: Historically, the CAHPS® program has used the term composite to refer to a summary measure that is derived from more than one question, such as Getting Needed Care and Getting Care Quickly. The QHP Enrollee Survey QI reports use the term composite in the same context as other CAHPS® surveys. However, for the QRS, a composite is a grouping of measures; it is the first level of summary results in the QRS hierarchy. For example, the Enrollee Experience with Health Plan composite in the QRS includes the scores for three QRS measures: Access to Information, Plan Administration, and the Rating of Health Plan.

The questions included in QRS survey *measures* may be different than the questions included in "*composites*" shown in the QHP Enrollee Survey QI reports. For example, in the 2016 QRS, the

Access to Care measure is composed of five questions, while the Access to Care "composite" as reported in the QHP Enrollee Survey QI reports is composed of four questions.

Denominator Size Calculation: There is a difference in how the denominator size is calculated and communicated in the QHP Enrollee Survey QI reports versus the QRS Proof Sheets. QHP Enrollee Survey QI reports include raw survey frequencies, meaning that the denominator size reported for measures are equal to the total number of eligible respondents who answered the question. For the QRS, CMS calculates survey measures from survey questions using specific QRS scoring specifications. For the QRS, the total denominator size for QRS survey measures reflects the total number of respondents who have a non-missing value for at least one of the questions within the measure.

For example, the QRS measure Care Coordination is identical to the QHP Enrollee Survey QI report composite Care Coordination. With 75 responses, the result for the Care Coordination composite would appear on the QI reports, but a Care Coordinate measure score would not appear in the QRS Proof Sheet as the score was not calculated due to an insufficient denominator size (<100). These differences stem from the different goals of the two products. The QRS is designed to generate results for public reporting and therefore has higher requirements associated with whether a measure can be reported, while the QHP Enrollee Survey QI reports are currently designed as a tool to be used for quality improvements undertaken by the QHP issuer.

Communicating Relative Performance: QRS measure data are standardized across all reporting units. Therefore, if a majority of eligible reporting units submit very high measure raw values, a single eligible reporting unit may submit a high raw value for a given measure, but may still receive a low standardized score for the measure because many other reporting units performed even better.

The QHP Enrollee Survey QI Reports use a different approach to convey relative performance. This approach is based on a pair-wise t-test with an alpha of 0.05. Additional information can be found in the CAHPS® Macro materials in *Instructions for Analyzing Data from CAHPS Surveys*.

Due to these different approaches, there are instances when an eligible reporting unit could score average or above average on QHP Enrollee Survey items in the QI Reports and receive one or two star ratings for certain QRS components.

Appendix G. Glossary and List of Acronyms

Exhibit 30 includes definitions for key terms used in this document. Exhibit 31 provides definitions for acronyms that appear in this 2017 Guidance.

Exhibit 30. Glossary

Term	Definition
Administrative data collection method	Method of data collection that obtains data from administrative sources (e.g., claims data) to help identify a measure's eligible population and numerator compliance.
Average	A single value obtained by adding several quantities together and then dividing this total by the number of quantities.
Benefit Not Offered (NB)	Data validation result assigned for a measure if the QHP issuer did not offer the health benefit required by the measure.
Biased Rate (BR)	Data validation result assigned for a measure if the QHP issuer's calculated rate was materially biased.
Component	The QRS hierarchy includes the following components, listed from the lowest to the highest level of the hierarchy: composites, domains, summary indicators, and global. These components represent levels of scores and ratings. Scores for a component are composed of averages of scores of components in the lower level of the hierarchy. Thus, the global score is an average of summary indicator scores, summary indicator scores are averages of associated domain scores, and domain scores are averages of associated composite scores.
Composite	A component of the QRS hierarchy. A score for this component is created by a combination of two or more measures. A composite may also consist of a QRS survey measure that is comprised of multiple survey questions (e.g., Access to Care measure forms the Access to Care composite). An exception to the definition relates to the Asthma Care composite. This composite currently consists of one measure; however, it is considered a composite for purposes of scoring higher level components.
Cut point	A numeric score value that serves as a threshold to delineate a category, or level of performance, for each component. These levels of performance produce the 5-star rating scale.
Data validation	A process by which an independent third party validates a QHP issuer's QRS measure data, including their data systems and processes. The data validator will verify completeness, accuracy, and comparability of the measure results. For 2016, CMS requires QHP issuers to contract with a HEDIS® Compliance Organization (National Committee for Quality Assurance [NCQA]-licensed). A HEDIS® Compliance Auditor, employed or contracted by that organization, will validate all QRS clinical measure results and the sampling frame for the QHP Enrollee Survey using the HEDIS Compliance Audit standards, policies, and procedures.
Data validator	An independent third party that validates the QRS clinical measure data and the sampling frame for the QHP Enrollee Survey prior to data submission. For 2016, QHP issuers must contract with a HEDIS® Compliance Auditor, who will serve as the data validator.
Domain	A component of the QRS hierarchy. A score for this component is created by combining scores from associated composites.
Exclusive Provider Organization (EPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO enrollees will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.
Federally-facilitated Exchange (FFE)	The Exchange model operated by HHS for individual and small group market coverage. For QHP issuers operating in the FFEs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov alongside other QHP information to inform consumers.

Term	Definition
FFEs where the States perform plan management functions	A type of FFE in which a State operates plan management functions, while the remaining Exchange functions are operated by HHS. For QHP issuers operating in States performing plan management functions in the FFEs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov.
Full-scale rule	A scoring rule that requires all component scores that form a higher level component score to be present in order for the component score to be calculated. For example, all summary indicator scores must be present in order to calculate the global score. This rule is intended for component scores to be comparable across reporting units.
Global	A component of the QRS hierarchy. A score or rating for this component is created by combining scores from summary indicators.
Half-scale rule	A scoring rule that requires at least half of the component scores that form a higher level component score to be present in order for the component score to be calculated. For example, at least half of the composite scores must be present in order to calculate the domain score. This rule is intended for component scores to be comparable across reporting units.
Health Insurance Exchange (Exchange)	A resource in each State where qualified individuals, families, and small businesses can learn about their health insurance options; compare QHPs based on quality, costs, benefits, and other important features; choose a QHP; and enroll in coverage. In some States, the Exchange is operated by the State. In others, it is operated by the Federal Government.
Health Maintenance Organization (HMO)	A type of health insurance product that usually limits coverage to care from providers who work for or contract with the HMO and generally will not cover out-of-network care except in an emergency. In this type of organization, enrollees must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.
HealthCare.gov	The consumer-facing website developed and operated by CMS/CCIIO that provides eligibility information, enrollment instructions, and QHP information for consumers looking to enroll in a health insurance plan through the FFEs. QRS ratings for QHP issuers operating in both the FFEs, States performing plan management functions, and State-based Exchanges on the Federal Platform (SBE-FPs) will be displayed on HealthCare.gov to support consumers as they search for and enroll in a QHP.
Healthcare Effectiveness Data and Information Set (HEDIS)® Compliance Audit™	The HEDIS Compliance Audit is a data validation process that consists of a standardized review of an organization's data management processes and algorithmic compliance with measure technical specifications. This process verifies the integrity of QRS measure data and allows for comparability across organizations. An overview of the HEDIS Compliance Audit, the list of NCQA-Certified HEDIS® Compliance Auditors, and a link to the *HEDIS Compliance Audit: Standards, Policies, and Procedures* that is available for purchase can be accessed at the following link: http://store.ncqa.org/index.php/performance-measurement.html
HEDIS® Compliance Auditor	An individual certified by NCQA to validate QRS clinical measure data and the QHP Enrollee Survey sampling frame using the standardized HEDIS Compliance Audit program.
Hybrid data collection method	Uses data obtained from both administrative and medical record/ electronic medical record sources to identify the eligible population and numerator compliance. The denominator consist of a systematic sample of enrollees drawn from the measure's eligible population. QHP issuers then: a) review administrative data to determine numerator compliance, and b) review medical record data for enrollees who do not meet numerator criteria based on administrative data, in order to identify additional numerator compliance for the measure. Details on the collection method are included in a measure's technical specifications (see *2016 Quality Rating System Measure Technical Specifications).*
Indicator	A rate that forms a measure. Some QRS measures have multiple indicators.
Interactive Data Submission System (IDSS)	The web-based system, owned and managed by the National Committee for Quality Assurance (NCQA), which QHP issuers will use to submit QRS clinical measure data.

Term	Definition
Measure	Rate variables that serve as the fundamental building blocks of the QRS hierarchy. Each measure is assigned to a composite and contributes to the scoring for the higher components of the hierarchy (i.e., domains, summary indicators, and global).
Measurement Year	The measurement year refers to the year reflected in the data. All measure data are retrospective. The exact period of time represented by the measure is dependent on the technical specifications of that measure.
Multi-State Plan (MSP)	A Multi-State Plan (MSP) is a private health insurance plan offered through the Exchanges under contract with the Office of Personnel Management (OPM). MSP options are recognized as QHPs, per 45 C.F.R. § 155.1010, and therefore are subject to the same federal quality reporting requirements. When describing requirements for "QHP issuers" within this document, it is assumed the same requirements apply to issuers offering MSP options, unless otherwise noted. OPM will provide any additional guidance to MSP issuers.
National Committee for Quality Assurance (NCQA)	The organization that developed and maintains the system through which QHP issuers will submit validated QRS clinical measure data to CMS, the Interactive Data Submission System (IDSS). NCQA is the measure steward for HEDIS® measures. NCQA also manages the HEDIS Compliance Audit program.
National Quality Forum (NQF)	NQF reviews, endorses, and recommends use of standardized healthcare performance measures. NQF issues an endorsement identification number (ID) for measures that they endorse. This ID is cited for QRS measures where applicable.
National Quality Strategy (NQS)	Mandated by the Patient Protection and Affordable Care Act, the National Quality Strategy (NQS) was first published in March 2011. The NQS established a set of three overarching aims that builds on the Institute for Healthcare Improvement's Triple Aim®, supported by six priorities that address the most common health concerns that Americans face.
Not Applicable (NA)	Data validation result assigned for a measure if the QHP issuer followed the specifications but the denominator was too small (i.e., less than 30) to report a valid rate. The QHP issuer did not have sufficient data to fulfill the continuous enrollment criteria for the measure.
Not Calculated (NC)	Invalid code assigned to measures with an insufficient denominator size.
No Global (NG)	Invalid code assigned to reporting units with insufficient data to calculate a global rating.
Not Reported (NR)	Data validation result assigned for a measure if the QHP issuer chose not to report the measure rate.
Office of Personnel Management (OPM)	OPM administers the Federal Employees Health Benefits (FEHB) Program. The Affordable Care Act directs OPM to contract with private health insurers in each State to offer high-quality, affordable health insurance options (Multi-State Plan options) through the Multi-state Plan (MSP) Program to drive competition and choice in the Exchanges.
Pharmacy Quality Alliance (PQA)	The measure steward for the Proportion of Days Covered (PDC) measure.
Point of Service (POS)	A type of health insurance product modeled after an HMO, but with an opt-out option. In this type of product, enrollees may choose to receive services either within the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner). The level of benefits or reimbursement is generally determined by whether the enrollee uses in-network or out-of-network services.
Preferred Provider Organization (PPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. PPO enrollees may use providers outside of this network, but out-of-network services are usually covered at a reduced rate (e.g., reduced reimbursement percentages, higher deductibles, higher co-payments).

Term	Definition
Product type	A discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type (for example, health maintenance organization [HMO], preferred provider organization [PPO], exclusive provider organization [EPO], point of service [POS]) within a service area. This term refers to a specific contract of covered benefits, rather than a specific level of cost-sharing imposed.
2016 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications	A document published on http://qhpcahps.cms.gov that includes detailed specifications and protocols for HHS-approved survey vendors to conduct the QHP Enrollee Survey.
QHP Enrollee Survey score	The average value for a measure from the QHP Enrollee Survey calculated for survey respondents in a given reporting unit. A survey score can be for a single assessment question or a combination of several questions on a similar topic that are combined to form a single measure.
QHP Enrollee Survey vendor	A HHS-approved survey vendor with which a QHP issuer contracts to administer the QHP Enrollee Survey to a sample of the QHP issuer's enrollees and that is authorized to submit the survey response data on the QHP issuer's behalf.
QRS clinical measures	QRS measures calculated using clinical data from a QHP issuer's administrative and medical record sources.
QRS hierarchy	The organization of the QRS measures into information categories ranging from the most granular information (measure scores) to a global rating.
QRS rating methodology	The rules for combining measures and converting scores into performance ratings for the QRS.
QRS survey measures	QRS measures calculated using enrollee responses to a subset of specified questions in the QHP Enrollee Survey. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to the CMS Health Insurance Marketplace℠ Quality Initiatives website (https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system).
Qualified Health Plan (QHP)	A health insurance plan that has in effect a certification that it meets the standards established by the Affordable Care Act and supporting regulation, issued or recognized by each Exchange through which such plan is offered.
Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)	A survey tool developed, as directed by the Affordable Care Act section 1311 (c)(4), that includes a comprehensive set of questions related to enrollee experience with their QHP offered through the Exchange. CMS will use enrollee response data for a specified subset of the questions to calculate the QRS survey measures.
Qualified Health Plan (QHP) issuer	A health insurance issuer that offers a QHP in accordance with a certification from an Exchange, as defined by 45 C.F.R. § 155.20. Each QHP issuer is defined by a separate federal Health Insurance Oversight (HIOS) Issuer ID. Each QHP issuer is defined by a State geographic unit.
2016 Quality Rating System Measure Technical Specifications	A document published on the CMS Health Insurance Marketplace℠ Quality Initiatives website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html) that includes detailed measure specifications and general guidelines for QRS measure data collection.
QHP quality rating information	Information that includes QRS scores and ratings, as well as QHP Enrollee Survey results.
Quality Rating System (QRS)	As directed by the Affordable Care Act section 1311 (c)(3), the Quality Rating System (QRS) is a system of rating QHPs offered through the Exchange based on quality and price. The QHP quality rating information will be provided to individuals and employers to inform their selection of a QHP and will provide a system for monitoring of QHP quality by regulators.

Term	Definition
QRS rating	Also referred to as "categorical rating" or "star rating." A value based on a score for QRS components (composites, domains, summary indicators, and global), which facilitates consumer understanding of QHP performance.
QRS score	A numerical value that indicates the level of QHP performance for QRS measures and hierarchy components (composites, domains, summary indicators, and global). For component scores, composite scores are averages of percentile ranks for a QHP; domain scores are averages of associated composite scores for a QHP; summary indicator scores are averages of associated domain scores for a QHP; and the global score is an average of summary indicator scores for a QHP.
Ratings Year	The ratings year refers to the year the data are collected (including fielding of the QHP Enrollee Survey), validated, submitted, and ratings are calculated.
Reference group	A population of reporting units that is defined based on specification of a geographical region and/or time period. A reporting unit's level of performance is its ranking among all reporting units within the defined group.
Reporting unit	The unit by which a QHP issuer groups their enrollees for purposes of QRS and QHP Enrollee Survey measure data collection and submission. The reporting unit for the QRS and QHP Enrollee Survey is defined by the unique State-product type for each QHP issuer.
Standardized score	A rank value ranging from 0 to 99 that indicates the percentage of reporting units scoring at and below the given raw measure score value. For a given measure, all values are ranked from lowest to highest with 99 representing the highest raw measure value among all reporting units nationally. Standardizing the measure scores allows for comparisons of a reporting unit relative to all other reporting units. Only QRS measure scores are standardized; component scores are not standardized.
State-based Exchange (SBE)	An Exchange model in which a State operates its own Health Insurance Exchange, for both the individual and small group markets. An SBE is responsible for certifying QHP issuers, overseeing QHP issuer compliance with federal Exchange quality standards as a condition of certification, and, starting with the individual market open enrollment period for 2018 (that begins November 1, 2017), displaying QHP quality rating information to help consumers compare QHPs.
State-based Exchange on the Federal Platform (SBE-FP)	An Exchange model in which a State operates its own Health Insurance Exchange, for both the individual and small group markets but relies on the federal platform to perform certain eligibility and enrollment functions. An SBE-FP is responsible for certifying issuers, overseeing issuer compliance with federal Exchange quality standards as a condition of certification. For QHP issuers operating in SBE-FPs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov.
Summary indicator	A component of the QRS hierarchy. A score for this component is created by combining scores from associated domains.
Summary-level measure data	The level of QRS clinical measure data that QHP issuers will submit to CMS for each eligible reporting unit. Summary-level data elements are specified for each QRS clinical measure in the *Quality Rating System Measure Technical Specifications*, and include elements such as eligible population (denominator), numerator, and the rate.
Survey sampling frame	The QHP issuer's eligible population source file that contains a list of the eligible enrollees for which the QHP Enrollee Survey can be administered. The data validator will validate the survey sampling frame, and the HHS-approved QHP Enrollee Survey vendor will generate an enrollee sample based on the validated sampling frame.
Weighted average	An average that is calculated in which some data points (values) contribute more than others to the final average.

Exhibit 31. List of Acronyms

Acronym	Definition
ACE	Angiotensin Converting Enzyme
AHRQ	Agency for Healthcare Research and Quality
AOD	Alcohol and Other Drug
API	Application Program Interface
ARB	Angiotensin Receptor Blockers
BMI	Body Mass Index
BR	Biased Rate
C&M	Continuation and Maintenance
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CCIIO	Consumer Information and Insurance Oversight
CSR-I	Insufficient data to calculate a score according to the QRS rating methodology.
CSR-NS	Component Score or Rating – Not Scored
CMS	Center for Medicare & Medicaid Services
EPO	Exclusive Provider Organization
FEHB	Federal Employees Health Benefits
FFE	Federally-facilitated Exchange
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	Department of Health & Human Services
HIOS-MQM	Health Insurance Oversight System-Marketplace Quality Module
HMO	Health Maintenance Organization
HOQ	Healthcare Organization Questionnaire
HPV	Human Papillomavirus
HTN	Diagnosis of Hypertension
IDSS	Interactive Data Submission System
IHS	Index Hospital Stays
MMR	Measles, Mumps and Rubella
MN-S	Measure – Not Scored
MQI	Marketplace Quality Initiatives
MSP	Multi-State Plan
NA	Not Applicable
NB	Benefit Not Offered
NC	Not Calculated
NCQA	National Committee For Quality Assurance
NG	No Global
NQF	National Quality Forum

Acronym	Definition
NQS	National Quality Strategy
NR	Not Reported
OB/GYN	Obstetrician/Gynecologist
OPM	Office of Personnel Management
PCP	Primary Care Physician
PCV	Pneumococcal Conjugate Vaccines
PDC	Proportion of Days Covered
POS	Point of Service
PPO	Preferred Provider Organization
PQA	Pharmacy Quality Alliance
QHP	Qualified Health Plan
QI	Quality Improvement
QIS	Quality Improvement Strategy
QRS	Quality Rating System
RAS	Renin Angiotensin System
REGTAP	Registration For Technical Assistance Portal
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
SERVIS	State Exchange Resource Virtual Information System
SHOP	Small Business Health Options Program
URI	Upper Respiratory Infection
VZV	Varicella Zoster Virus
XOSC	Exchange Operations Support Center