Health Insurance Exchange

Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019

October 2018

Document Change Log

Description	Date
Release of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019.* This guidance addresses requirements for 2019, which include data submission in the 2019 calendar year for quality rating information that will be publicly reported by the Exchanges, beginning during the open enrollment period for the 2020 plan year.	10/17/2018

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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 Marketplace Service Desk (MSD) 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 MSD (CMS_FEPS@cms.hhs.gov).
- **State-based Exchanges (SBEs):** Please submit questions to your respective State Officers.
- **Federally-facilitated Exchanges (FFEs):** Please submit questions via email to the MSD at 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 *2019 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, 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, the 2019 Quality Rating System Measure Technical Specifications, and the 2019 Qualified Health Plan Enrollee Experience Survey Technical Specifications.	http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

Website	Description	Link
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/CertifiedSurveyVendorsAuditors SoftwareVendors/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 (registration required)
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 Marketplace and Insurance Programs Group.	https://portal.cms.gov/ (registration required)

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

1. Document Purpose and Scope

This *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019* (2019 Guidance) document provides technical guidance regarding the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) for 2019. It specifies QRS and QHP Enrollee Survey requirements for QHP issuers offering coverage through the Health Insurance Exchanges (Exchanges) (also known as Health Insurance Marketplaces). 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]).

The 2019 Guidance communicates 2019 QRS requirements and includes QRS program refinements (including refinements to the QHP Enrollee Survey) described in the Final 2018 QRS Call Letter, published in June 2018,[2] as applicable.[3] Section 1.1 highlights all key updates between the 2018 and 2019 Guidance. CMS anticipates issuing guidance at least annually in the fall before the year of data submission.

The primary audience for the 2019 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 2019 Guidance addresses requirements for 2019, which include data submission in the 2019 calendar year for ratings for the 2020 plan year.

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.[4]

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 2018 Guidance[5] and 2019 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).

[2] The Final 2018 QRS Call Letter is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.
[3] This document does not reflect all proposed revisions to the Information Collection Request (ICR) for the QHP Enrollee Survey (CMS-10488) outlined in the *Federal Register* (FR) notices at https://www.gpo.gov/fdsys/pkg/FR-2016-07-12/pdf/2016-16445.pdf or at https://www.gpo.gov/fdsys/pkg/FR-2017-04-14/pdf/2017-07568.pdf.
[4] "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.).
[5] The term "2018 Guidance" refers to all CMS sub-regulatory guidance applicable to the 2018 ratings year, including Version 2.0 of the *QRS and QHP Enrollee Survey: Technical Guidance for 2018*; the updated date *Quality Rating Information Bulletin*; and other CMS guidance (e.g., frequently asked questions available on REGTAP).

- **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 QRS and QHP Enrollee Survey Requirements Between the 2018 Guidance and the 2019 Guidance

CMS did not modify the QRS and QHP Enrollee Survey participation criteria. However, CMS revised the structure of this section to improve readability and to provide additional resources to QHP issuers and other stakeholders (i.e., a graphic that depicts the process for determining QRS and QHP Enrollee Survey data submission eligibility and a checklist for identifying the enrollees to include in a reporting unit).

CMS added content regarding the survey sample frame (Section 6.2), and reporting of ineligible reporting units (Section 6.3). CMS added the following variables to the 2019 Sample Frame Layout:

- Enrollee Email Address
- Enrollee Phone 2
- Total Enrollment

Additionally, QHP issuers with ineligible reporting units must submit the reporting unit information to CMS. CMS will provide an ineligibility template and instructions in fall 2018 on the MQI website. QHP issuers must include complete information for each reporting unit that does not meet eligibility criteria by selecting from a menu of ineligibility reasons.

- **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 in the text boxes below reflect changes to the QRS rating methodology to align with technical specification changes by the applicable measure steward.

Key Differences in Methodology Between the 2018 Guidance and the 2019 Guidance

Measures Included in Scoring:

In the *Final 2018 Call Letter for the QRS and QHP Enrollee Survey (Final 2018 Call Letter)*, CMS announced the removal of two measures, *Comprehensive Diabetes Care: Hemoglobin A1c Testing* and *Cultural Competence*, from the QRS measure set beginning with the 2019 QRS ratings year. These measures will not be included in scoring and QHP issuers are not required to submit data for either measure as part of the 2019 QRS data submission.

Key Differences in Methodology
Between the 2018 Guidance and the 2019 Guidance

Measure Denominator Criteria:

For the 2018 QRS, CMS applied the minimum denominator size of 30 observations for QRS clinical measures (including the clinical measures captured in the QHP Enrollee Survey) and 100 for non-clinical QRS survey measures.

Beginning with the 2019 QRS, CMS will continue to apply the minimum denominator size of 30 observations to the QRS clinical measures with the exception of the *Plan All-Cause Readmission* (PCR) measure. For the 2019 scoring process, CMS will apply the denominator criterion of 150 observations to the PCR measure.

Please note, this denominator change will not impact data submission for the PCR measure. CMS finalized this revision to the PCR measure in the Final 2018 Call Letter to improve the reliability of the measure.

- **Section 8. Quality Rating Information and QHP Enrollee Survey 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.

Key Differences in Preview
Between the 2018 Guidance and the 2019 Guidance

QHP issuers are now able to preview their respective QRS and QHP Enrollee Survey results simultaneously during the annual preview period (anticipated August–September 2019). Both QRS and QHP Enrollee Survey results will be available for download via CMS' Health Insurance Oversight System-Marketplace Quality Module (HIOS-MQM). Specifically, QHP issuers will have access to the following resources:

- QRS Preview Reports
- QRS Proof Sheets
- QHP Enrollee Survey Quality Improvement (QI) Reports
- QHP Enrollee Survey QI Reports Methodology Guide
- National Quality Improvement Benchmark Report

- **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 2018 Guidance and 2019 Guidance

For the 2016, 2017, and 2018 ratings years, for Exchanges that used the HealthCare.gov website, CMS conducted a limited display pilot test in select States. SBEs whose consumers did not use HealthCare.gov could choose to display QHP quality rating information on their respective websites.

CMS intends to release subsequent guidance regarding display of 2019 quality rating information for the 2020 individual market open enrollment period. CMS anticipates publishing this guidance prior to the 2020 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.

2. Background

Section 1311(c)(3) of the Patient Protection and Affordable Care Act[6] 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.[7] As a condition of certification and participation in the Exchanges, CMS requires that QHP issuers submit QRS clinical measure data and QHP Enrollee Survey response data for their respective QHPs offered through an Exchange in accordance with CMS guidelines.[8] Exchanges are also required to display QHP quality rating information on their respective websites.[9] 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,

[6] 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).
[7] 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.
[8] 45 C.F.R. §§ 156.200(b)(5),(h); 156.1120; and 156.1125.
[9] 45 C.F.R. §§ 155.1400 and 155.1405.

- 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, as well as with the Meaningful Measures Initiative, aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess core quality of care issues that are most vital to advancing the agency's work to improve patient outcomes. [10] States have the flexibility to build upon the federal quality reporting standards for QHP issuers by setting additional standards 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.[11] 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 the 2019 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.[12] 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.

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).

[10] The Meaningful Measures Initiative, launched in 2017, is CMS' most recent initiative that identifies the highest priorities for quality measurement and improvement. It involves assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes. The initiative focuses on six quality priority areas: making care safer by reducing harm caused in the delivery of care, strengthening person and family engagement as partners in their care, promoting effective communication and coordination of care, promoting effective prevention and treatment of chronic disease, working with communities to promote best practices of healthy living, and making care affordable. For additional information, please visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html.

[11] 45 C.F.R. §§ 156.200(b)(5),(h); 156.1120; and 156.1125.

[12] 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.

4. Implementation Schedule for the QRS and QHP Enrollee Survey

Exhibit 1 highlights key events and dates associated with 2019 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 2019 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 3, 2018
QHP issuer contracts with an HHS-approved QHP Enrollee Survey vendor to conduct the QHP Enrollee Survey and submit survey response data to CMS.	**Deadline:** January 31, 2019
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, 2019
QHP issuer completes NCQA's Healthcare Organization Questionnaire (HOQ) to authorize a QHP Enrollee Survey vendor and to prepare for QRS clinical measure data and QHP Enrollee Survey response data submission.	**Deadline:** February 2019
QHP issuer and HEDIS® Compliance Auditor complete the HEDIS® Compliance Audit™.	January – June 2019[13]
HHS-approved QHP Enrollee Survey vendor conducts the QHP Enrollee Survey on the validated survey sampling frame.	February – May 2019
HHS-approved QHP Enrollee Survey vendor securely submits the QHP Enrollee Survey response data to CMS (on behalf of the QHP issuer).	**Deadline:** May 24, 2019
QHP issuer submits the validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS).[14] **Note:** Each QHP issuer must submit and plan-lock its QRS clinical measure data by June 3 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit-lock all submissions by the June 17 deadline.	**Deadline:** June 17, 2019
QHP issuers, Exchange administrators, and CMS preview the 2019 QHP quality rating information.	August/September 2019
Public display QHP quality rating information.	**Deadline:** Individual market open enrollment period for 2020[15]

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

[13] Please see the general guidelines in the *2019 Quality Rating System Measure Technical Specifications* for a more detailed timeline for the HEDIS® Compliance Audit.
[14] There are no fees for QHP issuers associated with accessing and using the IDSS.
[15] 45 C.F.R. § 155.410(e)(2).

is oversight of QHP issuer compliance with QRS and QHP Enrollee Survey requirements.[16] Thus, CMS (on behalf of the FFEs) and the SBEs[17] 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.[18]

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. The SBE can use additional State quality information 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 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 operating 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

[16] 45 C.F.R. § 155.200(d).
[17] SBEs, unless otherwise noted, include State-based Exchanges on the Federal Platform (SBE-FP) States (i.e., SBE States whose consumers use HealthCare.gov).
[18] 45 C.F.R. §§ 155.1010(a)(2) and 155.200(d).

State.[19] 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 Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point of Service (POS), and Preferred Provider Organization (PPO). 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[20] through an Exchange in the prior year (i.e., 2018 calendar year);
- Offered through an Exchange in the ratings year (i.e., 2019 calendar year); and
- Meets the QRS minimum enrollment requirements[21, 22]:
  - Included more than 500 enrollees as of July 1 in the prior year (i.e., July 1, 2018), and
  - Included more than 500 enrollees as of January 1 of the ratings year (i.e., January 1, 2019).

Reporting units discontinued before June 15 of the ratings year (i.e., June 15, 2019) 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.

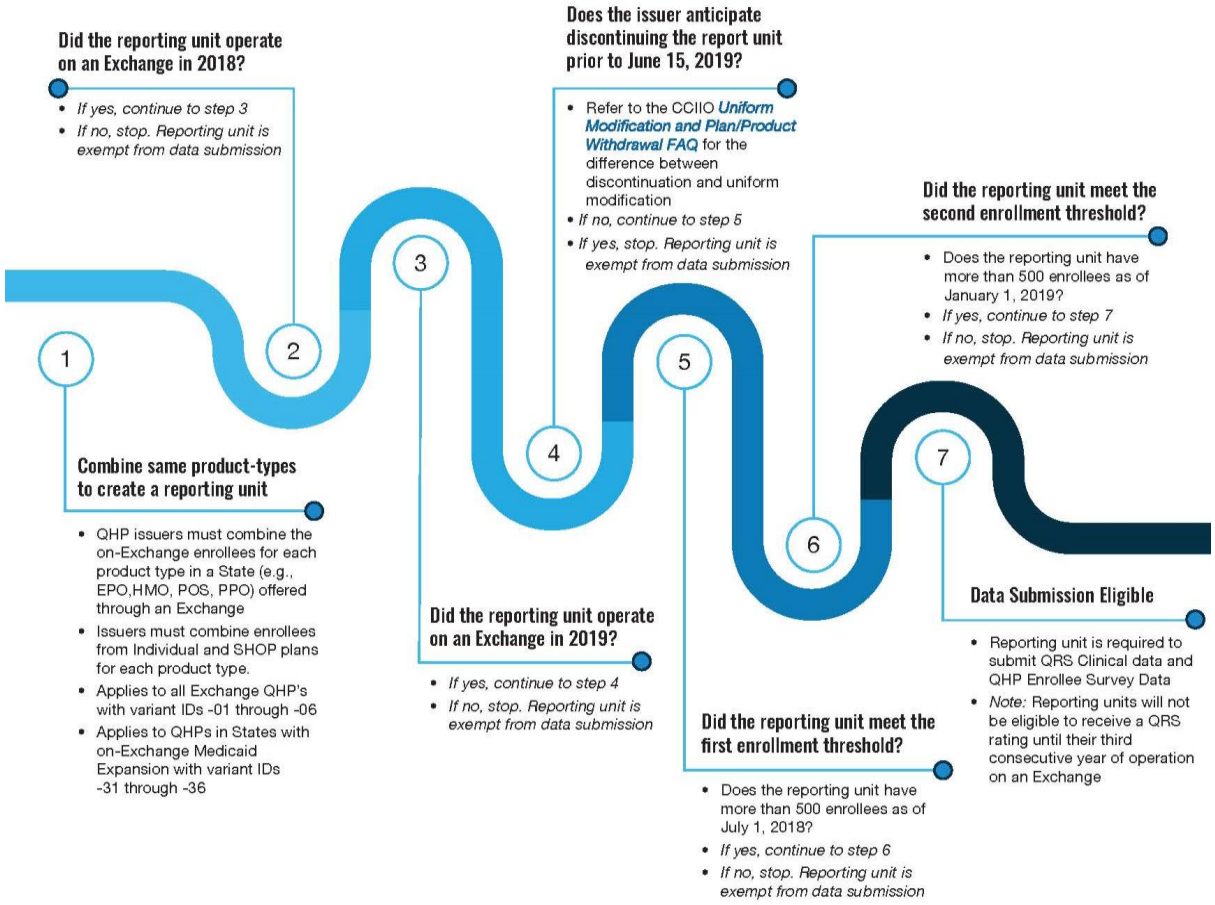
Please note, CMS will *not* accept voluntary data submissions for reporting units that do not meet participation criteria as defined above.

Exhibit 2 visually represents the process for creating a reporting unit and determining QRS and QHP Enrollee Survey data submission eligibility.

The process includes the following steps: (1) combine same product types to create a reporting unit (as defined above); (2) determine whether the reporting unit operated on an Exchange in 2018; (3) determine whether the reporting unit will operate on an Exchange in 2019; (4) confirm the reporting unit will not discontinue before June 15, 2019; (5) determine whether the reporting unit met the first enrollment threshold (i.e., had more than 500 enrollees as of July 1, 2018); (6) determine whether the reporting unit met the second enrollment threshold (i.e., had more than 500 enrollees as of January 1, 2019); and (7) if the criteria in steps 1-6 are met, submit QRS clinical measure data and QHP Enrollee Survey response data.

[19] 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.
[20] For purposes of QRS participation, the term "offered" includes all reporting units that are operational through an Exchange (i.e., reporting units that are available for purchase through an Exchange [SHOP or individual market], accepting new members or groups, or have active or existing members) during the applicable year.
[21] 45 C.F.R. §§ 156.1120(a) and 156.1125(b).
[22] 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.

Exhibit 2. QRS and QHP Enrollee Survey Data Submission Eligibility Roadmap



Definitions and Examples

- **Operational:** The QHPs in the reporting unit are available for purchase on an Exchange (SHOP or individual market), accepting new members or groups and/or have active or existing members during the applicable year.
- **Not Operational:** The QHPs in the reporting unit are not sold on an Exchange (SHOP or individual market), are not accepting new members or groups, and do not have active or existing members (i.e., zero members) during the applicable year.
- **Discontinued:** The QHPs in the reporting unit will not be offered (i.e., not offering to new members and/or not available for purchase during the upcoming open enrollment period) through an Exchange and will not be operational during the applicable year.
  - Example: The QHPs in the reporting unit will not be sold through an Exchange and have zero active members in the ratings year prior to June 15, 2019.
  - Please review the *Uniform Modification and Plan/Product Withdrawal FAQ* for additional information on discontinuation and uniform modification.

When determining which enrollees to include in each reporting unit, QHP issuers should follow the checklist in Exhibit 3.

Exhibit 3. QRS and QHP Enrollee Survey Enrollee Inclusions and Exclusions

Creating a Reporting Unit *Applies to QHP Enrollee Survey and QRS Clinical Measures*	√
Include the Following Enrollees:	
Enrollees in QHPs offered through an Exchange (HIOS variant IDs -01 through -06, ***and*** -31 through -36 for States with Medicaid 1115 waivers where the Medicaid expansion population is eligible to enroll in Exchange plans) in the prior year (i.e., 2018 calendar year).	
Enrollees in QHPs offered through an Exchange that provide family and/or adult medical coverage.	
Enrollees from MSP products offered through an Exchange if the QHP issuer offers both a QHP and an MSP option of the same product type in the same State (i.e., ***combine*** enrollees from both MSP products and QHP products)	
Enrollees from both the individual market and Small Business Health Options Program (SHOP) if the on-Exchange QHP issuer offers the same product type in the individual market as well as the SHOP within a State (i.e., ***combine*** SHOP and individual and family plans if they are the same product type offered in the same State). *Example:* • Issuer XYZ has 500 SHOP HMO enrollees in Rhode Island and 200 individual and family plan HMO enrollees. • Issuer XYZ pulls the reporting unit sample frame on January 15, 2019 containing 700 enrollees from SHOP and individual and family HMOs.	
Combine enrollees from multiple products of the same product type in a single State into one reporting unit. *Example:* • Issuer XYZ has three HMO plans in a particular State. • Issuer XYZ combines enrollees from the three HMO plans for that State into a single reporting unit.	
Combine enrollees from the same product type with multiple plan levels (e.g., bronze, expanded bronze, silver, gold, platinum, catastrophic) into one reporting unit. *Example:* • Issuer XYZ has silver and gold HMOs in a particular State, • Issuer XYZ combines the silver and gold HMOs for that State into a single reporting unit.	
Exclude the Following Enrollees:	
Enrollees in plans offered outside the Exchange (HIOS variant ID-00) and non-QHPs.	
Enrollees in child-only health plans or stand-alone dental plans.	
Confirm Minimum Enrollment Criteria:	
The QHPs in the reporting unit are offered through an Exchange in the ratings year (i.e., 2019 calendar year).	
There were more than 500 enrollees in the reporting unit as of July 1 in the prior year (i.e., July 2018).	
There were more than 500 enrollees in the reporting unit as of January 1 of the ratings year (i.e., January 2019).	
Enrollees in QHPs offered through an Exchange that may be aligned to a different 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 (i.e., 2019 calendar year) should be included. In cases of such mergers or acquisitions, the gaining QHP issuer should include enrollees previously aligned to the ceding QHP issuer.	

Example:

A fictional QHP issuer is certified to offer family medical coverage in two States: West Virginia (WV) and Maryland (MD). Exhibit 4 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 units: 12345-WV-PPO, 12345-MD-EPO. The other reporting units either did not have a sufficient number of enrollees as of July 1, 2018; did not have a sufficient number of enrollees as of January 1, 2019; or were discontinued before June 15, 2019.

Exhibit 4. Example Reporting Units for a QHP Issuer Assessed Against 2019 QRS and QHP Enrollee Survey Participation Criteria

Reporting Unit	Enrollment as of July 1, 2018 (total and per individual market vs. SHOP	Enrollment as of January 1, 2019 (total and per individual market vs. SHOP)	Offered as of June 15, 2019	Meet participation criteria? (i.e., required to submit QRS and QHP Enrollee Survey measure data)?
12345-WV-PPO	505 (505 individual, 0 SHOP)	505 (505 individual, 0 SHOP)	Yes	Yes
12345-WV-HMO	601 (501 individual, 100 SHOP)	N/A	No – discontinued as of December 31, 2018	No – not operating in ratings year
12345-MD-PPO	100 (55 individual, 45 SHOP)	100 (55 individual, 45 SHOP)	Yes	No – insufficient enrollment size in both years
12345-MD-HMO	700 (700 individual, 0 SHOP)	300 (300 individual, 0 SHOP)	Yes	No – insufficient enrollment size as of January 1, 2019
12345-MD-EPO	505 (300 individual, 205 SHOP)	501 (300 individual, 201 SHOP)	Yes	Yes
12345-WV-EPO	500 (300 individual, 200 SHOP)	500 (300 individual, 200 SHOP)	Yes	No – insufficient enrollment size in both years

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 Marketplace Service Desk (MSD). Details on addressing membership changes in measure data collection are provided in the "General Guidelines for Data Collection" section of the *2019 Quality Rating System Measure Technical Specifications* under "Membership Changes."

6.2 QHP Enrollee Survey Sample Frame

This section provides detailed instructions to QHP issuers eligible to field the QHP Enrollee Survey for determining which enrollees to include in each reporting unit's sample frame and to vendors for drawing the QHP Enrollee Survey sample from each sample frame.

New Sample Frame Variables
The following variables were added to the 2019 Sample Frame Layout: **Enrollee Email Address** **Enrollee Phone 2** **Total Enrollment** The Enrollee Email Address and Enrollee Phone 2 variables will support vendors with survey outreach. The Total Enrollment Field is also included in the QHP Enrollee Survey Data File.

6.2.1 Create the Sample Frame (QHP Issuers)

QHP issuers must populate a complete, accurate, and valid sample frame of all survey-eligible enrollees for each reporting unit required to field the survey. The sample frame includes one record or line for each survey eligible enrollee (i.e., one enrollee record per line). ***All sample frames must include current enrollees as of 11:59 p.m. on January 7, 2019 (the anchor date), Sample frames may not be pulled before this date; sample frames pulled on or after January 8, 2019 must include all enrollees as of the anchor date – NOT the date the sample frame was pulled.*** QHP issuers must draw all sample frames in a time frame that supports validation by a HEDIS® Compliance Auditor and submission to the vendor completed no later than January 31, 2019.

Note: Survey eligible enrollees must meet the criteria in Exhibit 5. *Survey eligible enrollees will be part of the total enrollment in an eligible reporting unit, however, not all enrollees in an eligible reporting unit will be survey eligible enrollees.*

6.2.1.1 Inclusion and Exclusion Criteria

Exhibit 5 provides an overview for QHP issuers to determine which enrollees to include in each reporting unit's sample frame. Enrollees are considered continuously enrolled if they are enrolled in the eligible QHP from July 1 through December 31, 2018 with no more than one 31-day break in enrollment. Enrollees are considered currently enrolled if they are enrolled in the eligible QHP at the end of the continuous enrollment period (i.e., December 31, 2018) and on January 7, 2019.

To ensure all enrollees meet the continuous and current enrollment criteria, QHP issuers may ***not*** generate sample frames earlier than 11:59 pm, January 7, 2019. CMS will ***not*** accept submissions for reporting units that do not follow the specified guidelines for determining which enrollees should be included in the sample frame. QHP issuers must use a consistent approach when determining the eligible population and reporting for the QHP Enrollee Survey, the QRS clinical measures, and for each product offering.

Exhibit 5. Enrollee Eligibility Requirements for the 2018 QHP Enrollee Survey (Survey Eligible Enrollees)

Enrollee Eligibility Status	Eligibility Criteria	✓
Eligible if all the listed criteria are met.	**Include in Sample Frame:**	
	Enrollee is in a QHP offered through the Exchange (HIOS variant IDs -01 through -06 or -31 through -36 for states with Medicaid 1115 waivers allowing access to Exchange plans).	
	Enrollee is in a QHP offered through the Exchange that provides family and/or adult medical coverage.	
	Enrollee is 18 years of age or older as of December 31, 2018.	
	Enrollee meets continuous enrollment criteria.	
	Enrollee is still enrolled on January 15, 2019 (i.e., meets current enrollment criteria).	
	Enrollees who have requested to not be contacted (i.e., a "do not call" list). *NOTE: Vendors will exclude from fielding these enrollees using their internal do not call list; however, these enrollees remain eligible for sampling.*	
Ineligible if any of the listed criteria apply.	**Exclude from the Sample Frame:**	
	Enrollee is in a QHP offered outside the Exchange (HIOS variant ID-00) or a non-QHP.	
	Enrollee is in a QHP offered through the Exchange that provides child-only health plans or stand-alone dental plans.	
	Enrollee is younger than 18 years of age as of December 31, 2018.	
	Enrollee does not meet continuous enrollment criteria.	
	Enrollee discontinued enrollment for the plan year 2019 prior to 11:59 p.m. on January 7, 2019. *NOTE: QHP issuers are not permitted to generate a separate list of disenrollees. All exclusions of disenrollees must occur prior to submitting the sample frame for the HEDIS® Compliance Audit.*	
	Enrollee is deceased as of January 7, 2019.	

6.2.1.2 Sample Frame Data Format

The standardized sample frame layout is an ASCII fixed-width text file with defined fixed-column positions for each data element. Appendix H provides the data elements that should be included for each enrollee in the sample frame. Data elements must adhere to the value label characteristics described in Appendix H and are to be placed in the designated columns (i.e., specified field positions) without delimiters. Field contents must be left aligned, and data must start in the first position of each field. QHP issuers must fully populate all sample frame variables. When portions of required enrollee data are missing, QHP issuers must denote these data elements with the valid value for *Missing* provided in Appendix H. QHP issuers may not

append any additional data fields to the sample frame that are not specified in the sample frame file layout.

6.2.2 Validate Sample Frame

For 2019, CMS requires that QHP issuers use a HEDIS® Compliance Auditor (auditor) and follow the HEDIS® Compliance Audit standards to validate the QHP Enrollee Survey sample frame and the QRS clinical measure data. Each QHP issuer is responsible for selecting a HEDIS® Compliance Organization, determining fees, and entering into a data validation contract (if necessary). This process is designed to give QHP issuers the maximum opportunity to have valid and publicly reportable results. 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.

Exhibit 6 provides an overview of the sample frame validation process.

Exhibit 6. Sample Frame Validation Process

Step	Description	✓
Step 1	In the NCQA HOQ, the QHP issuer enters information for each QHP Enrollee Survey reporting unit it is required to report. This is the number of sample frames the QHP issuer must produce. **Note:** *This is also the number of reporting units for which the QHP issuer must authorize an HHS-approved QHP Enrollee Survey vendor and verify required reporting unit information (e.g., enrollment, year plan began operating, three-year operational status) within the HOQ.*	
Step 2	The QHP issuer generates the sample frame data file(s) per specifications.	
Step 3	The QHP issuer delivers the sample frame data file(s) to the NCQA HEDIS® Compliance Auditor (auditor).	
Step 4	The auditor validates the sample frame data file(s) and notifies the QHP issuer of the results. If the auditor determines the quality or completeness of the sampling frame poses a threat to the desired survey response rate, the QHP issuer makes corrections to the sample frame until the desired audit result is achieved.	
Step 5	The auditor enters the result of the sample frame validation in the HOQ.	
Step 6	The QHP issuer forwards the sample frame data file(s) and documentation of the validation results to the QHP Enrollee Survey vendor.	
Step 7	The vendor draws the survey sample and administers the QHP Enrollee Survey per specifications.	

6.2.3 Provide Sample Frame to Vendor

Once a QHP issuer has received a validated sample frame from the auditor, the issuer must provide it directly to the issuer's contracted vendor in a secure manner. Vendors assess the completeness of the contact information (e.g., mailing address, telephone number) included in the sample frame for each eligible enrollee. Vendors must notify CMS (qhpsurveyvendor@bah.com) of any QHP issuer clients that have not provided a validated sample frame by the deadline established by CMS (see Exhibit 1).

6.3 Reporting Ineligible Reporting Units

QHP issuers with ineligible reporting units must submit the reporting unit information to CMS. CMS will provide an ineligibility template and instructions in fall 2018 on the MQI website. QHP issuers must include complete information for each reporting unit that does not meet eligibility criteria by selecting from a menu of ineligibility reasons.

6.4 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 7. The QRS measure set consists of measures that address the areas of: clinical quality management; enrollee experience; and plan efficiency, affordability, and management. The QRS measures align with the six quality priority areas that are focal to the Meaningful Measure Initiative: (1) making care safer by reducing harm caused in the delivery of care, (2) strengthening person and family engagement as partners in their care, (3) promoting effective communication and coordination of care, (4) promoting effective prevention and treatment of chronic disease, (5) working with communities to promote best practices of healthy living, and (6) making care affordable.

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 the *Childhood Immunization Status [Combination 3]* measure, 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®)[23] surveys. Note that the QRS survey measures (except for the two clinical measures captured in the QHP Enrollee Survey) and the QRS clinical measure *Plan All-Cause Readmissions* are case-mix adjusted. See Section 6.5 for details on the QHP Enrollee Survey.

Exhibit 7. QRS Measure Set

Measure Title	National Quality Forum (NQF) ID[24]	QRS Measure Type
Access to Care	Not Endorsed[25]	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	Not Endorsed	Clinical
Antidepressant Medication Management	0105	Clinical

[23] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The CAHPS® surveys are available at https://cahps.ahrq.gov.
[24] Definitions of NQF-endorsed measures can be found here: http://www.qualityforum.org/Home.aspx.
[25] 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[24]	QRS Measure Type
Appropriate Testing for Children with Pharyngitis	Not Endorsed	Clinical
Appropriate Treatment for Children with Upper Respiratory Infection	0069	Clinical
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: Medical Attention for Nephropathy	0062	Clinical
Controlling High Blood Pressure	0018	Clinical
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)	Not Endorsed	Clinical
Plan Administration	Not Endorsed	Survey
Plan All-Cause Readmissions	1768	Clinical
Prenatal and Postpartum Care	Not Endorsed	Clinical
Proportion of Days Covered	0541	Clinical
Rating of All Health Care	0006	Survey
Rating of Health Plan	0006	Survey
Rating of Personal Doctor	0006	Survey
Rating of Specialist	0006	Survey
Use of Imaging Studies for Low Back Pain	Not Endorsed	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 *2019 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.

6.5 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 QHP Enrollee Survey assesses enrollee experience with a QHP offered through an Exchange on the topics presented in Exhibit 8. 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.

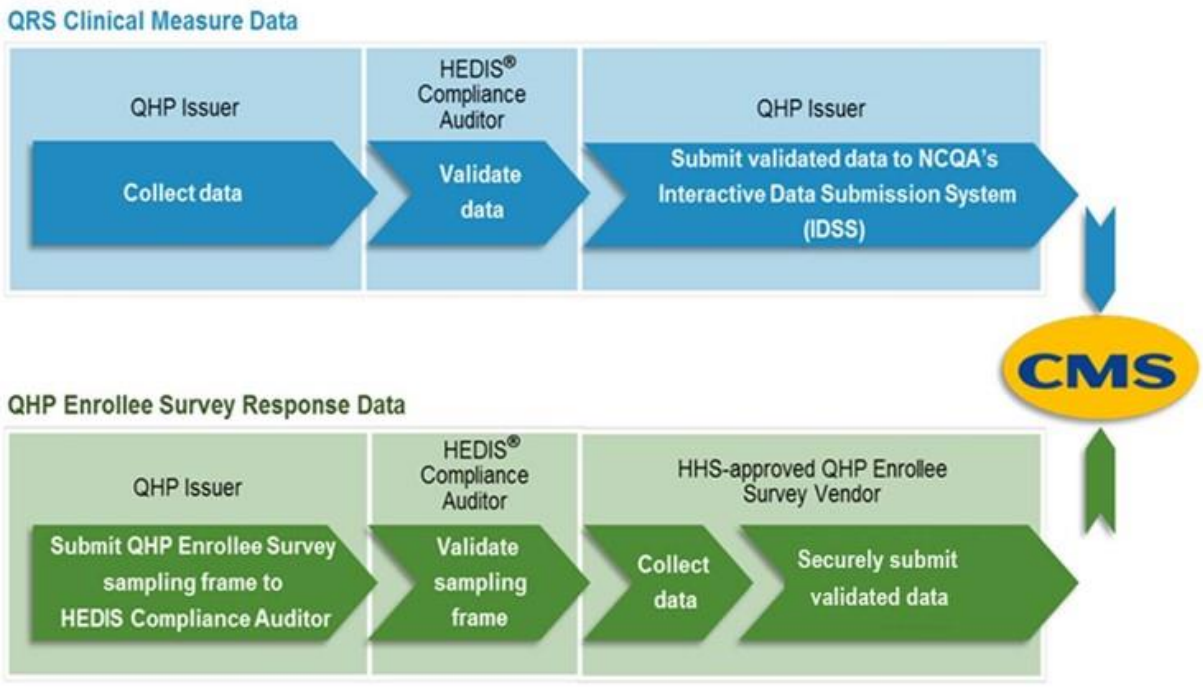
Exhibit 8. QHP Enrollee Survey Topics

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

6.6 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 9 illustrates the process and stakeholders with primary responsibility for the associated steps. The steps are detailed in subsequent sections.

Exhibit 9. QRS Clinical Measure and QHP Enrollee Survey Response Data Process Flow



6.6.1 Data Collection

The next sections summarize details related to the data collection protocols for QRS clinical measure data and QHP Enrollee Survey response data. For additional data collection instructions for the QRS clinical measures, including the required data elements, refer to the *2019 Quality Rating System Measure Technical Specifications*. For additional data collection procedures related to the QHP Enrollee Survey, refer to the *2019 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications.*

6.6.1.1 QRS Clinical Measure Data Collection

QHP issuers will collect data for QRS clinical measures using administrative sources or 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 *2019 Quality Rating System Measure Technical Specifications* to determine which data collection method is appropriate for each clinical measure. If more than one method is allowed, the QHP issuer may choose its preferred method.

6.6.1.2 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.[26] These vendors will collect enrollee responses to the survey questions on behalf of the QHP issuer.[27]

Each QHP issuer must formally authorize its chosen survey vendor to collect and submit QHP Enrollee Survey response data to CMS on its behalf.[28] In fall 2018, QHP issuers will receive instructions on the survey vendor authorization process. Issuers are not required to contract with the same vendor from the previous survey administration year so long as the contracted survey vendor is on the list of approved survey vendors for the current survey administration year.

Issuers are required to authorize a survey vendor for eligible reporting units beginning in January 2019, via NCQA's HOQ. QHP issuers must confirm that all eligible reporting units are included in the HOQ and verify required reporting unit information (e.g., general information, enrollment year plan began operating, three-year operational status). For reporting units not eligible for the 2019 reporting year, QHP issuers will receive instructions via email to provide justification for non-reporting units. A list of HHS-approved survey vendors is available on the MQI website; survey vendors are conditionally approved until the completion of training in the fall of each year. QHP issuers should contact the QHP Enrollee Survey technical assistance help desk (MQITier2HelpDesk@bah.com) with questions.

6.6.2 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.[29] For 2019, 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.[30] The sections below contain details related to these data validation requirements.

6.6.2.1 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

[26] 45 C.F.R. § 156.1125(a).
[27] 45 C.F.R. § 156.1105.
[28] 45 C.F.R. § 156.1125(a).
[29] 45 C.F.R. §§ 156.1120(a)(2) and 156.1125(b)(2).
[30] 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.

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.

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.

6.6.2.2 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 *2019 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.

6.6.2.3 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 [or 150 for the PCR measure]) 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 the *Breast Cancer Screening* measure, which

requires multi-year continuous enrollment as outlined in the *2019 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.

6.6.2.3.1 Compliance Reviews

CMS may conduct targeted compliance reviews under 45 C.F.R. § 156.715 to examine 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) by QHP issuers participating in an FFE. 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.[31]

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.

6.6.3 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.

6.6.3.1 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, the IDSS will create a QRS-specific submission ID for the issuer.

NCQA will open the annual HOQ completion process in early January 2019 and close access in February 2019. 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.

[31] 45 C.F.R. § 156.800.

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 17, 2019. QHP issuers should submit questions regarding the IDSS to the NCQA portal.

6.6.3.2 QHP Enrollee Survey Data Submission

On behalf of the QHP issuer, the HHS-approved QHP Enrollee Survey vendor will securely submit de-identified enrollee response data to CMS.

QHP Enrollee Survey vendors must submit the QHP Enrollee Survey response data by 11:59 p.m. ET, May 24, 2019.

7. QRS Rating Methodology

This section describes how CMS will calculate 2019 QRS quality ratings based on the QRS clinical measure and QHP Enrollee Survey response data submitted in 2019. CMS made refinements to the rating methodology to incorporate applicable changes based on stakeholder feedback, which were finalized in the Final 2018 QRS Call Letter.

Appendix D provides the final 2019 QRS rating methodology.

7.1 Measures and Scoring

For 2019, QHP issuers are required to collect and submit validated data for 38 measures in the QRS measure set. Beginning in 2019, CMS removed the *Cultural Competence* and the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing* measures from the QRS measure set. CMS will include all 38 measures in scoring in 2019.

Exhibit 10 offers a comparative summary of the QRS measures and scoring approach for the 2018 and 2019 ratings years.

Exhibit 10. QRS Measures and Scoring[32]

QRS Measures	2018	2019 (current year)
Number of measures required for QRS data submission	40	38*
Number of measures to be used for QRS scoring	40	38

* 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).

[32] 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 41 measures in total (rather than 38). 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

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 11, to receive QRS scores and ratings in 2019, a reporting unit must be in operation in 2017, 2018, and 2019.

Exhibit 11. Reporting Unit Data Submission and Scoring Example

Criteria	Required to submit data?	Eligible to be scored?
Reporting unit operates in ratings year only (2019)	No, does not meet the QRS participation criteria	No
Reporting unit operates in ratings year and prior year (2019 and 2018) and meets the QRS participation criteria (as defined in Section 6.1)	Yes	No
Reporting unit operates for at least three consecutive years (2019, 2018, and 2017) 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

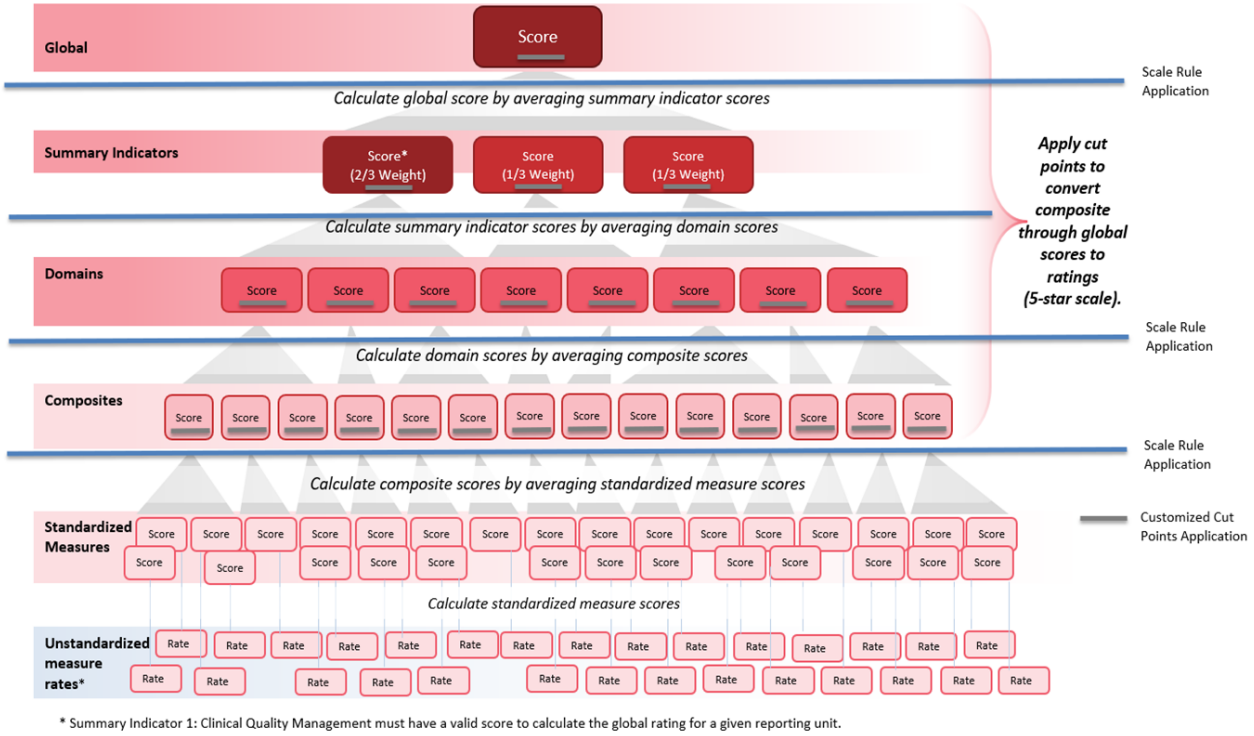
The QRS measures are organized into a hierarchical structure that serves as a foundation of the QRS rating methodology (Appendix D). The measures are grouped into hierarchy components (composites, domains, and summary indicators) to form a single global rating.

7.3 Overview of Process for Calculating QRS Scores and Ratings

Exhibit 12 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 weighted summary indicator scores (e.g., a weight of two-thirds (66.67%) to the Clinical Quality Management summary indicator, and a weight of one sixth (16.67%) to the Enrollee Experience and the Plan Efficiency, Affordability, & Management summary indicators), summary indicator scores will be averages of associated domain scores, and domain scores will be averages of associated composite scores.

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*.

Exhibit 12. Overview of QRS Rating Methodology



* Summary Indicator 1: Clinical Quality Management must have a valid score to calculate the global rating for a given reporting unit.

Exhibit 13 further describes the process for calculating 2019 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.

Exhibit 13. Steps for Calculating QRS Scores and Ratings

Step	Sub-steps
Step 1. Calculate measure rates	▪ For QRS clinical measures with multiple indicators, calculate the measure rate according to the method defined by the measure's technical specifications. ▪ For QRS survey measures, calculate the measure rate from QHP Enrollee Survey question data.
Step 2: Determine if measure denominator size is sufficient for scoring	▪ Measures that do not meet the minimum denominator size requirement for scoring are excluded from QRS scoring. The minimum denominator size is 30 observations for QRS clinical measures (including the clinical measures captured in the QHP Enrollee Survey), except for the PCR measure, which has the minimum denominator criteria of 150 observations. The minimum denominator size is 100 for non-clinical QRS survey measures.
Step 3. Calculate standardized measure scores	▪ Independently transform all raw measure rates using z-standardization. Compare the measure rate values of each reporting unit to the mean measure rate using a national reference group (i.e., across all reporting units), and control the spread using the standard deviation.
Step 4. Calculate composite scores	▪ *Determine if the score can be calculated.* Apply the half-scale rule, meaning the composite score can be calculated only if at least half (>= 50%) of the associated measures have a score. ▪ *Calculate the score.* Average the standardized measure scores if the half-scale rule is met. Otherwise, no score is calculated.

Step	Sub-steps
Step 5. Calculate domain scores	▪ *Determine if the score can be calculated.* Apply the half-scale rule, meaning the domain score can be calculated only if at least half (>= 50%) of the associated composites have a score. ▪ *Calculate the score.* If the half-scale rule is met, average the composite scores. Otherwise, no score is calculated.
Step 6. Calculate summary indicator scores	▪ *Determine if the score can be calculated.* Apply the half-scale rule, meaning the summary indicator score can be calculated only if at least half (>= 50%) of the associated domains have a score. ▪ *Calculate the preliminary score.* If the half-scale rule is met, average the domain scores. Otherwise, no score is calculated.
Step 7. Apply explicit weights to summary indicator scores	▪ *Calculate the final score.* Multiply the summary indicator scores calculated in Step 6 by the appropriate explicit weights (e.g., Clinical Quality Management score x 0.6667 = weighted Clinical Quality Management score).
Step 8. Calculate global score	▪ *Determine if the score can be calculated*. The global score can be calculated only if the Clinical Quality Management summary indicator received a score and at least one of the other two summary indicators received a score. ▪ *Calculate the score*. If above scoring rule is met, sum the weighted summary indicator scores (e.g., a weight of 2/3 (66.67%) to the Clinical Quality Management summary indicator, and a weight of 1/6 (16.67%) to the Enrollee Experience and the Plan Efficiency, Affordability, & Management summary indicators). Otherwise, no score is calculated.
Step 9. Convert scores to ratings	▪ *Identify cut point values for each QRS hierarchy component using cluster analysis and a jackknife procedure (at the global level only).* CMS uses submitted QRS measure data to identify four cut point values (to delineate five-star rating categories). ▪ *Convert scores to ratings*. Convert each composite, domain, summary indicator, and global score into a rating using respective cut points.
Step 10. Produce QRS results for preview and finalization	▪ Prepare Ratings Output File (ROF). ▪ Prepare QRS preview reports and proof sheets for QRS preview period.

8. Quality Rating Information and QHP Enrollee Survey Results and Preview

QHP issuers and State Exchange administrators will receive QHP quality rating information and QHP Enrollee Survey results and will be able to preview these results via the CMS Health Insurance Oversight System-Marketplace Quality Module (HIOS-MQM)[33] website during the annual preview period (anticipated August-September 2019). 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 website prior to the start of preview.

8.1 QRS and QHP Enrollee Survey Preview via CMS' HIOS-MQM

During the QRS and QHP Enrollee Survey preview period, QHP issuers in all Exchanges will be able to preview their respective QRS and QHP Enrollee Survey results via CMS' HIOS-MQM website and submit any related inquiries to CMS. Exhibit 14 provides descriptions of the documents available for preview on the HIOS-MQM website. The QRS Preview Reports, QRS Proof Sheets, QHP Enrollee Survey Quality Improvement (QI) reports, QHP Enrollee Survey QI

[33] Users must register for access to HIOS and the MQM via https://portal.cms.gov/.

Reports Methodology Guide, and National Quality Improvement Benchmark Report for the applicable ratings year will be available for preview on CMS' HIOS-MQM website concurrently.

Exhibit 14. QRS and QHP Enrollee Survey 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. • Mean and standard deviation information for raw measure rates.
QRS Proof Sheet User Guide	A PDF file 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.
QHP Enrollee Survey Quality Improvement Reports (QI Reports)	These reports communicate the results of the full 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.
QHP Enrollee Survey QI Reports Methodology Guide	A PDF file that describes the contents of the QHP Enrollee Survey QI Reports and includes details regarding the survey process and timeline and the methods for analyzing the survey data.
National Quality Improvement Benchmark Report	The National Quality Improvement Benchmark Report provides national-level statistics for the QHP Enrollee Survey scoring questions, screener questions, about-the-enrollee questions, and survey disposition. QHP issuers can use this report to compare the performance of their respective reporting units to the performance of all reporting units that participated in the QHP Enrollee Survey for the given year.

8.1.1 Instructions for Accessing QRS and QHP Enrollee Survey Results

Access to the HIOS-MQM is required to view QRS and QHP Enrollee Survey results during the preview period. For QHP issuers seeking to access results for their reporting units during the 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 and Survey Results** webpage and reports will populate for the user's corresponding QHPs. To access the QRS Preview Report, QRS Proof Sheet, and Quality Improvement (QI) Report, click the appropriate **Download** link at the bottom of the page.

Exchange administrators who need to access the results for all reporting units operating in their respective States can do so by following these instructions:

1) Log in to the HIOS-MQM website.
   - Users new to HIOS need to contact the appropriate authorizing official: CMS (via the Marketplace Service Desk) or the cognizant State Access Administrator (SAA) to initiate a role request.
2) Navigate to the **Preview Ratings and Survey Results** webpage and reports will populate for the user's corresponding QHPs. To access the QRS Preview Report, QRS Proof Sheet, and Quality Improvement (QI) Report click the appropriate **Download** link at the bottom of the page.
3) Navigate to the **Download State Ratings and Survey Results** webpage and download the State-level compiled QHP Enrollee Survey QI Report by selecting the **Download** link in the State Level QI Report column.

   In September of the ratings year, download the State-level compiled QRS quality ratings data file by selecting the **Download** link in the State Rating File column.

8.2 Additional Ratings Preview by SBEs

An SBE may choose to conduct an additional ratings preview period 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 QI reports 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.

9. Display Guidelines for QHP Quality Rating Information

CMS intends to release subsequent guidance regarding display of 2019 quality rating information for the 2020 individual market open enrollment period. Subsequent guidance will specify the

Exchanges where display of QHP quality rating information is required, the form and manner for display of the 2019 ratings, and details for what to display in cases where a QHP did not receive a rating. CMS anticipates publishing this guidance prior to the 2020 individual market open enrollment period.

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 release subsequent guidance specifying the form and manner in which CMS will display 2019 QHP quality rating information at HealthCare.gov. For example, on HealthCare.gov, CMS anticipates referring to the QRS global rating as the "Overall Quality Rating," the Clinical Quality Management summary indicator as "Medical Care," the "Enrollee Experience" summary indicator as "Member Experience," and the "Plan Efficiency, Affordability, & Management" summary indicator as "Plan Administration."

9.2 Display Guidance for SBEs

CMS intends to release subsequent guidance regarding display of 2019 QHP quality rating information for SBEs that do *not* rely on the federal eligibility and enrollment platform (i.e., SBEs whose consumers do not use HealthCare.gov). SBEs that display the QHP quality ratings information, whether directly on the SBE website or a static website, 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 2019. The ratings will be displayed for health plans for the 2020 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 SBE's site.]*

9.3 Display Guidance for Direct Enrollment Entities

CMS intends to release subsequent display guidance for QHP issuer and web-broker Direct Enrollment (DE) entities that facilitate enrollment through Exchanges.

QHP issuer and web-broker DE entities that display 2019 QHP quality rating information on their websites during 2020 open enrollment period should 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 2019. The ratings will be displayed for health plans for the 2020 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.]*

10. Marketing Guidelines for QHP Quality Rating Information

QHP issuers in Exchanges that display QHP quality rating information during the 2020 individual market open enrollment period may reference the 2019 QRS quality ratings and QHP

Enrollee Survey results for their QHPs in marketing materials in a manner specified by CMS.[34] Any QHP issuer that elects to include its 2019 QHP quality rating information—specifically, its 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.[35]

The 2019 marketing guidelines are generally based on CMS guidance related to marketing QHPs as communicated in the annual *Letter to Issuers in the Federally-facilitated Exchanges*.[36] 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 marketing materials referencing QRS or QHP Enrollee Survey information. All disclaimers must be clear and conspicuous. Disclaimers are not required on call scripts, banners and banner-like ads, envelopes, outdoor advertising (e.g., billboards), text messages, and social Media.
  - 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-*

[34] 45 C.F.R. §§ 156.1120(c) and 156.1125(c).
[35] 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.
[36] See Chapter 5 in the *Final 2019 Letter to Issuers in the Federally-facilitated Exchanges*, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf and Chapter 5, Section 5, "Oversight of Marketing Activities," in the *Addendum to the Final 2018 Letter to Issuers in the Federally-facilitated Marketplaces*, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.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).

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,[37] and QHP issuers must discontinue marketing based on the previous year's information. CMS 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

[37] 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.

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 may 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.[38]

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.[39]

As noted in the 2019 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.[40] 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.

[38] See 45 C.F.R. § 156.225.
[39] 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).
[40] 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 15 through Exhibit 18Exhibit 18 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 15. 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)
	(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 16. 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 Patient Protection and 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 Patient Protection and Affordable Care Act; (v) Quality ratings assigned in accordance with section 1311(c)(3) of the Patient Protection and Affordable Care Act.	45 C.F.R. § 155.205(b)(1)(iv),(v) Consumer assistance tools and programs of an Exchange

Exhibit 17. 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; (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;	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
	(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 18. 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
QHP certification standards: public reporting of QHP quality rating information[41]	(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 Patient Protection and Affordable Care Act consistent with the standards of section 1311(g) of the Patient Protection and 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 Patient Protection and Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Patient Protection and 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

[41] 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
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
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.	45 C.F.R. § 156.1125 (a)–(e) Enrollee satisfaction survey system

Topic	Provisions	Citation
	(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.	

Appendix B. QRS Measure Summaries

Exhibit 19 includes measure summaries for the final 2019 QRS measure set, organized alphabetically. For detailed QRS clinical measure specifications, refer to the *2019 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), please see Appendix C.

Exhibit 19. QRS Measure Summaries

Measure Name:	**Access to Care**
Measure Steward:	Agency for Healthcare Research and Quality (AHRQ), CMS
NQF Endorsement ID:	Not Endorsed[42]
Description:	Enrollee experience related to the following: • Got care for illness/injury as soon as needed • Got non-urgent appointment as soon as needed • 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 body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.
Data Source(s):	Administrative and Hybrid

[42] 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:	Not Endorsed
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)[43]
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 were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 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

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

Measure Name:	Appropriate Testing for Children with Pharyngitis
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
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

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.
Data Source(s):	Administrative Data

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.
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/human papillomavirus (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: 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:** Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.
Data Source(s):	Hybrid Method must be used

Measure Name:	Follow-Up Care for Children Prescribed ADHD Medication
Measure Steward:	NCQA
NQF Endorsement ID:	0108
Description:	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (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 have completed the human papillomavirus (HPV) vaccine series 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, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. • *Engagement of AOD Treatment*. The percentage of members who initiated treatment and who had two or more additional AOD services or MAT within 34 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 following 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:	Not Endorsed
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. The following 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). • Expected Readmission Rate.
Data Source(s):	Administrative Data

Measure Name:	Prenatal and Postpartum Care
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
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:	Use of Imaging Studies for Low Back Pain
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
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.
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 members 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. - Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value. • 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 members 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 2019 QHP Enrollee Survey Questions Included in the QRS

Exhibit 20. Crosswalk of 2019 QHP Enrollee Survey Questions Included in the QRS

This crosswalk maps each QRS survey measure to the relevant QHP Enrollee Survey item(s).

2019 QRS Survey Measure	2019 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Access to Care	Getting Care Quickly	20	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
		21	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	23	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	CAHPS® Health Plan 5.0
		39	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
Access to Information	Access to Information[44]	3	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®)
		4	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®)
		5	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	31	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
		32	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
		33	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
		41	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

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

2019 QRS Survey Measure	2019 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Care Coordination (continued)	Care Coordination (continued)	34	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
		36	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	24	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
		11	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
		12	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	6	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
		7	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)	8	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
		9	In the last 6 months, how often were the forms from your health plan easy to fill out?	CAHPS® Health Plan 5.0
		10	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	25	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	19	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
Rating of Personal Doctor	Single Item Measure	38	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

2019 QRS Survey Measure	2019 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Rating of Specialist	Single Item Measure	42	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)	45	Have you had either a flu shot or flu spray in the nose since July 1, 2017?	CAHPS® 5.0H[45] Survey
Medical Assistance with Smoking and Tobacco Use Cessation	Single Item Measure (Preventive Services)	47	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
		48	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
		49	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

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

Appendix D. Final 2019 QRS Rating Methodology

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 appear in the Denominator Size field). A measure rate is considered invalid if the reporting unit received one of the audit designations provided in Exhibit 21.

Exhibit 21. 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 (Calculate Standardized Measure Scores) or beyond. Invalid measure data is assigned an invalid code, **NC (Not Calculated)**, for the measure score (i.e., shown in the Standardized score field).

Measures not used in scoring: 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 field). Note that all measures are used in scoring in 2019, therefore this code will not appear in the 2019 Proof Sheets. 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, 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 22 for a summary of each method; further detail can be found in the *2019 Quality Rating System Measure Technical Specifications*.

Exhibit 22. Aggregation Methods for QRS Clinical Measures with Multiple Indicators

Measure (M)	Measure Indicator (MI) Asterisk (*) indicates sub-measure indicator (b-sub-MI)[46]	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)	$\frac{\sum Numerator}{\sum Denominator}$ [47]	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 (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

[46] Below sub-measure indicators (b-sub-MI) are rates for a single age-band across several assessment areas; they are aggregated together to calculate the sub-MI rate estimate for a single assessment area.
[47] 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.

Measure (M)	Measure Indicator (MI) Asterisk (*) indicates sub-measure indicator (b-sub-MI)[46]	Method for Calculating Measure Rate	Method for Calculating Total Measure Denominator Size
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence	• Initiation of Alcohol and Other Drug Dependence Treatment (Total) – Initiation (13-17)*[48] ▪ Alcohol Abuse or Dependence ▪ Opioid Abuse or Dependence ▪ Other Drug Abuse or Dependence – Initiation (18+)* ▪ Alcohol Abuse or Dependence ▪ Opioid Abuse or Dependence ▪ Other Drug Abuse or Dependence • Engagement of Alcohol and Other Drug Dependence Treatment (Total) – Engagement (13-17) * ▪ Alcohol Abuse or Dependence ▪ Opioid Abuse or Dependence ▪ Other Drug Abuse or Dependence – Engagement (18+)* ▪ Alcohol Abuse or Dependence ▪ Opioid Abuse or Dependence ▪ Other Drug Abuse or Dependence	Three Steps: 1. Sub-MI = Count of unique enrollees per age band across treatments (b-sub-MIs) 2. $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 3. Average of MI rates	Three Steps: 1. Sub-MI = Count of unique enrollees per age band across treatments (b-sub-MIs) 2. $\sum Denominator_{sub-MI}$ 3. 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
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. $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 2. Average of MI rates	Two Steps: 1. $\sum Denominator_{sub-MI}$ 2. Average of MI denominators

[48] 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 (b-sub-MI)[46]	Method for Calculating Measure Rate	Method for Calculating Total Measure Denominator Size
Medical Assistance with Smoking and Tobacco Use Cessation[49]	• 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. $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 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.

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

(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.[50]

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

[49] 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., 2017) and the ratings year (i.e., 2018). 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 2018, CMS will use the reporting unit's reported data for 2017 and 2018 to calculate the Tobacco measure score.

[50] 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/).

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 2019 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.

Rating of Health Plan

Question 19 in the 2019 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 19.
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 25 in the 2019 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 38 in the 2019 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 42 in the 2019 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 four questions, all of which are coded on a 1 – 4 scale in the 2019 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 20: In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
   - Question 21: 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 23: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
   - Question 39: 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 four 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.

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 2019 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 32 and 33 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 20 and 21 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 31: 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 32: 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 33: 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 41: 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 34: In the last 6 months, how often did you and your personal doctor talk about all the prescriptions you were taking?
   - Question 37: 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 31, 41, 26, and 37, and the average of Questions 32 and 33 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 2019 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 3: 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 4: 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 5: 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 2019 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 6: In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
   - Question 7: In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
   - Question 8: 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 8 consistent with the other questions, Question 8 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 9: In the last 6 months, how often were the forms from your health plan easy to fill out?
   - Question 10: 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

Scoring specifications for the clinical measures collected through the 2019 QHP Enrollee Survey follow the HEDIS® specifications as defined by NCQA., CMS applies the QRS clinical measure denominator criterion of 30 to all clinical measures captured in the QHP Enrollee survey. The scoring procedures are described below. These specifications are also presented in the *2019 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, 2019).
   - 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 (discuss_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).

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., 2018] and the ratings year [i.e., 2019]).

Reporting units that do not meet the ratings eligibility criteria are removed from scoring and will receive an invalid code. Similarly, while QHP issuers submit measure data to CMS regardless of denominator size, measures that do not meet the minimum denominator criteria for scoring) are excluded from QRS scoring.

Exhibit 23. Minimum Denominator Size Required for Inclusion in QRS Scoring

Measure	Minimum Denominator Criteria for Inclusion in QRS Scoring
QRS Clinical Measure	30
PCR measure	150
QRS Clinical Measures Captured in QHP Enrollee Survey	30
QRS CAHPS®-based 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 2019 QHP Enrollee Survey), with the exception of the PCR measure.

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 24.

As shown in the illustrative example in Exhibit 22, the measure *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* has three indicators. For this example reporting unit, the measure's denominator size of 995 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 24. Example Denominator Size for QRS Clinical Measure Indicators

Name	Denominator Size
BMI percentile documentation (Indicator)	1641
Counseling for nutrition (Indicator)	17
Counseling for physical activity (Indicator)	1327
***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (Measure)**	**995**

CAHPS®-based 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 25 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 four questions. As shown, there can be valid denominator observations for each of the four 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), meaning that 161 unique respondents answered across the four questions needed to calculate *Access to Care*, 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 four survey questions to obtain the Access to Care measure score.

Exhibit 25. Example of Total Denominator Size Calculation for CAHPS®-Based 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 9: 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 31: In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	90
Measure	***Access to Care***		**161**

STEP 3: CALCULATE STANDARDIZED MEASURE SCORES

CMS calculates standardized measure scores by independently transforming the raw measure rate using Z-standardization and comparing measure rate values of each reporting unit to the mean measure rate based on one national, all-product reference group (i.e., not stratified by any characteristics, such as product type or Exchange). The scores reflect how well a reporting unit did compared to the other reporting units in a given measure. CMS uses a Z-score approach to transform all raw measure rates, independently, by calculating each measure's respective mean and standard deviation. The Z-score approach compares a reporting unit's measure rate values to the mean measure rate and standardized deviation of all available reporting units at a national level. After Z-scoring, the standardized values are converted to a 0 to 100 scale, using a normal curve equivalent (NCE).[51] All values under 0 or over 100 are truncated to 0 or 100, respectively.[52] Reporting units with tied measure rates will receive the same standardized score without impacting the preceding or proceeding reporting units' scores.[53] CMS excludes reporting units that do not meet the minimum denominator criterion from standardization.

For example, as shown in Exhibit 26, CMS uses the valid rates for the Cervical Cancer Screening measure across all reporting units to calculate the mean and standard deviation, across all products (i.e., EPO, HMO, POS, and PPO) and all Exchanges. If a QHP issuer's HMO product has a measure rate (raw value) equal to the mean of the measure, the product's Z-score equals zero. From here, the Z-score is convert to a 0-100 scale using the NCE, and converted to a standardized score of 50.

[51] The NCE is a standardization method used to rescale values onto a 0-100 scale. While similar to a percentile-rank, the NCE differs by preserving the distance between values, such that differences between z-scores reflect real differences in the underlying data. The closer the underlying data follows a normal distribution, the closer the transformed z-scores mimic the percentiles of the normal distribution at 1, 50, and 99. The property fails the further the underlying data is from normal.

[52] This is an artifact from the conversion using NCE.

[53] Prior to the 2018 ratings year, CMS used the PROC RANK standardization approach. Under the PROC RANK approach reporting units with tied measure rates were assigned the value of the average rank.

Exhibit 26. Example Score after Z-score Standardization

Measure Name	Raw Value	Standardized Score
Annual Monitoring for Patients on Persistent Medications	0.82	50.0000

Summary Statistics for *Cervical Cancer Screening* (CCS): $\hat{\mu}_{CCS} = 0.82, \hat{\sigma}_{CCS} = 2.15$

$$Z - Score = \frac{(0.82 - 0.82)}{2.15} = 0$$

Converted value using NCE: $50 + 21.063 * Z - Score$

Reporting Unit Standardized Score for CCS: $50 + 21.063 * (0) = 50$

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

Exhibit 27. 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]) defined in **Appendix G**.
Chlamydia Screening in Women	Measure	99.5169
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])

Measure	Type of QRS Component	Score
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%).

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 28.

Exhibit 28. 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 29Exhibit 29.

Exhibit 29. 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: APPLY EXPLICIT WEIGHTS TO SUMMARY INDICATOR SCORES

CMS applies explicit weights at the summary indicator level when calculating QRS scores and ratings. CMS assigns a weight of 2/3 (66.67%) to the Clinical Quality Management summary indicator, and a weight of 1/6 (16.67%) to the Enrollee Experience and the Plan Efficiency, Affordability, & Management summary indicators. This weighting structure reflects the approximate percentage of measures in each summary indicator. Exhibit 30 includes an example of the application of the explicit weights to the summary indicator scores using mock data.

Exhibit 30. Application of the Explicit Weights to the Summary Indicator Score

Name	Type of QRS Component	Unweighted Score	Weight	Weighted Summary Indicator Score
Clinical Quality Management	Summary Indicator	84.8161	* .6667	**56.5469**
Enrollee Experience	Summary Indicator	59.9472	*.16665	**9.9932**
Plan Efficiency, Affordability, and Management	Summary Indicator	57.8032	* .16665	**9.6358**

STEP 8: CALCULATE GLOBAL SCORE

CMS calculates the global score based on sum of summary indicator scores. The steps for reporting units with three summary indicator scores 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 sums the available weighted summary indicator scores. An example using mock data is shown in Exhibit 31.

Exhibit 31. Example Global Score Calculation

Name	Type of QRS Component	Example Weighted Summary Indicator Score
Clinical Quality Management	Summary Indicator	56.5384
Enrollee Experience	Summary Indicator	9.9932
Plan Efficiency, Affordability, and Management	Summary Indicator	9.6358
Global	**Global**	**76.1674 (Sum of available summary indicator scores)**

For reporting units with two summary indicator scores (i.e., Clinical Quality Management and either Enrollee Experience or Plan Efficiency, Affordability, and Management), CMS applies an

80% weight to the Clinical Quality Management summary indicator score and a 20% weight to the other scored summary indicator[54]. CMS then sums the weighted scores to calculate the global score.

STEP 9: CONVERT SCORES TO RATINGS

CMS converts scores to ratings by following these steps:

1. **Identify cut point values.** After calculating scores for composites through the global result, CMS uses cluster analysis of scores in combination with the jackknifing procedure (for the global scores only), 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. 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. CMS then conducts a jackknife procedure to calculate QRS cut points using sub-samples of data with one observation removed at a time (i.e., 1st data set has the 1st observation removed, 2nd data set has the 2nd observation removed). CMS conducts the cluster and analysis for each component of the hierarchy from composites through the summary indicator scores (i.e., 26 independent clustering runs). At the global level, CMS conducts the cluster analysis in combination with a jackknife procedure. 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 in the preview reports and proof sheets 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.

[54] In scenarios where a reporting unit has only two valid summary indicator scores, CMS calculates the summary indicator weights by redistributing the weight assigned to the missing summary indicator (i.e., .1667). Because the total weight of the two available summary indicators does not equal 100 (i.e., ~66.67% + ~ 16.67% = 83.34%), CMS scales up the two valid summary indicators proportional to 83.34%. Thus, the calculation of summary indicator weights in these scenarios is as follows: S1 weight = 0.6667/0.8334 = 0.8000; Other SI weight = 0.1667/0.8334 = 0.2000.

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 32 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 32. 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 10: PRODUCE QRS RESULTS FOR PREVIEW AND FINALIZATION

The last step in applying the QRS rating methodology is production of the Ratings Output File (ROF) (for internal CMS use). 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., the Center for Consumer Information and Insurance Oversight [CCIIO], State-based Exchange [SBE] administrators, FFE State contacts, the Office of Personnel Management [OPM]). Please note, CMS does not publish the ROF. Within the HIOS-MQM, States are only granted access to ratings information for QHP issuers operating within their State, and QHP issuers may only access ratings information for their respective reporting units.

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.[55]

Exhibit 33 illustrates the 2019 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 (*).

Exhibit 33. 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: Medical Attention for Nephropathy	0062
			Proportion of Days Covered (Diabetes All Class)	0541
	Patient Safety	Patient Safety	Annual Monitoring for Patients on Persistent Medications	Not Endorsed
			Plan All-Cause Readmissions	1768

[55] 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 43 measures that are collected and used in scoring (rather than 40). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care 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
Clinical Quality Management (continued)	Prevention	Checking for Cancer	Breast Cancer Screening	2372
			Cervical Cancer Screening	0032
			Colorectal Cancer Screening	0034
		Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	Not Endorsed
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	Not Endorsed
		Staying Healthy Adult	Adult BMI Assessment	Not Endorsed
			Chlamydia Screening in Women	0033
			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 and Care Coordination	Access and Care Coordination	Access to Care*	Not Endorsed
			Care Coordination*	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	Not Endorsed
			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	Not Endorsed
	Plan Service	Enrollee Experience with Health Plan	Access to Information*	Not Endorsed
			Plan Administration*	Not Endorsed
			Rating of Health Plan*	0006

Appendix F. Overview of QHP Enrollee Survey Results

Exhibit 34 provides an overview of different resources through which QHP Enrollee Survey results are communicated to QHP issuers.

Exhibit 34. QHP Issuer Resources for Reviewing QHP Enrollee Survey Results

Resource	Description
QHP Enrollee Survey Quality Improvement Reports (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 during the QRS preview period. Note that some response categories may be missing due to CMS' policies regarding minimum cell sizes. CMS' standard practice is to not publicly 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*. The QI Reports, available via the MQM, contain 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.
QHP Enrollee Survey QI Reports Methodology Guide	A PDF file that describes the contents of the QHP Enrollee Survey QI Reports and includes details regarding the survey process and timeline and the methods for analyzing the survey data.
National QI Benchmark Report	The National Quality Improvement Benchmark Report provides national-level statistics for the QHP Enrollee Survey scoring questions, screener questions, about-the-enrollee questions, and survey disposition. QHP issuers can use this report to compare the performance of their respective reporting units to the performance of all reporting units that participated in the QHP Enrollee Survey for the given year.
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 construct that is derived from more than one survey question. The QHP Enrollee Survey QI Reports use the term composite in the same context as other CAHPS® surveys (e.g., Getting Needed Care and Getting Care Quickly). However, for the QRS, the term composite refers to 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, the *Access to Care measure* is composed of four questions, while in the QHP Enrollee Survey QI Reports these four questions make up two separate composites: Getting Care Quickly and Getting Needed Care.

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 Coordination* 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 1-star or 2-star ratings for certain QRS components.

Appendix G. Glossary and List of Acronyms

Exhibit 35 includes definitions for key terms used in this document. Exhibit 36 provides definitions for acronyms that appear in this 2019 Guidance.

Exhibit 35. 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 2019, 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 2019, QHP issuers must contract with a HEDIS® Compliance Auditor, who will serve as the data validator.
Discontinued	The QHPs in the reporting unit will not be offered (i.e., not offering to new members and/or not available for purchase during the upcoming open enrollment period) through an Exchange and will not be operational.
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.

Term	Definition
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 will display QHP quality rating information on HealthCare.gov alongside other QHP information to inform consumers.
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 service 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 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 the National Committee for Quality Assurance (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 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, in order to identify additional numerator compliance for the measure. Details on the collection method are included in a measure's technical specifications (see *Quality Rating System Measure Technical Specifications).*
Indicator	A rate that forms a measure. Some QRS measures have multiple indicators.

Term	Definition
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.
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)	An 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)	NCQA 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 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.
Not Operational	The QHPs in the reporting unit are not sold on an Exchange (SHOP or individual), are not accepting new members or groups, and do not have active or existing members (i.e., zero members).
Office of Personnel Management (OPM)	OPM administers the Multi-State Plan (MSP) Program. The Patient Protection and 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 MSP Program to drive competition and choice in the Exchanges.
Operational	The QHPs in the reporting unit are available for purchase on an Exchange (SHOP or individual), accepting new members or groups, and/or have active or existing members.
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.

Term	Definition
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).
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.
2019 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications	A document published on the MQI website 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 Appendix C of this Guidance.
Qualified Health Plan (QHP)	A health insurance plan that has in effect a certification that it meets the standards established by the Patient Protection and 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 Patient Protection and 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.
2019 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.

Term	Definition
Quality Rating System (QRS)	As directed by the Patient Protection and Affordable Care Act section 1311 (c)(3), the 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.
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 2019, 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 36. 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
DE	Direct Enrollment
EPO	Exclusive Provider Organization
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
MSD	Marketplace Service Desk
MSP	Multi-State Plan
NA	Not Applicable
NB	Benefit Not Offered
NC	Not Calculated
NCQA	National Committee for Quality Assurance
NG	No Global

Acronym	Definition
NQF	National Quality Forum
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

Appendix H. Sampling Frame Layout for 2019 QHP Enrollee Survey

New Sample Frame Variables
The following variables were added to the 2019 Sample Frame Layout: Enrollee Email Address Enrollee Phone 2 Total Enrollment The Enrollee Email Address and Enrollee Phone 2 variables will support vendors with survey outreach. The Total Enrollment Field is also included in the QHP Enrollee Survey Data File.

An individual sample frame must be generated for each reporting unit required to administer the 2019 QHP Enrollee Survey (i.e., multiple reporting units cannot be combined into a single file) and must include a single record for each enrollee that meets the eligibility requirements outlined in the *2019 QHP Enrollee Survey Technical Specifications*. The sample frame must be specific to a given reporting unit (unique state-product type for each QHP issuer) and must ***not*** be combined with other product lines or products. The following data elements must be included for each enrollee included in the sample frame. QHP issuers must attempt to populate the sample frame file layout to the extent possible; missing data should be the exception. All entries must be left justified. The sample frame includes PII, therefore all vendors and QHP issuers must safeguard sample frame data in accordance with HIPAA, other applicable privacy laws, and the security requirements outlined in the *2019 QHP Enrollee Survey Technical Specifications*.

Exhibit 37. 2019 QHP Enrollee Survey Sampling Frame Data Elements

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values
QHP Issuer Legal Name	Char	60	1	60	Legal name of the issuer of the QHP in which the individual is enrolled, specific to the state in which the QHP is operating.	**NOTE: This variable MUST be identical for all enrollees included in the sample frame and MUST not be blank.** **NOTE: Do NOT use acronyms or abbreviations. Do NOT include extra spaces or parenthesis.** **NOTE: This variable is used in the QI Reports. Please confirm the responses are spelled correctly.**
Product Line	Num	1	61	61		3 = Exchange **NOTE: A valid value is required for every enrollee in the record. Only "3" is valid for Exchange.**

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values
Product Type	Num	1	62	62	Name of the product type under which the enrollee's QHP falls.	1 = Health Maintenance Organization (HMO) 2 = Point of Service (POS) 3 = Preferred Provider Organization (PPO) 4 = Exclusive Provider Organization (EPO) **NOTE: A valid value is required for every enrollee in the record. QHP issuers may NOT combine product types. This variable MUST be identical for all enrollees included in the sample frame.** **NOTE: This variable MUST match the reported 3-character product type in the Reporting Unit ID variable.**
Subscriber ID	Char	25	63	87	Subscriber or family ID number, which is the common ID for the subscriber and all dependents. Each issuer can decide the format used for this ID.	
Enrollee Unique ID	Char	25	88	112	Unique enrollee ID. This ID differentiates between individuals when family members share the Subscriber ID. Each issuer can decide the format used for this ID, given it uniquely identifies the enrollee and can be linked back to the issuer's records.	
Enrollee First Name	Char	25	113	137	Enrollee first name	
Enrollee Middle Initial	Char	1	138	138	Enrollee middle initial	
Enrollee Last Name	Char	25	139	163	Enrollee last name	
Enrollee Gender	Num	1	164	164		1 = Male 2 = Female 9 = Missing/Not Available **NOTE: A valid value is required for every enrollee in the record.**
Enrollee Date of Birth	Num	8	165	172		MMDDYYYY
Enrollee Mailing Address 1	Char	50	173	222	Street address or post office box	

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values
Enrollee Mailing Address 2	Char	50	223	272	Mailing address, 2nd line (if needed)	
Enrollee City	Char	30	273	302		
Enrollee State	Char	2	303	304	2-character Postal Service state abbreviation	
Enrollee Zip Code	Num	5	305	309	5-digit number	
Enrollee Phone 1	Num	10	310	319	3-digit area code plus 7-digit phone number; No separators or delimiters	
Flu Flag	Num	1	320	320	Flu Vaccinations for Adults Ages 18-64 Eligibility Flag coded based on enrollee's age as of July 1, 2018.	1 = Eligible (the member was born on or between July 2, 1953, and July 1, 2000) 2 = Ineligible (the member was born before July 2, 1953, or after July 1, 2000) **NOTE: A valid value is required for every enrollee in the record.**
Enrollee Age	Num	2	321	322	Enrollee age as of December 31, 2018.	Numeric, 2-digit variable. For enrollees age 80 years and older, code as 80. For example, an enrollee who is 89 years of age as of December 31, 2018, will be coded 80. **NOTE: A valid value is required for every enrollee in the record.**
Issuer ID	Num	5	323	327	Unique HIOS issuer ID number.	**NOTE: A valid value is required for every enrollee in the record. This variable MUST be identical for all enrollees included in the sample frame.** **NOTE: This variable MUST match the reported 5-digit Issuer ID in the Reporting Unit ID variable.**
QHP State	Char	2	328	329	State associated with the QHP issuer. This variable is different than Enrollee State.	2-character Postal Service state abbreviation. **NOTE: A valid value is required for every enrollee in the record. This variable MUST be identical for all enrollees included in the sample frame.** **NOTE: This variable MUST match the reported 2-character QHP state postal code in the Reporting Unit ID variable.**

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values
Reporting Unit ID	Char	12	330	341	Reporting Unit ID. It is made up of the following parts (with a hyphen separating each part): 5-digit Issuer ID, 2-character QHP State postal code, and 3-character Product Type.	5-digit Issuer ID= Issuer ID variable. 2-character QHP state postal code=QHP State variable. 3-character product type=Product Type (HMO, POS, PPO, EPO) variable. For example: 12345-TX-PPO. **NOTE: A valid value is required for every enrollee in the record. This variable MUST be identical for all enrollees included in the sample frame and the components of this variable MUST match the reported values for the Issuer ID, QHP State, and Product Type variables.** **NOTE: This Reporting Unit ID MUST be listed as it appears in the "Reporting Units Required to Submit 2019 QHP Enrollee Survey Response Data and QRS" in the *2019 Qualified Health Plan Enrollee Experience Survey: Operational Instructions*, which will be made available in December 2018.**
Metal Level	Num	1	342	342	Metal level associated with enrollee's QHP.	1 = Platinum 2 = Gold 3 = Silver 4 = Bronze 5 = Catastrophic 6 = Bronze Expanded 9 = Missing **NOTE: A valid value is required for every enrollee in the record.**

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values
Variant ID	Char	2	343	344	Variant ID* associated with enrollee's QHP. Variant IDs 02 and 03 are for federally-recognized tribes and eligible Alaska Natives with incomes above 300% of the federal poverty line. The Variant IDs associated with Medicaid Expansion Enrollees (31-36) are determined based on the actuarial value and issuers should have the Variant IDs assigned to their enrollees and plans. **NOTE: Variant IDs relate to the plan's cost-sharing structure.**	01 = Exchange variant (No CSR) 02 = Zero Cost Sharing Plan Variation 03 = Limited Cost Sharing Plan Variation 04 = 73% Actuarial Value (AV) Level Silver Plan CSR 05 = 87% AV Level Silver Plan CSR 06 = 94% AV Level Silver Plan CSR 31 = Medicaid Expansion 32 = Medicaid Expansion 33 = Medicaid Expansion 34 = Medicaid Expansion 35 = Medicaid Expansion 36 = Medicaid Expansion 09 = Missing **NOTE: A valid value is required for every enrollee in the record. Only the Variant IDs listed above can be included in the sample frame. Do NOT include enrollees in QHPs offered outside the Exchange (off-Exchange health plans) or in non-QHPs, designated by HIOS Variant ID 00.** **NOTE: Variant IDs of 09=Missing remain in the sample frame; the enrollee is assumed to be eligible (in an on-Exchange health plan) unless there is evidence to suggest otherwise.**
Spoken Language Preference	Num	1	345	345	Enrollee's preferred spoken language.	1 = English 2 = Spanish 3 = Chinese 4 = Other 9 = Missing
Written Language Preference	Num	1	346	346	Enrollee's preferred written language.	1 = English 2 = Spanish 3 = Chinese 4 = Other 9 = Missing

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values
APTC Eligibility Flag	Num	1	347	347	Indicates whether enrollee qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction.	1 = Yes 2 = No 9 = Missing
Plan Marketing Name	Char	250	348	597	The common name of the QHP in which the individual is enrolled (e.g., the name a consumer would see on an Exchange website when enrolling or on a bill).	If missing, use "Unavailable."
Medicaid Expansion QHP Enrollee	Num	1	598	598	QHPs operating in states offering Section 1115 waivers as part of the Medicaid Expansion **MUST** include all QHP enrollees and their status as enrolled via a 1115 waiver. It is the responsibility of the QHP to know whether their Reporting Units contain such persons.	1 = Yes 2 = No 3 = Missing 9 = Not Applicable, No Medicaid 1115 Waiver **NOTE: Organizations with Medicaid Expansion QHP enrollees (1=Yes) should have Variant ID values between 31-36.** **NOTE: QHPs operating in states not offering Section 1115 waivers use 9 = Not Applicable.**
Reporting Status	Num	1	599	599	This variable is an identifier to determine whether a particular Reporting Unit is eligible for reporting as part of the Quality Rating System. Only plans that began offering coverage within a state's Exchange in Plan Year 2017 or before are eligible for public reporting. This variable is based on the plan year (2017 or 2018) the QHP issuer began offering the Reporting Unit within the state's Exchange. Please refer to the *Create Sample Frame and Draw Sample (Sampling)* section of the *2019 QHP Enrollee Survey Technical Specifications* for more information.	1 = Issuer began offering this product type within state's Exchange in Plan Year 2017 or before 2 = Issuer began offering this product type within state's Exchange in Plan Year 2018 9 = Missing
Enrollee Email Address	Char	320	600	919	Email address.	Maximum of 64 characters for the username, 1 character for the @, and 255 characters for the domain name.

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values
Enrollee Phone 2	Num	10	920	929	3-digit area code plus 7-digit phone number; No separators or delimiters	
Total Enrollment	Num	9	930	938	The total number of members enrolled in the reporting unit. This must be total number of enrollees within the reporting unit, not by the number of survey eligible enrollees. Please refer to the *Evaluate Reporting Unit Eligibility Criteria* section of the *2019 QHP Enrollee Survey Technical Specifications*.	0 - 999999999 -1 = Unknown/Missing