



---

Quality Rating System and Qualified  
Health Plan Enrollee Experience  
Survey: Technical Guidance for 2016

---

September 2015

## Document Change Log

| Description   | Revision Date |
|---|---------------|
| Initial release of the <i>Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016</i> . This guidance addresses requirements for 2016, which includes data submission in the 2016 calendar year for ratings to be displayed for the 2017 coverage year. Please see Section 1.1 for a summary of key differences between this document and the <i>2015 Beta Test for the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2015</i> . | 9/14/2015     |

## Table of Contents

|  |    |
|--|----|
| Technical Assistance.....  | v  |
| 1. Document Purpose and Scope .....  | 1  |
| 1.1 Section Guide.....   | 1  |
| 2. Background.....   | 3  |
| 3. Overview.....   | 3  |
| 4. Implementation Schedule for the QRS and QHP Enrollee Survey.....        | 4  |
| 5. Marketplace Oversight Responsibilities .....                            | 5  |
| 6. QRS and QHP Enrollee Survey Requirements.....                           | 6  |
| 6.1 Participation Criteria for QHP Issuers .....                           | 6  |
| 6.2 QRS Measure Set.....   | 7  |
| 6.2.1 QHP Enrollee Survey.....   | 9  |
| 6.3 Data Collection, Validation, and Submission.....                       | 10 |
| 6.3.1 Data Collection .....  | 11 |
| 6.3.2 Data Validation .....  | 12 |
| 6.3.3 Data Submission .....  | 14 |
| 7. QRS Rating Methodology.....   | 15 |
| 7.1 Measures and Scoring.....  | 15 |
| 7.2 QRS Hierarchy.....   | 16 |
| 7.3 Overview of Process for Calculating QRS Scores and Ratings.....        | 17 |
| 8. Quality Rating Information Preview Process .....                        | 18 |
| 9. Marketplace Display Guidelines for QHP Quality Rating Information ..... | 18 |
| 10. Marketing Guidelines for QHP Quality Rating Information.....           | 19 |
| Appendix A. Relevant Statutory and Regulatory Citations.....               | 23 |
| Appendix B. QRS Measure Summaries.....                                     | 29 |
| Appendix C. QRS Hierarchy.....   | 41 |
| Appendix D. Process for Calculating QRS Scores and Ratings.....            | 43 |
| Appendix E. Glossary .....   | 51 |

## List of Exhibits

|  |    |
|--|----|
| Exhibit 1. Implementation Schedule for the 2016 QRS and QHP Enrollee Survey.....   | 4  |
| Exhibit 2. Example reporting Units for a QHP Issuer Assessed against 2016 QRS and<br>QHP Enrollee Survey Participation Criteria..... | 7  |
| Exhibit 3. QRS Measure Set.....  | 8  |
| Exhibit 4. QHP Enrollee Survey Topics.....   | 10 |
| Exhibit 5. QRS Clinical Measure and QHP Enrollee Survey Response Data Process Flow.....  | 11 |
| Exhibit 6. QRS Measures and Scoring.....   | 16 |
| Exhibit 7. Reporting Unit Data Submission and Scoring Example.....   | 16 |
| Exhibit 8. Overview of QRS Rating Methodology.....   | 17 |
| Exhibit 9. Steps for Calculating the QRS Scores and Ratings.....   | 17 |
| Exhibit 10. QRS Hierarchy.....   | 41 |
| Exhibit 11. QRS Measures with Multiple Indicators with Weighted Average Scores.....  | 43 |
| Exhibit 12. Example of Weighted Average of Indicator Scores.....   | 44 |
| Exhibit 13. Example of Observed Denominator Size in Comparison to a Hypothetical<br>Minimum Denominator Size Requirement.....        | 45 |
| Exhibit 14. Example Composite Score Calculation.....   | 46 |
| Exhibit 15. Conversion of a Component Score to a Rating.....   | 47 |
| Exhibit 16. Example Domain Score Calculation.....  | 48 |
| Exhibit 17. Example Summary Indicator Score Calculation.....   | 49 |
| Exhibit 18. Example Global Score Calculation.....  | 49 |

## Technical Assistance

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

- **QHP issuers:** Please submit questions to the Exchange Operations Support Center (XOSC) Help Desk via email at [CMS\\_FEPS@cms.hhs.gov](mailto: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.
- **States and Marketplace administrators:** Please submit questions to your respective State Officers.
- **Multi-State Plan options:** Please submit questions via email to [MSPP@OPM.gov](mailto:MSPP@OPM.gov) and reference “Marketplace Quality Initiatives (MQI)-QRS” in the subject line. For MSP options that are also QHP issuers, please copy the QHP issuer contact ([CMS\\_FEPS@cms.hhs.gov](mailto:CMS_FEPS@cms.hhs.gov)).
- **Other stakeholders:** Please submit questions via email at [Marketplace\\_Quality@cms.hhs.gov](mailto:Marketplace_Quality@cms.hhs.gov) and reference “Marketplace Quality Initiatives (MQI)-QRS” in the subject line.

## Accompanying Documents

The accompanying document, the *2016 Quality Rating System Measure Technical Specifications*, can be found on the Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives (MQI) website (link in the Website Links section below). The technical specifications detail QRS clinical measure specifications and guidelines for data collection. 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 site provides resources related to CMS MQI, including the QRS, Consumer Experience Surveys, Quality Improvement Strategy (QIS) requirements, and Patient Safety Standards. As the central site for QRS resources, this site contains instructional documents regarding QRS implementation and reporting, including this document, and the <i>2016 Quality Rating System Measure Technical Specifications</i> . | <a href="http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html">http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html</a> |
| CMS QHP Enrollee Survey website | As the central site for the QHP Enrollee Survey, this site includes detailed information on the survey questionnaire, a list of the Department of Health and Human Services (HHS)-approved QHP Enrollee Survey vendors, and survey protocols for vendors (including the <i>2016 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications</i> ).                   | <a href="http://qhpcahps.cms.gov">http://qhpcahps.cms.gov</a>   |

| Website   | Description   | Link  |
|---|---|---|
| National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) <sup>1</sup> Compliance Audit™ website | This site provides additional information related to data validation, including the data validator contracting process, as well as HEDIS Compliance Audit™ standards, policies, and procedures.   | <a href="http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx">http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx</a> |
| Registration for Technical Assistance Portal (REGTAP)   | This site serves as an information hub for CMS technical assistance related to Marketplace 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 "QRS" to identify any resources related to the QRS. | <a href="https://www.REGTAP.info">https://www.REGTAP.info</a>   |

---

<sup>1</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance.

## 1. Document Purpose and Scope

This 2016 Guidance document provides technical guidance regarding the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) for 2016.<sup>1</sup> It specifies QRS and QHP Enrollee Survey requirements for QHP issuers offering coverage through the Health Insurance Marketplaces (Marketplaces). Unless the context indicates otherwise, the term Marketplaces refers to the Federally-facilitated Marketplaces (FFMs) (inclusive of states performing plan management functions in State Partnership States) and the State-based Marketplaces (SBMs).

The primary audience for the 2016 Guidance is QHP issuers, but it also includes information relevant to other stakeholders involved with QRS and QHP Enrollee Survey implementation (e.g., SBMs, data validators, and Department of Health and Human Services [HHS]-approved survey vendors). The 2016 Guidance addresses requirements for 2016, which includes data submission in the 2016 calendar year for ratings to be displayed for the 2017 coverage 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.<sup>2</sup>

The 2016 Guidance includes refinements to the data collection, validation, and submission processes based on the 2015 beta test. During the 2015 beta test, CMS tested QRS and QHP Enrollee Survey implementation processes including data collection, data validation, data submission, data scoring, and data preview.

CMS intends to publish a subsequent version of the 2016 Guidance soon after analysis of 2015 beta test data to allow for CMS to make refinements to the rating methodology. CMS anticipates that the subsequent version will include the finalized rating methodology and additional details regarding preview and display of QHP quality rating information. Therefore, the subsequent version of the 2016 Guidance should not impact QHP issuers’ ability to effectively prepare for data collection, validation, and submission.

### 1.1 Section Guide

In addition to the initial background sections, this document includes the information noted below. The section descriptions also highlight key differences in QRS and QHP Enrollee Survey requirements between the 2016 Guidance and the 2015 Beta Test Guidance.<sup>3</sup>

- **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).

---

<sup>1</sup> Data submission in 2016 calendar year for ratings to be displayed for 2017 coverage year.

<sup>2</sup> 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 CFR Parts 144, 146, 147, et al.).

<sup>3</sup> The guidance for the 2015 beta test was titled *2015 Beta Test for the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2015*.

- **Section 5. Marketplace Oversight Responsibilities:** This section describes Marketplace responsibilities related to the QRS and QHP Enrollee Survey.
- **Section 6. QRS and QHP Enrollee Survey Requirements:** This section outlines the criteria for determining which QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS. This section also describes the QRS measure set and details the requirements for data collection, data validation, and data submission for the QRS and the QHP Enrollee Survey.

**Key Differences in Requirements  
Between the 2015 Beta Test Guidance and the 2016 Guidance**

For 2015, QHP issuers were given the option to include enrollees from identical QHPs offered outside the Marketplace. For 2016, enrollees in QHPs that are offered outside the Marketplace (off-Marketplace) and non-QHPs are not included.

For 2015, QHP issuers were required to collect and submit validated data for 29 of the 43 measures in the QRS measure set. For 2016, QHP issuers are required to collect and submit validated data for all 43 measures in the QRS measure set.

- **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 details shown here reflect a draft QRS rating methodology. Pending the results of the 2015 beta test data analysis, CMS will finalize the rating methodology and release it in a subsequent version of the 2016 Guidance.
- **Section 8. Quality Rating Information Preview Process:** This section describes the process by which QHP issuers and Marketplaces will be able to review QRS ratings and QHP Enrollee Survey results in advance of public display of the data. CMS will issue additional details regarding preview as part of a subsequent version of the 2016 Guidance.
- **Section 9. Display Guidelines for QHP Quality Rating Information:** This section gives an overview of the guidelines for display of QHP quality rating information on Marketplace websites to help consumers compare QHPs. CMS will issue additional details regarding display as part of a subsequent version of the 2016 Guidance.

**Key Differences in Display  
Between the 2015 Beta Test Guidance and the 2016 Guidance**

In 2016, Marketplaces are required to publicly display QHP quality rating information for the first time, making the ratings available for consumers for the Open Enrollment Period for 2017.

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

**Key Differences in Marketing  
Between the 2015 Beta Test Guidance and the 2016 Guidance**

The 2015 Beta Test Guidance did not provide marketing guidelines. Moving forward, a QHP issuer that elects to include 2016 QHP quality rating information in its marketing materials must do so in accordance with the information included in this section.

## 2. Background

Section 1311(c)(3) of the Affordable Care Act<sup>4</sup> directs the Secretary of HHS to develop a quality rating for each QHP offered through a Marketplace, based on quality and price. Section 1311(c)(4) of the Affordable Care Act directs the Secretary to establish an enrollee satisfaction survey that will assess enrollee satisfaction with each QHP offered through the Marketplaces 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 Marketplace.<sup>5</sup> CMS requires that QHP issuers submit this information (QRS clinical measure data and QHP Enrollee Survey response data) for their respective QHPs offered through a Marketplace in accordance with CMS guidelines as a condition of certification and participation in the Marketplaces.<sup>6</sup> Marketplaces are also required to display the QHP quality rating information on their respective websites.<sup>7</sup> 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 of QHPs offered through the Marketplaces;
- To facilitate oversight of QHP issuer compliance with quality reporting standards set forth in the Affordable Care Act and implementing regulations; and
- To provide actionable information that QHP issuers can use to improve quality and performance.

CMS has aligned federal quality reporting standards for QHP issuers with other federal and state quality reporting program standards, while continuing to reflect the National Quality Strategy (NQS) priorities for improving the quality of health and health care.<sup>8</sup> States have the flexibility to

---

<sup>4</sup> The Patient Protection and Affordable Care Act of 2010 (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 Affordable Care Act).

<sup>5</sup> 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 CFR Parts 144, 146, 147, et al.).

<sup>6</sup> 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125).

<sup>7</sup> 45 CFR § 155.1400 and § 155.1405.

<sup>8</sup> The NQS was first published by the Agency for Healthcare Research and Quality (AHRQ) in March 2011 as the *National Strategy for Quality Improvement in Health Care*. It established a framework for coordinating quality

build upon the federal quality reporting standards by setting additional standards for QHPs that reflect state priorities and population-based needs.

QHP issuers and Multi-State Plan (MSP) issuers that offered coverage through a Marketplace 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.<sup>9</sup> An MSP option, certified by and under contract with the U.S. Office of Personnel Management (OPM), is recognized as a QHP for purposes of 45 CFR §155.1010. Therefore, the QHP issuer requirements as described in this 2016 Guidance also apply to QHP issuers offering MSP options. Additional MSP quality reporting requirements, if required, will be specified by OPM.

CMS will calculate the quality performance ratings for QHPs offered through all Marketplaces, regardless of the Marketplace 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.<sup>10</sup> CMS will collect data and 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 these ratings to each product type’s QHPs in that state. Beginning with the Open Enrollment Period for 2017, Marketplaces are required to display QHP quality rating information on their websites prominently to help consumers compare QHPs.<sup>11</sup>

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 Marketplaces.

#### 4. Implementation Schedule for the QRS and QHP Enrollee Survey

Exhibit 1 highlights key events and dates associated with 2016 QRS and QHP Enrollee Survey implementation. Adherence to this schedule enables timely data submission and ratings calculations. CMS expects QHP issuers to meet the following deadlines so that data validators (Healthcare Effectiveness Data and Information Set [HEDIS<sup>®</sup>] Compliance Auditors<sup>™</sup>) 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 2016 QRS and QHP Enrollee Survey**

| Event   | Date                              |
|---|-----------------------------------|
| QHP issuer contracts with a HEDIS <sup>®</sup> Compliance Organization (National Committee for Quality Assurance [NCQA]-licensed) for validation of the QHP Enrollee Survey sampling frame and the QRS clinical measure data. | <b>Deadline:</b> December 1, 2015 |

improvement efforts of health care payers, purchasers, providers, and consumers. The NQS established a set of three broad aims, building on the Institute for Healthcare Improvement’s Triple Aim,<sup>®</sup> supported by six priorities. See <http://www.ahrq.gov/workingforquality/> for additional information.

<sup>9</sup> 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125.

<sup>10</sup> 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.

<sup>11</sup> 45 CFR § 155.1400 and § 155.1405.

| Event  | Date   |
|--|--|
| QHP issuer contracts with an HHS-approved QHP Enrollee Survey vendor and authorizes vendor to conduct the QHP Enrollee Survey and submit survey response data to CMS.  | <b>Deadline:</b> January 5, 2016                 |
| QHP issuer and HEDIS® Compliance Auditor (employee of or contracted by of the HEDIS® Compliance Organization) complete validation of QHP Enrollee Survey sampling frame.   | <b>Deadline:</b> January 29, 2016                |
| QHP issuer completes NCQA's Healthcare Organization Questionnaire (HOQ) to prepare for QRS clinical measure data submission.   | <b>Deadline:</b> February 29, 2016               |
| QHP issuer and HEDIS® Compliance Auditor complete the HEDIS® Compliance Audit.   | January – June 2016 <sup>12</sup>                |
| HHS-approved QHP Enrollee Survey vendor conducts the QHP Enrollee Survey on the validated survey sampling frame.   | February – May 2016                              |
| HHS-approved QHP Enrollee Survey vendor submits the QHP Enrollee Survey response data to CMS (on behalf of the QHP issuer) via a secure data submission function on the QHP Enrollee Survey website ( <a href="http://qhpcahps.cms.gov">http://qhpcahps.cms.gov</a> ).   | <b>Deadline:</b> May 25, 2016                    |
| QHP issuer submits the validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS). <sup>13</sup><br>Note: Each QHP issuer must submit and “plan-lock” its QRS clinical measure data by June 8 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit lock all submissions by the June 15 deadline. | <b>Deadline:</b> June 15, 2016                   |
| QHP issuers, Marketplace administrators, and CMS preview the QHP quality rating information.   | Anticipated August 2016                          |
| The FFMs and SBMs publicly display QHP quality rating information.   | <b>Deadline:</b> Open Enrollment Period for 2017 |

## 5. Marketplace Oversight Responsibilities

Marketplaces are responsible for QHP certification and oversight of compliance with certification standards by QHP issuers operating in their respective Marketplaces. This responsibility includes a requirement to oversee QHP issuer implementation and compliance with the QRS and QHP Enrollee Survey.<sup>14</sup> As a function of this responsibility, CMS (on behalf of the FFMs) and the SBMs will monitor and enforce compliance with QRS and QHP Enrollee Survey requirements with respect to QHP issuers operating in their respective Marketplaces. Similarly, OPM is responsible for MSP certification and MSP issuer oversight and, therefore, will oversee MSP issuer compliance with these requirements. Since CMS is responsible for calculating quality ratings for all QHPs and MSP options in every Marketplace, CMS will coordinate with the SBMs and OPM as needed to support their oversight efforts.<sup>15</sup>

CMS will provide the SBMs with: (1) a list of QHP issuers that have eligible reporting units (as defined in Section 6.1) and are, therefore, required to submit QRS clinical measure and QHP Enrollee Survey response data; and (2) a status update following the data submission deadline

<sup>12</sup> Please see the general guidelines in the *2016 Quality Rating System Measure Technical Specifications* for a more detailed timeline for the HEDIS® Compliance Audit.

<sup>13</sup> There are no fees for QHP issuers associated with accessing and using the IDSS.

<sup>14</sup> 45 C.F.R. § 155.200(d).

<sup>15</sup> 45 CFR § 155.1010(a)(2) and § 155.200(d).

with a list of QHP issuers that submitted data for their eligible reporting units. The SBMs can use this information to support their 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.

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

## 6. QRS and QHP Enrollee Survey Requirements

This section outlines which QHP issuers must comply with QRS and QHP Enrollee Survey requirements (i.e., collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS). This section also describes 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.

### 6.1 Participation Criteria for QHP Issuers

QRS and QHP Enrollee Survey requirements apply to QHP issuers offering QHPs through the Marketplaces<sup>16</sup> 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 by product type with separate submissions by state.<sup>17</sup>** QHP issuers may not combine product types. 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 include EPOs, HMOs, POSs, and PPOs. Indemnity plans should not be included

**QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data for each product type offered through a Marketplace in the previous year. For 2016 reporting, validated data must be submitted for each product type offered through a Marketplace in 2016 that had more than 500 enrollees as of July 1, 2015.<sup>18,19</sup>** Reporting units that are decertified or discontinued before June 15, 2016, are exempt. When determining which enrollees to include in each reporting unit, QHP issuers must consider the following requirements:

---

<sup>16</sup> Marketplaces refer to the FFMs (inclusive of states performing plan management functions in State Partnership States) and the SBMs.

<sup>17</sup> 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.

<sup>18</sup> 45 CFR § 156.1120(a) and § 156.1125(b).

<sup>19</sup> The QHP Enrollee Survey minimum enrollment requirement aligns with standards set forth in 45 CFR § 156.1125(b)(1). CMS established the minimum enrollment requirement for QRS to align with the QHP Enrollee Survey minimum enrollment requirement and to ensure a sufficient size for credible and reliable results.

- All enrollees in QHPs offered through the Marketplace should be included. Enrollees in QHPs offered outside the Marketplace (off-Marketplace) and non-QHPs should not be included.
- All enrollees in QHPs that provide family and/or adult-only medical coverage should be included (unless noted otherwise in the *2016 Quality Rating System Measure Technical Specifications*). At this time, QRS and QHP Enrollee Survey requirements do not apply to child-only plans<sup>20</sup> or stand-alone dental plans.<sup>21</sup>
- A QHP issuer that offers both a QHP and an MSP option of the same product type in the same state must combine enrollees from both QHP and MSP products.
- A QHP issuer that offers the same product type in the individual marketplace as well as the Small Business Health Options Program (SHOP) within a state must combine enrollees from both the individual marketplace and SHOP.

**Example:**

A fictional QHP issuer is certified to offer family medical coverage in two states: West Virginia (WV) and Maryland (MD). Exhibit 2 below shows the characteristics of its 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: WV PPO, and MD EPO. The other reporting units either do not have sufficient number of enrollees as of July 1, 2015, or were discontinued before June 15, 2016.

**Exhibit 2. Example reporting Units for a QHP Issuer Assessed against 2016 QRS and QHP Enrollee Survey Participation Criteria**

| Reporting Unit | Number of enrollees in the reporting unit as of July 1, 2015 (total and per individual marketplace vs. SHOP) | Offered in 2016 as of June 15, 2016 | Met participation criteria? |
|----------------|--|-------------------------------------|-----------------------------|
| <b>WV PPO</b>  | 505 (505 individual, 0 SHOP)   | Yes                                 | Yes                         |
| <b>WV HMO</b>  | 601 (501 individual, 100 SHOP)   | No                                  | No                          |
| <b>MD PPO</b>  | 100 (55 individual, 45 SHOP)   | Yes                                 | No                          |
| <b>MD HMO</b>  | 500 (300 individual, 200 SHOP)   | Yes                                 | No                          |
| <b>MD EPO</b>  | 700 (600 individual, 100 SHOP)   | Yes                                 | Yes                         |

## 6.2 QRS Measure Set

For 2016, QHP issuers that meet the participation criteria as defined in Section 6.1 are required to collect and submit validated data for all measures as listed in Exhibit 3 below. The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Some measures have multiple

<sup>20</sup> HHS will continue to monitor the number of child-only QHPs in the Marketplaces. A limited number of child-only QHPs and enrollees may prohibit reliable child-only QRS rating calculations and QHP Enrollee Survey results.

<sup>21</sup> CMS will continue to monitor both of these plan types and will consider developing a quality rating system and QHP Enrollee Survey for these in the future.

indicators (or rates). QHP issuers are required to submit validated data for all indicators within a measure, unless a specific indicator is shown in parentheses next to the measure, in which case only the indicator must be reported (e.g., for Childhood Immunization Status [Combination 3], only Combination 3 must be reported). 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).

The survey measures in the QRS measure set, noted with an asterisk (\*) in Exhibit 3, will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)<sup>22</sup> surveys. See Section 6.2.1 for details on the QHP Enrollee Survey. For a crosswalk that maps each survey measure in the QRS measure set to the relevant QHP Enrollee Survey item(s), please see <https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system>.

Appendix B includes summaries of each measure. For detailed measure specifications, refer to the 2016 *Quality Rating System Measure Technical Specifications*.

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

Exhibit 3. QRS Measure Set

| Measure Title<br><i>(Asterisk [*] indicates survey measures derived from the QHP Enrollee Survey)</i> | National Quality Forum (NQF) ID <sup>23</sup> |
|---|---|
| Access to Care *  | Not Endorsed <sup>24</sup>                    |
| Access to Information *   | Not Endorsed                                  |
| Adult BMI Assessment  | Not Endorsed                                  |
| Annual Dental Visit   | Not Endorsed                                  |
| Annual Monitoring for Patients on Persistent Medications  | 2371  |
| Antidepressant Medication Management  | 0105  |
| Appropriate Testing for Children With Pharyngitis   | 0002  |
| Appropriate Treatment for Children With Upper Respiratory Infection                                   | 0069  |
| Aspirin Use and Discussion *  | Not Endorsed                                  |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis                                     | 0058  |
| Breast Cancer Screening <sup>25</sup>   | 2372  |
| Care Coordination *   | Not Endorsed                                  |

<sup>22</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The CAHPS® surveys are available at <https://cahps.ahrq.gov>.

<sup>23</sup> Definitions of NQF-endorsed measures can be found here: <http://www.qualityforum.org/Home.aspx>

<sup>24</sup> 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.

<sup>25</sup> The Breast Cancer Screening measure requires three years of continuous member enrollment. Therefore, QHP issuers will be unable to report a numerical rate for this measure given coverage was first offered in the Marketplaces for 2014.

| Measure Title<br><i>(Asterisk [*] indicates survey measures derived from the QHP Enrollee Survey)</i> | National Quality Forum (NQF) ID <sup>23</sup> |
|---|---|
| Cervical Cancer Screening   | 0032  |
| Childhood Immunization Status (Combination 3)   | 0038  |
| Chlamydia Screening in Women  | 0033  |
| Colorectal Cancer Screening   | 0034  |
| Comprehensive Diabetes Care: Eye Exam (Retinal) Performed   | 0055  |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)                                   | 0575  |
| Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing   | 0057  |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy  | 0062  |
| Controlling High Blood Pressure   | 0018  |
| Cultural Competence*  | Not Endorsed                                  |
| Flu Vaccinations for Adults Ages 18-64*   | 0039  |
| Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)                                  | 0576  |
| Follow-Up Care for Children Prescribed ADHD Medication  | 0108  |
| Human Papillomavirus Vaccination for Female Adolescents   | 1959  |
| Immunizations for Adolescents (Combination 1)   | 1407  |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment                              | 0004  |
| Medical Assistance With Smoking and Tobacco Use Cessation*  | 0027  |
| Medication Management for People With Asthma (75% of Treatment Period)                                | 1799  |
| Plan Administration*  | Not Endorsed                                  |
| Plan All-Cause Readmissions   | 1768  |
| Prenatal and Postpartum Care  | 1517  |
| Proportion of Days Covered  | 0541  |
| Rating of All Health Care*  | 0006  |
| Rating of Health Plan*  | 0006  |
| Rating of Personal Doctor*  | 0006  |
| Rating of Specialist*   | 0006  |
| Relative Resource Use for People with Diabetes (Inpatient Facility Index)                             | 1557  |
| Use of Imaging Studies for Low Back Pain  | 0052  |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents     | 0024  |
| Well-Child Visits in the First 15 Months of Life (6 or More Visits)                                   | 1392  |
| Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life                                | 1516  |

### 6.2.1 QHP Enrollee Survey

The QHP Enrollee Survey draws heavily from CAHPS<sup>®</sup> Health Plan Surveys, which are used widely to assess Medicare, Medicaid, and other commercial health plan performance. The survey assesses enrollee experience with a QHP offered through a Marketplace on the topics presented in Exhibit 4. Measures derived from a subset of survey questions are included in the QRS measure set and accompanying ratings.

## Exhibit 4. QHP Enrollee Survey Topics

| <b>QHP Enrollee Survey Topics</b><br>(Asterisk [*] indicates survey questions within this topic are <u>not</u> included in QRS survey measures) |
|---|
| Access to Care  |
| Access to Information   |
| Care Coordination   |
| Cost*   |
| Cultural Competence   |
| Doctor Communication*   |
| Plan Administration   |
| Prevention  |

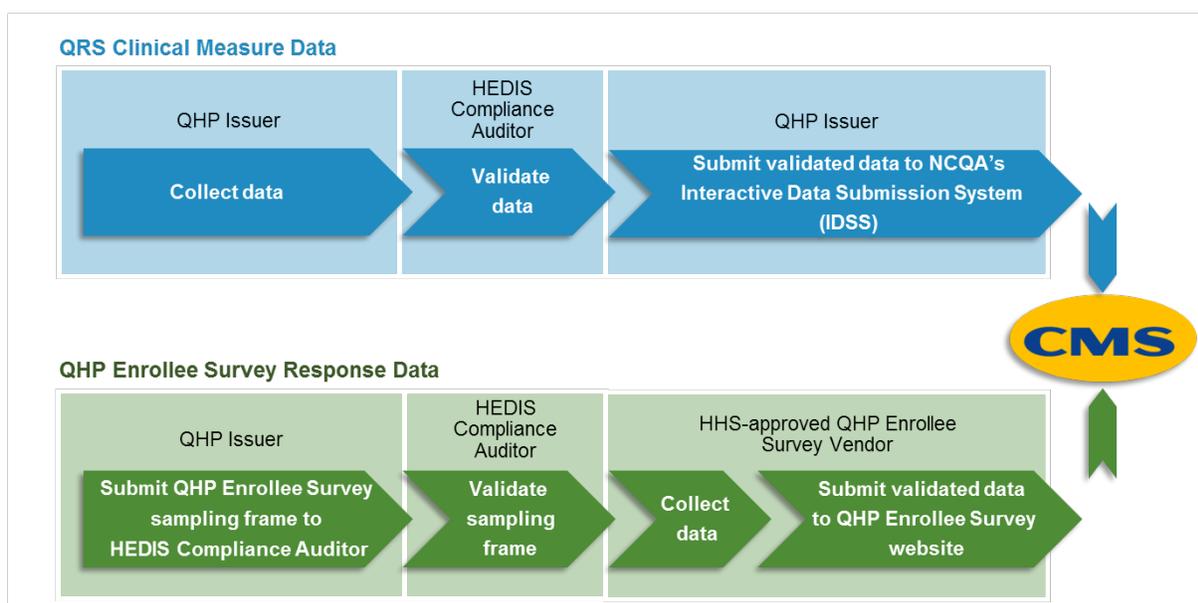
To adjust for any systematic biases with the enrollee response data, CMS will apply a case-mix adjustment to the QHP Enrollee Survey response data and use the adjusted data when calculating the QRS survey measures. It is common in survey-based applications to case-mix adjust scores for such factors as overall health status, age, and education to account for biases due to survey response tendencies. For example, QHPs with higher concentrations of enrollees with certain characteristics would tend to receive higher scores, even if they provided comparable quality of service as other QHPs. Factors to be used in the case-mix adjustment will be determined based on psychometric testing and additional analyses using the 2015 beta test data, which will be detailed in the subsequent version of the 2016 Guidance.

The calculation of QHP Enrollee Survey scores, including those used in QRS, will be done using the CAHPS<sup>®</sup> Analysis Program (“CAHPS<sup>®</sup> Macro”), which was developed by the CAHPS<sup>®</sup> Consortium under the auspices of the Agency for Healthcare Research and Quality (AHRQ). A comprehensive description of calculations performed by the CAHPS<sup>®</sup> Analysis Program can be found in *Instructions for Analyzing Data from CAHPS<sup>®</sup> Surveys*, in the *CAHPS<sup>®</sup> Survey and Reporting Kit*. These materials are available at: <https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf>.

### 6.3 Data Collection, Validation, and Submission

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

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



### 6.3.1 Data Collection

Details related to the data collection protocols for QRS clinical measure data and QHP Enrollee Survey response data are summarized below. For additional data collection instructions for the QRS clinical measures, including the required data elements, refer to the *2016 Quality Rating System Measure Technical Specifications*. For additional data collection instructions related to the QHP Enrollee Survey, refer to the *2016 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications*.

#### 6.3.1.1 QRS Clinical Measure Data Collection

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

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

CMS does not require one method of data collection or the other. Rather, QHP issuers must refer to the *2016 Quality Rating System Measure Technical Specifications* to determine which data collection method is allowed for each clinical measure. The QHP issuer may choose which it prefers if more than one method is allowed.

### 6.3.1.2 QHP Enrollee Survey Data Collection

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

Each QHP issuer must formally authorize its chosen survey vendor to collect and submit QHP Enrollee Survey response data to CMS on its behalf.<sup>26</sup> In the fall of 2015, QHP issuers will receive instructions on the survey vendor authorization process. These instructions will include the step-by-step process for authorizing a survey vendor, including information on how to log in to the QHP Enrollee Survey website, the timeline for authorizing a survey vendor, and the list of reporting units that the QHP issuer must include to comply with the survey requirements.

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

### 6.3.2 Data Validation

Each QHP issuer must have its clinical measure data and the QHP Enrollee Survey sampling frame validated by a data validator, in accordance with measure stewards' protocols, prior to data submission.<sup>27</sup> For 2016, CMS requires that QHP issuers use a HEDIS<sup>®</sup> Compliance Auditor and follow the HEDIS<sup>®</sup> Compliance Audit standards to validate all QRS measures, including the QHP Enrollee Survey sampling frame.<sup>28</sup> The sections below contain details related to these data validation requirements.

#### 6.3.2.1 Data Validators

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

The HEDIS<sup>®</sup> 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

---

<sup>26</sup> 45 CFR § 156.1125(a).

<sup>27</sup> 45 CFR § 156.1120(a)(2) and § 156.1125(b)(2).

<sup>28</sup> The Pharmacy Quality Alliance (PQA) does not have a defined measure validation strategy for the Proportion of Days Covered measure. For 2016, CMS requires this measure to be validated using the HEDIS Compliance Audit<sup>™</sup> standards, policies, and procedures.

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<sup>®</sup> Compliance Auditors: <http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx>

### 6.3.2.2 Data Validation Standards

The data validation standards are specified in the *HEDIS<sup>®</sup> 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 *2016 Quality Rating System Measure Technical Specifications*. The HEDIS<sup>®</sup> 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<sup>®</sup> Compliance Audit: Standards, Policies, and Procedures*, available for purchase on the following website: <http://store.ncqa.org/index.php/performance-measurement.html>.

### 6.3.2.3 Data Validation Results

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

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

- **A rate:** The QHP issuer followed the specifications and produced a reportable rate (numeric result) for the measure.
- **Benefit Not Offered (NB):** The QHP issuer did not offer the health benefit required by the measure.
- **Biased Rate (BR):** The QHP issuer's calculated rate was materially biased.
- **Not Reported (NR):** The QHP issuer chose not to report the measure.
- **Not Applicable (NA):** The QHP issuer followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. The QHP issuer did not have sufficient data to fulfill the continuous enrollment criteria for the measure. For example, a QHP issuer that has operated for only one year will be unable to meet the continuous enrollment criteria for Breast Cancer Screening, which requires multi-year continuous enrollment as outlined in the *2016 Quality Rating System Measure 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 do not proceed with fielding the survey until they receive the validator's approval notice

In the subsequent version of the 2016 Guidance, CMS will be releasing information on how non-numerical audit results (i.e., BR, NA, NB, and NR results) will be handled by the QRS rating methodology. Additionally, as part of display guidelines in Section 9, CMS will be issuing further details for what will be displayed publicly on Marketplace websites in the case that a reporting unit is unable to receive a rating.

#### 6.3.2.3.1 Compliance Reviews

CMS may conduct targeted compliance reviews under 45 CFR 156.715 to examine QHP issuer compliance with the federal data submission and reporting requirements for the QRS and QHP Enrollee Survey subsequent to the data validation of QRS clinical measure and QHP Enrollee Survey response data. This could occur in cases where CMS suspects QHP issuers' mishandling of data, inappropriate processing, or implementation of incorrect practices has resulted in erroneous data, scores, or ratings. Examples would 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.<sup>29</sup>

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

### 6.3.3 Data Submission

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

#### 6.3.3.1 QRS Clinical Measure Data Submission

All QHP issuers submitting QRS clinical measure data must complete the Healthcare Organization Questionnaire (HOQ) to gain access to NCQA's web-based tool, the Interactive Data Submission System (IDSS). There are no fees for QHP issuers associated with accessing and using the IDSS. Upon completion of the HOQ, a QRS-specific submission ID will be created in the IDSS. NCQA will open the annual HOQ completion process in early January 2016 and will close access at the end of February 2016. The HOQ can be accessed at <http://CustomerCenter.ncqa.org> once opened by NCQA. For more information regarding the HOQ, visit <http://www.ncqa.org/tabid/219/Default.aspx>. QHP issuers should submit questions about the HOQ to the NCQA portal at <https://my.ncqa.org/>.

QHP issuers must submit summary-level QRS clinical measure data (for each reporting unit) via NCQA's IDSS, once the data have been validated by a HEDIS<sup>®</sup> Compliance Auditor. Summary-

---

<sup>29</sup> 45 C.F.R. 156.800.

level data are specific to each clinical measure and will include such elements as eligible population or denominator, numerator, and the reported rate. Patient-level data are not required 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., data are accurate and reflect plan performance) by 11:59 p.m. ET, June 15, 2016. QHP issuers should submit questions regarding the IDSS to the NCQA portal at <https://my.ncqa.org>.

### 6.3.3.2 QHP Enrollee Survey Data Submission

On behalf of the QHP issuer, the HHS-approved QHP Enrollee Survey vendor will submit de-identified enrollee response data directly to the QHP Enrollee Survey website at <http://qhpcahps.cms.gov>. Detailed instructions for survey vendors on how to submit the response data are found on the QHP Enrollee Survey website and in the *2016 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications*.

QHP Enrollee Survey vendors must submit the QHP Enrollee Survey response data by May 25, 2016.

## 7. QRS Rating Methodology

This section describes how CMS anticipates calculating quality ratings based on the QRS clinical measure and QHP Enrollee Survey response data submitted in 2016. This section is intended to provide details about the rating methodology to understand the scores and ratings.

Section 7.2 and 7.3 currently remain unchanged from the 2015 Beta Test Guidance. CMS continues to conduct analyses of the 2015 beta test data to inform pending methodological decisions<sup>30</sup> and to make any necessary refinements. CMS intends to publish a subsequent version of the 2016 Guidance that includes the final QRS rating methodology to be applied in 2016. Additionally, CMS anticipates including information on how Not Applicable (NA), Benefit Not Offered (NB), Not Reported (NR), and Biased Rate (BR) results will be handled by the QRS rating methodology.

### 7.1 Measures and Scoring

For the 2015 beta test, QHP issuers were required to collect and submit validated data for 29 of the 43 measures in the QRS measure set. CMS anticipates using a maximum of 28 of the 29 QRS measures to calculate QRS ratings. (Note that the Relative Resource Use measure will be excluded from 2015 beta test scoring).

For 2016, QHP issuers are required to collect and submit validated data for all 43 measures in the QRS measure set. Although 43 measures are required for data collection and submission in 2016, CMS anticipates using the same rating methodology that is used for the 2015 beta test, meaning, at maximum, only 28 of the required 43 measures will be used for scoring. After scoring in 2016,

---

<sup>30</sup> CMS' pending methodological decisions for the 2015 beta test include establishing a minimum denominator size, identifying cut points, and determining the weighting approach associated with the QRS survey measure indicators.

CMS will use data from all measures submitted in 2016 to conduct further analyses to inform refinements to the 2017 QRS rating methodology. This approach is summarized in Exhibit 6.

**Exhibit 6. QRS Measures and Scoring**

|  | 2015<br>(beta test) | 2016<br>(current year) |
|--|---------------------|------------------------|
| <b>Number of measures required for QRS data submission</b>   | 29                  | 43 (all measures)*     |
| <b>Maximum number of measures to be used for QRS scoring</b>   | 28**                | 28***                  |
| <p>* 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).</p> <p>** Relative Resource Use measure will be collected, but excluded from scoring.</p> <p>*** CMS anticipates using the same measures for scoring as were used for the beta test allowing CMS to calculate QRS scores and ratings based on the rating methodology used for the 2015 beta test.</p> |                     |                        |

While QHP issuers are required to submit QRS measure data beginning with their second year as a certified entity, a QHP issuer is not eligible to receive QRS scores and ratings for its eligible reporting unit until its third consecutive year operating in the Marketplace. For example, as shown in Exhibit 7, the QHP issuers eligible for receiving a QRS score and rating in 2016 need to have had a reporting unit that operated in 2014, 2015, and 2016.

**Exhibit 7. Reporting Unit Data Submission and Scoring Example**

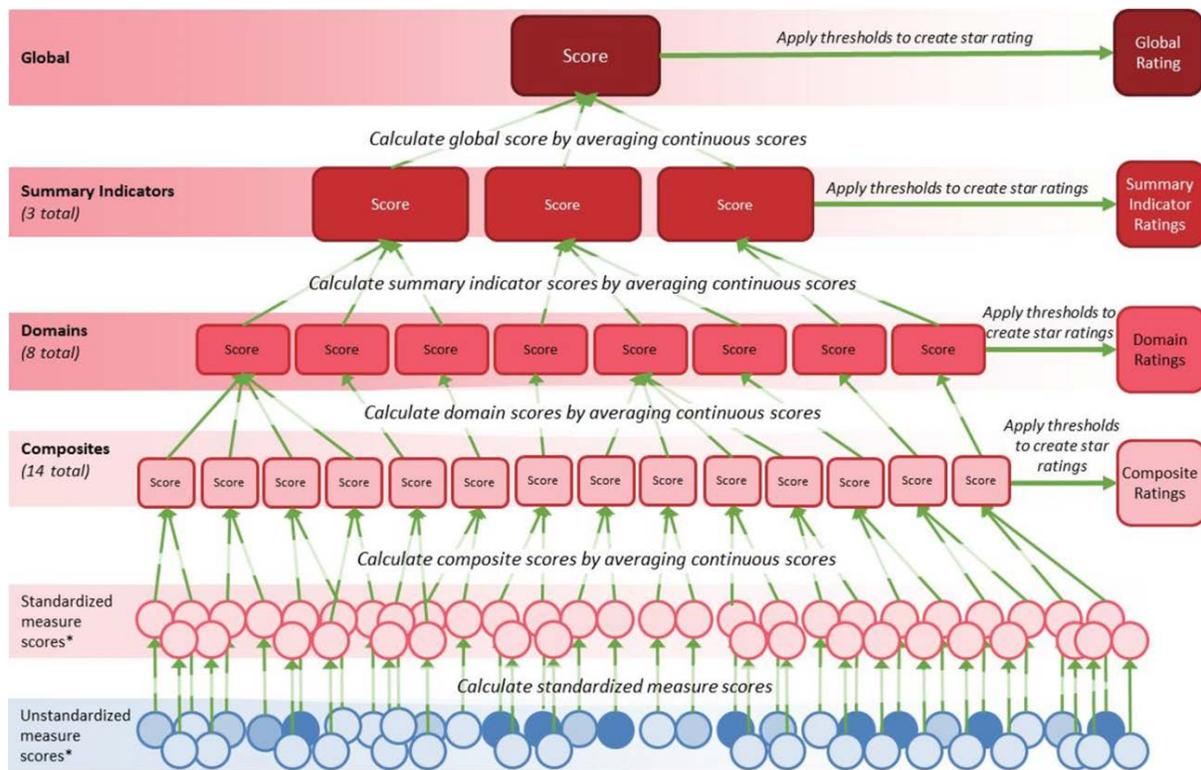
| QRS Eligibility          | Reporting unit operates in current year only (2016) | Reporting unit operates in current year and prior year only (2016 and 2015) | Reporting unit operates in more than two consecutive years (2016, 2015, 2014) |
|--------------------------|---|---|---|
| Eligible to submit data? | No  | Yes   | Yes   |
| Eligible to be scored?   | No  | No  | Yes   |

## 7.2 QRS Hierarchy

The QRS measures, as outlined in Section 6.2, are organized into a hierarchical structure (the QRS hierarchy) designed to make the QRS scores and ratings more understandable (see Appendix C). The measures are the building blocks of the hierarchical structure and are grouped into hierarchy components (composites, domains, summary indicators) that are used to form a single global score (and rating).

Exhibit 8 illustrates how the measures and components are grouped to create 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. The following sections include details related to this process.

Exhibit 8. Overview of QRS Rating Methodology



\* One measure, Relative Resource Use for People with Diabetes (Inpatient Facility) (NQF #1557) will be collected, but will not be included in the QRS ratings.

### 7.3 Overview of Process for Calculating QRS Scores and Ratings

Exhibit 9 outlines the process for calculating QRS scores and ratings. Appendix D describes each step in greater detail.

Exhibit 9. Steps for Calculating the QRS Scores and Ratings

| Step  | Sub-steps   |
|---|---|
| <b>Step 1. Prepare Data for Scoring</b>               | <ul style="list-style-type: none"> <li>Average the measure's indicators to create the measure score. For measures with more than one indicator, average the measure's indicators to create the measure score.</li> <li>Determine if the measure denominator size is sufficient for including the measure in scoring. Calculation of the measures is required before evaluation of denominator size to ensure all indicators needed for a given measure are included and complete.</li> </ul>        |
| <b>Step 2. Standardize Measure Scores</b>             | <ul style="list-style-type: none"> <li>Standardize the measure scores. Using a national reference group based on calculable QHP issuer product performance rates, standardize each measure score by assigning a percentile rank. Creating measure percentile ranks allows for comparisons of performance within product type relative to the other QHP product values.</li> </ul>   |
| <b>Step 3. Calculate Composite Scores and Ratings</b> | <ul style="list-style-type: none"> <li>Determine if the score can be calculated. Apply the half-scale rule, meaning that the composite score can be calculated only if at least half of the associated measures have a score.</li> <li>Calculate the score. Average available measure scores using equal weights.</li> <li>Convert the score to a rating. Convert each composite score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.</li> </ul> |

| Step  | Sub-steps  |
|---|--|
| <b>Step 4. Calculate Domain Scores and Ratings</b>            | <ul style="list-style-type: none"> <li>▪ <i>Determine if the score can be calculated.</i> Apply the half-scale rule, meaning that the domain score can be calculated only if at least half of the associated composites have a score.</li> <li>▪ <i>Calculate the score.</i> Average available composite scores using equal weights.</li> <li>▪ <i>Convert the score to a rating.</i> Convert each domain score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.</li> </ul>       |
| <b>Step 5. Calculate Summary Indicator Scores and Ratings</b> | <ul style="list-style-type: none"> <li>▪ <i>Determine if the score can be calculated.</i> Apply the full-scale rule, meaning that the summary indicator score can be calculated only if all of the associated domains have a score.</li> <li>▪ <i>Calculate the score.</i> Average available domain scores using equal weights.</li> <li>▪ <i>Convert the score to a rating.</i> Convert each summary indicator score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.</li> </ul> |
| <b>Step 6. Calculate Global Score and Rating</b>              | <ul style="list-style-type: none"> <li>▪ <i>Determine if the score can be calculated.</i> Apply the full-scale rule, meaning that the global score can be calculated only if all of the associated summary indicators have a score.</li> <li>▪ <i>Calculate the score.</i> Average available summary indicator scores using equal weights.</li> <li>▪ <i>Convert the score to a rating.</i> Convert the global score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.</li> </ul>  |

## 8. Quality Rating Information Preview Process

CMS will provide QHP issuers and Marketplace administrators the opportunity to preview their QHP quality rating information. QHP issuers in all Marketplaces will be able to review their QRS ratings and to submit any related inquiries to CMS during a two-week preview period. CMS will provide further instructions in advance of the preview period. In addition, CMS will provide the SBMs with the QRS ratings for the QHPs offered in their respective Marketplaces. CMS will also provide OPM with the QRS ratings for the MSPs.

An SBM may choose to conduct an additional ratings preview for QHP issuers operating in that Marketplace, and CMS encourages the SBMs to do so, particularly if the state requires its QHP issuers to report additional quality measures beyond the QRS and QHP Enrollee Survey requirements.

During the preview process, CMS intends to work with QHP issuers and Marketplace administrators to address any inquiries about the QRS ratings and to resolve potential discrepancies, if necessary. CMS will coordinate with the SBMs throughout the process to mitigate duplicative efforts.

QHP issuers will also receive their complete QHP Enrollee Survey results, including results for those survey measures not used for the QRS.

## 9. Marketplace Display Guidelines for QHP Quality Rating Information

Marketplaces are required to display QHP quality rating information as calculated by CMS on their respective websites in time for the Open Enrollment Period for 2017, to facilitate consumer shopping for the 2017 coverage year. CMS anticipates displaying the 2016 QHP quality rating information, including the global rating and the rating for the Enrollee Experience summary indicator on HealthCare.gov (by the start of the Open Enrollment Period for 2017) for each QHP

offered through the FFM and through the SBMs that rely on the federal eligibility and enrollment platform (i.e., use HealthCare.gov for enrollment).

CMS anticipates requiring the SBMs that do not rely on the federal eligibility and enrollment platform (i.e., SBMs that do not use HealthCare.gov for enrollment) to display QHP quality rating information via a link to a HHS website where the QHP quality rating information will be publicly available. The SBMs that do not rely on the federal eligibility and enrollment platform will also have the option to display QHP quality rating information directly on their websites. CMS will coordinate with the SBMs to support their adherence to these display requirements.

CMS will issue technical details in the future regarding the display requirements for Marketplaces, in addition to specifying the form and manner in which CMS will display QHP quality rating information on HealthCare.gov.

OPM reserves the authority to display quality rating information for MSP options, and will issue further guidance on display.

Lastly, separate from display on Marketplace websites, CMS intends to release QHP quality rating information via public use data files.

## 10. Marketing Guidelines for QHP Quality Rating Information

QHP issuers may reference the quality ratings and survey results for its QHPs in its marketing materials, in a manner specified by HHS.<sup>31</sup> Any QHP issuer that elects to include its QHP quality rating information, specifically QRS scores and ratings and QHP Enrollee Survey results, in its marketing materials (whether paper, electronic, or other media) must do so in accordance with the instructions below.<sup>32</sup>

As 2015 was the beta test year, all 2015 QRS and QHP Enrollee Survey results (including numerical scores and star ratings) may not be used by QHP issuers for marketing activities.

The 2016 marketing guidelines are generally based on CMS guidance related to marketing QHPs as communicated in the *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces*.<sup>33</sup>

- 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.

---

<sup>31</sup> 45 CFR 156.1120(c), 156.1125(c)

<sup>32</sup> The scope of the definition for “marketing” extends beyond the public’s general concept of advertising materials. The definition of marketing materials, as referenced here, is equivalent to what is described for the Medicare Advantage program in 42 CFR 422.2260.

<sup>33</sup> See Chapter 4, Section 5, “Oversight of Marketing Activities,” in the *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces*, available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf>. See also 45 CFR 156.225 Marketing and Benefit Design of QHPs, 155.260 Privacy and Security, and 156.200(e) Non-discrimination.

- QHP issuers must include the following disclaimer on all marketing materials referencing QRS information:
  - CMS rates qualified health plans (QHPs) offered through the Marketplaces 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 each year (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 Marketplaces using QHP Enrollee Survey response data. QHP issuers contract with HHS-approved survey vendors who independently conduct the survey each year. QHP Enrollee Survey results may change from one year to the next. For more information, please see CMS' Health Insurance Marketplace Quality Initiatives website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>.
- If marketing materials reference QRS and QHP Enrollee Survey information, QHP issuers must include the following disclaimer on all materials:
  - CMS rates qualified health plans (QHPs) offered through the Marketplaces 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 each year 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>.
- All disclaimers must be clear and conspicuous.
- QHP issuers that choose to include QHP quality rating information in marketing materials must use the most up-to-date information within 30 days of the release of final information by CMS and discontinue marketing based on the previous year's information. CMS anticipates issuing the final QRS ratings each year prior to the start of the Open Enrollment Period for 2017.
- Materials should reference specific QHPs and their CMS-assigned quality rating information. Materials should be specific as to the state to which the information applies.

QHP issuers may also 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.

- QHP issuers with one or more QHPs 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 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 QRS global ratings rather than ratings 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. Additionally, the QHP issuer must always include the QRS global rating alongside the QRS component rating.
- The use of a general label in reference to the rating of a specific QHP (e.g., "a 5-star plan") can only be used to reference the QRS global rating, unless the component is specified (e.g., "a 5-star plan for [insert component name]"). QHP issuers may not use the rating for another QRS component (i.e., summary indicator, domain, composite, or measure) to imply a higher global quality rating than actually received. For example, a QHP issuer may not promote a QHP that received a global rating of three stars and a summary indicator rating of five stars as a "5-star plan."
- QHP issuers should not use superlatives (e.g., "highest ranked," "one of the best") in a manner that could mislead consumers or without additional context. For example, a QHP that is the only one in the state 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 Marketplaces. This includes, but is not limited to, use of the Department's name or logo; the Agencies' name and marks; or the Marketplaces' names, logos, and marks in a manner that would convey the false impression that any product type recommended or endorsed by the federal government, HHS or its Agencies, or the Marketplaces.
- 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.<sup>34</sup>

Pursuant to 45 CFR 156.340 (a)(1) and 156.225, a QHP issuer participating in an FFM 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

---

<sup>34</sup> 45 C.F.R. § 156.225.

marketing standards. As noted in the 2015 (and 2016) 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 FFMs, CMS may review QHP marketing materials for compliance with 45 C.F.R. 156.200(e) and 45 C.F.R. 156.225(b). CMS will work with states to determine where additional monitoring and review of marketing activities may be needed.

If CMS receives a complaint about a QHP issuer's marketing activities related to quality rating information, which is generally overseen by the state, CMS will send the complaint to the state regulators or federal entities, as appropriate, for investigation. Following investigation by the state or another federal agency investigation, CMS may also take the necessary enforcement action.

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

## Appendix A. Relevant Statutory and Regulatory Citations

This appendix includes excerpts from the Patient Protection and Affordable Care Act and supporting regulation that are relevant to QRS and the QHP Enrollee Survey (referred to in the statute as the enrollee satisfaction survey system). This appendix is intended for reference only, and is not an exhaustive list of QHP issuer and/or Marketplace requirements.

### PATIENT PROTECTION AND AFFORDABLE CARE ACT, 42 U.S.C. SEC. 18031 (MARCH 23, 2010)

| Topic   | Provisions  | Citation                   |
|---|---|----------------------------|
| <b>QHP certification standards: Public reporting of quality information</b>               | <p>(c) RESPONSIBILITIES OF THE SECRETARY.—</p> <p>(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—</p> <p>(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.</p> <p>(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. <i>[As added by section 10203(a)]</i>"</p>   | Section 1311 (c)(1)(H),(I) |
| <b>Marketplace standards: Public reporting of QRS and QHP Enrollee Survey information</b> | <p>(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).</p>   | Section 1311 (c)(3)        |
|   | <p>(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.</p>   | Section 1311 (c)(4)        |
|   | <p>(5) INTERNET PORTALS.—The Secretary shall —</p> <p>(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.</p> | Section 1311 (c)(5)(B)     |

| Topic | Provisions  | Citation                          |
|-------|---|-----------------------------------|
|       | <p>(d) REQUIREMENTS.—</p> <p>(4) FUNCTIONS.—An Exchange shall, at a minimum—</p> <p>(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);</p> <p>(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;</p> | <p>Section 1311 (d)(4)(D),(E)</p> |

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

**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   |
|---|--|--|
| <p><b>Application &amp; standards for QHP Enrollee Survey vendors; List of HHS-approved vendors</b></p> | <p>(a) <i>Application for approval.</i> 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.</p> <p>(b) <i>Standards.</i> To be approved by HHS, an enrollee satisfaction survey vendor must meet each of the following standards:</p> <p>(1) Sign and submit an application form for approval in accordance with paragraph (a) of this section;</p> <p>(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;</p> <p>(3) Ensure the accuracy of their data collection, calculation and submission processes and attest to HHS the veracity of the data and these processes;</p> <p>(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;</p> <p>(5) Adhere to the enrollee satisfaction survey protocols and technical specifications in a manner and form required by HHS;</p> <p>(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;</p> <p>(7) Adhere to privacy and security standards established and implemented under § 155.260 of this subchapter by the Exchange with which they are associated;</p> <p>(8) Comply with all applicable state and federal laws;</p> <p>(9) Become a registered user of the enrollee satisfaction survey data warehouse to submit files to HHS on behalf of its authorized QHP contracts;</p> <p>(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,</p> <p>(11) Comply with minimum business criteria as established by HHS.</p> <p>(c) <i>Approved list.</i> A list of approved enrollee satisfaction survey vendors will be published on an HHS Web site.</p> | <p>45 CFR § 156.1105(a)-(c)<br/>Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges</p> |

**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  |
|---|--|---|
| <b>Marketplace standards for public display of QRS ratings</b>                                      | 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 CFR § 155.1400<br>Quality rating system                        |
| <b>Marketplace standards for public display of QHP Enrollee Survey information</b>                  | 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 CFR § 155.1405<br>Enrollee satisfaction survey system          |
| <b>QHP certification standards: Public reporting of QHP quality rating information<sup>35</sup></b> | <p>(a) <i>General requirement.</i> 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.</p> <p>(b) <i>QHP issuer requirement.</i> A QHP issuer must—</p> <p>(5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Affordable Care Act consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;</p> <p>(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.</p> | 45 CFR § 156.200(a),(b)(5),(h) QHP issuer participation standards |

<sup>35</sup> The QHP participation standards at 45 CFR § 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 & Market Standards for the 2015 & 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   |
|--|---|--|
| <p><b>Monitoring of QHP Enrollee Survey vendors and vendor appeals</b></p>   | <p>(d) <i>Monitoring.</i> 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.</p> <p>(e) <i>Appeals.</i> 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.</p>  | <p>45 CFR § 156.1105(d),(e)<br/>Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges</p> |
| <p><b>Standards for QRS data submission, data validation, implementation timeline, and marketing of QRS ratings; Multi-State Plan requirements</b></p> | <p>(a) <i>Data submission requirement.</i></p> <p>(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.</p> <p>(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.</p> <p>(3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS.</p> <p>(b) <i>Timeline.</i> 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.</p> <p>(c) <i>Marketing requirement.</i> A QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS.</p> <p>(d) <i>Multi-State plans.</i> 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.</p> | <p>45 CFR § 156.1120 (a)–(d)<br/>Quality rating system</p>   |

| Topic   | Provisions  | Citation  |
|---|---|---|
| <p><b>Standards for administering the QHP Enrollee Survey and marketing survey results; Multi-State Plan requirements</b></p> | <p>(a) <i>General requirement.</i> 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.</p> <p>(b) <i>Data requirement.</i> (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.</p> <p>(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.</p> <p>(3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS.</p> <p>(c) <i>Marketing requirement.</i> A QHP issuer may reference the survey results for its QHPs in its marketing materials, in a manner specified by HHS.</p> <p>(d) <i>Timeline.</i> 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.</p> <p>(e) <i>Multi-State plans.</i> 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.</p> | <p>45 CFR § 156.1125 (a)–(e)</p> <p>Enrollee satisfaction survey system</p> |

## Appendix B. QRS Measure Summaries

This appendix includes measure summaries for the final QRS measure set, organized alphabetically according to the year in which the measure was first required for reporting in the QRS. For detailed QRS clinical measure specifications, refer to the *2016 Quality Rating System Measure Technical Specifications* at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), see <https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system>.

### MEASURES FIRST REQUIRED FOR REPORTING IN 2015

|                      |   |
|----------------------|---|
| <b>Measure Name:</b> | <b>Access to Care</b>   |
| Measure Steward:     | AHRQ, CMS   |
| NQF Endorsement ID:  | Not Endorsed <sup>36</sup>  |
| Description:         | <p>Enrollee experience related to the following:</p> <ul style="list-style-type: none"> <li>• Got care for illness/injury as soon as needed</li> <li>• Got non-urgent appointment as soon as needed</li> <li>• Easy to get care after regular office hours</li> <li>• How often it was easy to get necessary care, tests, or treatment</li> <li>• Got appointment with specialists as soon as needed</li> </ul> |
| Data Source(s):      | QHP Enrollee Survey   |
| <b>Measure Name:</b> | <b>Access to Information</b>  |
| Measure Steward:     | AHRQ, CMS   |
| NQF Endorsement ID:  | Not endorsed  |
| Description:         | <p>Enrollee experience related to the following:</p> <ul style="list-style-type: none"> <li>• Written materials or Internet provided information needed about how plan works</li> <li>• Found out from health plan about cost for health care service or equipment</li> <li>• Found out from health plan about cost for specific prescriptions</li> </ul>   |
| Data Source(s):      | QHP Enrollee Survey   |
| <b>Measure Name:</b> | <b>Annual Dental Visit</b>  |
| 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   |

<sup>36</sup> The QRS Access to Care measure includes two separate NQF-endorsed measures (Getting Needed Care and Getting Care Quickly) along with an additional CAHPS<sup>®</sup> Health Plan Supplemental question regarding getting after-hours care.

**Measure Name: Annual Monitoring for Patients on Persistent Medications**

Measure Steward: NCQA

NQF Endorsement ID: 2371

Description: The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the three rates separately and as a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for members on digoxin
- Annual monitoring for members on diuretics
- Total rate (the sum of the three numerators divided by the sum of the three denominators)<sup>37</sup>

Data Source(s): Administrative Data

---

**Measure Name: Appropriate Testing for Children with Pharyngitis**

Measure Steward: NCQA

NQF Endorsement ID: 0002

Description: The percentage of children 2–18 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.

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics *were not* prescribed).

Data Source(s): Administrative Data

---

<sup>37</sup> The total rate for Annual Monitoring for Patients on Persistent Medications will not be used for QRS scoring.

**Measure Name: Care Coordination**

Measure Steward: AHRQ, CMS

NQF Endorsement ID: Not Endorsed

Description: Enrollee experience related to the following:

- Doctor seemed informed and up-to-date about care from other health providers
- Doctor had your medical records
- Doctor followed up about blood test, x-ray results
- Got blood test, x-ray results as soon as you needed them
- Doctor talked about prescription drugs you are taking
- Got help you needed from doctor's office manage your care among different providers

Data Source(s): QHP Enrollee Survey

---

**Measure Name: Cervical Cancer Screening**

Measure Steward: NCQA

NQF Endorsement ID: 0032

Description: The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years
- Women age 30–64 who had cervical cytology/HPV co-testing performed every 5 years

Data Source(s): Administrative and Hybrid

---

**Measure Name: 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: Comprehensive Diabetes Care: Eye Exam (Retinal) Performed**

Measure Steward: NCQA

NQF Endorsement ID: 0055

Description: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Data Source(s): Administrative Data and Hybrid

---

**Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)**

Measure Steward: NCQA

NQF Endorsement ID: 0575

Description: The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.

Data Source(s): Administrative and Hybrid

---

**Measure Name: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing**

Measure Steward: NCQA

NQF Endorsement ID: 0057

Description: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

Data Source(s): Administrative and Hybrid

---

**Measure Name: Comprehensive Diabetes Care: Medical Attention for Nephropathy**

Measure Steward: NCQA

NQF Endorsement ID: 0062

Description: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or monitoring test or had evidence of nephropathy during the measurement year.

Data Source(s): Administrative Data and Hybrid

---

**Measure Name: Controlling High Blood Pressure**

Measure Steward: NCQA

NQF Endorsement ID: 0018

Description: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg

**Note:** A single rate is reported and is the sum of all three groups.

Data Source(s): Hybrid Method must be used

---

**Measure Name: Cultural Competence**

Measure Steward: AHRQ, CMS

NQF Endorsement ID: Not Endorsed

Description: Enrollee experience related to the following:

- How often got an interpreter
- Forms available in preferred language
- Forms available in preferred format, such as large print or braille

**Note:** How often got an interpreter includes American Sign Language

Data Source(s): QHP Enrollee Survey

---

**Measure Name: 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 an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.

Data Source(s): Administrative Data

---

**Measure Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

Measure Steward: NCQA

NQF Endorsement ID: 0004

Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

- *Initiation of AOD Treatment.* The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
- *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

Data Source(s): Administrative Data

---

**Measure Name: 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: Prenatal and Postpartum Care**

Measure Steward: NCQA

NQF Endorsement ID: 1517

Description: The percentage of deliveries of live births 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 or within 42 days of enrollment in the organization
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery

Data Source(s): Administrative and Hybrid

---

**Measure Name: Proportion of Days Covered**

Measure Steward: PQA

NQF Endorsement ID: 0541

Description: The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement period. Report a rate for the following: Diabetes All Class, Renin Angiotensin System (RAS) Antagonists, and Statins.

Data Source(s): Administrative Data

---

**Measure Name: Rating of All Health Care**

Measure Steward: AHRQ

NQF Endorsement ID: 0006

Description: Enrollee experience related to the following:

- Rating of all health care

Data Source(s): QHP Enrollee Survey

---

**Measure Name: Rating of Health Plan**

Measure Steward: AHRQ

NQF Endorsement ID: 0006

Description: Enrollee experience related to the following:

- Rating of health plan

Data Source(s): QHP Enrollee Survey

---

**Measure Name: Rating of Personal Doctor**

Measure Steward: AHRQ

NQF Endorsement ID: 0006

Description: Enrollee experience related to the following:

- Rating of personal doctor

Data Source(s): QHP Enrollee Survey

---

**Measure Name: Rating of Specialist**

Measure Steward: AHRQ

NQF Endorsement ID: 0006

Description: Enrollee experience related to the following:

- Rating of specialist

Data Source(s): QHP Enrollee Survey

---

**Measure Name: Relative Resource Use for People with Diabetes (Inpatient Facility)**

Measure Steward: NCQA

NQF Endorsement ID: 1557

Description: The relative resource use by members with diabetes during the measurement year.

Data Source(s): Administrative Data

---

**Measure Name: Use of Imaging Studies for Low Back Pain**

Measure Steward: NCQA

NQF Endorsement ID: 0052

Description: The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Data Source(s): Administrative Data

---

|                      |   |
|----------------------|---|
| <b>Measure Name:</b> | <b>Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents</b>  |
| Measure Steward:     | NCQA  |
| NQF Endorsement ID:  | 0024  |
| Description:         | The percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> <li>• Body mass index (BMI) percentile documentation</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul> |
| Data Source(s):      | Administrative and Hybrid   |

|                      |  |
|----------------------|--|
| <b>Measure Name:</b> | <b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>  |
| 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  |

## MEASURES FIRST REQUIRED FOR REPORTING IN 2016

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

|                      |   |
|----------------------|---|
| <b>Measure Name:</b> | <b>Antidepressant Medication Management</b>   |
| Measure Steward:     | NCQA  |
| NQF Endorsement ID:  | 0105  |
| Description:         | The percentage of members 18 years of age and older who had a diagnosis of major depression, and were treated with antidepressant medication and remained on an antidepressant medication treatment. Two rates are reported: <ol style="list-style-type: none"> <li>1. <i>Effective Acute Phase Treatment.</i> The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)</li> <li>2. <i>Effective Continuation Phase Treatment.</i> The percentage of members who remained on an antidepressant medication for at least 180 days (6 months)</li> </ol> |
| Data Source(s):      | Administrative Data   |

**Measure Name: Aspirin Use and Discussion**

Measure Steward: NCQA

NQF Endorsement ID: Not Endorsed

Description: The two components of this measure assess different facets of aspirin use management.

- *Aspirin Use.* A rolling average represents the percentage of members who are currently taking aspirin. A single rate is reported for which the denominator includes:
  - Women 56–79 years of age with at least two risk factors for cardiovascular disease
  - Men 46–65 years of age with at least one risk factor for cardiovascular disease
  - Men 66–79 years of age, regardless of risk factors
- *Discussing Aspirin Risks and Benefits.* A rolling average represents the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. A single rate is reported for which the denominator includes:
  - Women 56–79 years of age
  - Men 46–79 years of age

Data Source(s): QHP Enrollee Survey

---

**Measure Name: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**

Measure Steward: NCQA

NQF Endorsement ID: 0058

Description: The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

The measure is reported as an inverted rate  $[1 - (\text{numerator}/\text{eligible population})]$ . A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were *not* prescribed).

Data Source(s): Administrative Data

---

**Measure Name: Breast Cancer Screening**

Measure Steward: NCQA

NQF Endorsement ID: 2372

Description: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Data Source(s): Administrative Data

---

**Measure Name: 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 (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”).

|                      |  |
|----------------------|--|
| <b>Measure Name:</b> | <b>Childhood Immunization Status (Combination 3)</b> |
| Data Source(s):      | Administrative and Hybrid                            |

|                      |  |
|----------------------|--|
| <b>Measure Name:</b> | <b>Colorectal Cancer Screening</b>   |
| 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  |

|                      |  |
|----------------------|--|
| <b>Measure Name:</b> | <b>Follow-Up Care for Children Prescribed ADHD Medication</b>  |
| Measure Steward:     | NCQA   |
| NQF Endorsement ID:  | 0108   |
| Description:         | <p>The percentage of children newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:</p> <ul style="list-style-type: none"> <li>• <i>Initiation Phase.</i> 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</li> <li>• <i>Continuation and Maintenance (C&amp;M) Phase.</i> 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</li> </ul> |
| Data Source(s):      | Administrative Data  |

|                      |  |
|----------------------|--|
| <b>Measure Name:</b> | <b>Human Papillomavirus Vaccination for Female Adolescents</b>   |
| Measure Steward:     | NCQA   |
| NQF Endorsement ID:  | 1959   |
| Description:         | The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. |
| Data Source(s):      | Administrative and Hybrid  |

|                      |   |
|----------------------|---|
| <b>Measure Name:</b> | <b>Immunizations for Adolescents (Combination 1)</b>  |
| Measure Steward:     | NCQA  |
| NQF Endorsement ID:  | 1407  |
| Description:         | The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate. |
| Data Source(s):      | Administrative and Hybrid   |

**Measure Name: Medical Assistance With Smoking and Tobacco Use Cessation**

Measure Steward: NCQA

NQF Endorsement ID: 0027

Description: The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

- *Advising Smokers and Tobacco Users to Quit*: A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.
- *Discussing Cessation Medications*: A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- *Discussing Cessation Strategies*: A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.

Data Source(s): QHP Enrollee Survey

---

**Measure Name: Medication Management for People With Asthma (75% of Treatment Period)**

Measure Steward: NCQA

NQF Endorsement ID: 1799

Description: The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. One rate is reported:

- The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period

Data Source(s): Administrative Data

---

**Measure Name: Plan All-Cause Readmissions**

Measure Steward: NCQA

NQF Endorsement ID: 1768

Description: For members 18-64 years of age, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator)
- Count of 30-Day Readmissions (numerator)
- Average Adjusted Probability of Readmission

Data Source(s): Administrative Data

---

**Measure Name: Well-Child Visits in the First 15 Months of Life (6 or More Visits)**

Measure Steward: NCQA

NQF Endorsement ID: 1392

Description: The percentage of patients who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

Data Source(s): Administrative Data

---

## Appendix C. QRS Hierarchy

The table below illustrates the QRS hierarchy, which is the organization of measures into composites, domains, summary indicators, and, ultimately, a single global rating.

Exhibit 10. QRS Hierarchy

| QRS Summary Indicator       | QRS Domain             | QRS Composite  | Measure Title   | NOF ID   |      |
|-----------------------------|------------------------|--|---|--|------|
| Clinical Quality Management | Clinical Effectiveness | Asthma Care  | Medication Management for People With Asthma (75% of Treatment Period)                            | 1799   |      |
|                             |                        |  | Behavioral Health   | Antidepressant Medication Management                       | 0105 |
|                             |                        | Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)     |   | 0576   |      |
|                             |                        | Follow-Up Care for Children Prescribed ADHD Medication                   |   | 0108   |      |
|                             |                        | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |   | 0004   |      |
|                             |                        | Cardiovascular Care  |   | Controlling High Blood Pressure                            | 0018 |
|                             |                        |  | Proportion of Days Covered (RAS Antagonists)  | 0541   |      |
|                             |                        |  | Proportion of Days Covered (Statins)  | 0541   |      |
|                             |                        | Diabetes Care  | Comprehensive Diabetes Care: Eye Exam (Retinal) Performed   | 0055   |      |
|                             |                        |  | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)                               | 0575   |      |
|                             |                        |  | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing                                       | 0057   |      |
|                             |                        |  | Comprehensive Diabetes Care: Medical Attention for Nephropathy                                    | 0062   |      |
|                             |                        |  | Proportion of Days Covered (Diabetes All Class)   | 0541   |      |
|                             |                        | Patient Safety   | Patient Safety  | Annual Monitoring for Patients on Persistent Medications   | 2371 |
|                             |                        |  |   | Plan All-Cause Readmissions                                | 1768 |
|                             |                        | Prevention   | Checking for Cancer   | Breast Cancer Screening                                    | 2372 |
|                             |                        |  |   | Cervical Cancer Screening                                  | 0032 |
|                             |                        |  |   | Colorectal Cancer Screening                                | 0034 |
|                             |                        |  | Maternal Health   | Prenatal and Postpartum Care (Postpartum Care)             | 1517 |
|                             |                        |  |   | Prenatal and Postpartum Care (Timeliness of Prenatal Care) | 1517 |
|                             | Staying Healthy Adult  |  | Adult BMI Assessment  | Not Endorsed   |      |
|                             |                        |  | Chlamydia Screening in Women  | 0033   |      |
|                             |                        |  | Aspirin Use and Discussion  | Not Endorsed   |      |
|                             |                        |  | Flu Vaccinations for Adults Ages 18-64  | 0039   |      |
|                             |                        |  | Medical Assistance With Smoking and Tobacco Use Cessation   | 0027   |      |
|                             | Staying Healthy Child  |  | Annual Dental Visit   | Not Endorsed   |      |
|                             |                        |  | Childhood Immunization Status (Combination 3)   | 0038   |      |
|                             |                        |  | Human Papillomavirus Vaccination for Female Adolescents   | 1959   |      |
|                             |                        |  | Immunizations for Adolescents (Combination 1)   | 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   |      |

| QRS Summary Indicator                        | QRS Domain  | QRS Composite                        | Measure Title   | NQF ID       |
|--|---|--------------------------------------|---|--------------|
| Enrollee Experience                          | Access  | Access to Care                       | Access to Care  | Not Endorsed |
|  | Care Coordination   | Care Coordination                    | Care Coordination   | Not Endorsed |
|  | Doctor and Care   | Doctor and Care                      | Cultural Competence   | Not Endorsed |
|  |   |                                      | Rating of All Health Care   | 0006         |
|  |   |                                      | Rating of Personal Doctor   | 0006         |
|  | Rating of Specialist  | 0006                                 |   |              |
| Plan Efficiency, Affordability, & Management | Efficiency & Affordability  | Efficient Care                       | Appropriate Testing for Children With Pharyngitis                   | 0002         |
|  |   |                                      | Appropriate Treatment for Children With Upper Respiratory Infection | 0069         |
|  |   |                                      | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis   | 0058         |
|  |   |                                      | Use of Imaging Studies for Low Back Pain                            | 0052         |
|  | Plan Service  | Enrollee Experience with Health Plan | Access to Information   | Not Endorsed |
|  |   |                                      | Plan Administration   | Not Endorsed |
|  |   |                                      | Rating of Health Plan   | 0006         |
|  | <b>Collected but not included for purposes of QRS scores or ratings</b> |                                      |   |              |
| N/A  | N/A   | N/A                                  | Relative Resource Use for People with Diabetes (Inpatient Facility) | 1557         |

## Appendix D. Process for Calculating QRS Scores and Ratings

This appendix describes in detail the process for calculating QRS scores and ratings, which is summarized in Section 7.3. The information described below reflects the draft QRS rating methodology. Pending the results of the 2015 beta test data analysis, CMS will finalize the rating methodology and release it in a subsequent version of the 2016 Guidance.

### STEP 1: PREPARE DATA FOR SCORING

Prior to scoring, CMS will prepare the available measure data<sup>38</sup> by averaging each measure's indicators (for measures with two or more indicators or rates), and then determining whether each measure's results can be included in QRS scoring, based on the measure's denominator size. The two steps include the following details:

#### 1. Average the measure's indicators to create the measure score.

Several QRS measures are comprised of two or more indicators (or QHP Enrollee Survey questions, in this case). For the QRS clinical measures, CMS will use a weighted average method (see equation below) to average each measure's individual indicator rates and calculate a measure score. Indicators with larger denominators will contribute more to the scoring than indicators with smaller denominators.

Exhibit 11 below lists QRS clinical measures that are composed of multiple indicators and the weighting approach used for these indicators. Most measures are scored using the weighted average method, where the "weights" are based on the respective denominator sizes. The exception is for two measures, Prenatal and Postpartum Care and Proportion of Days Covered, whose indicators are treated as unique measures.

Exhibit 11. QRS Measures with Multiple Indicators with Weighted Average Scores

| Measure  | Indicator  | Weighting Approach  |
|--|--|---|
| Annual Monitoring for Patients on Persistent Medications | Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs) | Three indicators combined as weighted averages to create the measure score. |
|  | Digoxin  |   |
|  | Diuretics  |   |
| Antidepressant Medication Management                     | Effective Acute Phase Treatment  | Two indicators combined as weighted averages to create the measure score.   |
|  | Effective Continuation Phase Treatment   |   |
| Chlamydia Screening in Women                             | 16-20 Years  | Two indicators combined as weighted averages to create the measure score.   |
|  | 21-24 Years  |   |

<sup>38</sup> CMS will issue future guidance on how non-reportable measure data, including instances where data are materially biased or a QHP issuer does not report measure data, will be handled for QRS scoring.

| Measure   | Indicator                                      | Weighting Approach  |
|---|--|---|
| Follow-Up Care for Children Prescribed ADHD Medication  | Initiation Phase                               | Two indicators combined as weighted averages to create the measure score.   |
|   | Continuation and Maintenance (C&M) Phase       |   |
| Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence                              | Initiation of AOD Treatment                    | Two indicators combined as weighted averages to create the measure score.   |
|   | Engagement of AOD Treatment                    |   |
| Prenatal and Postpartum Care  | Timeliness of Prenatal Care                    | Two indicators will be treated as two distinct measures. Each will be weighted equally alongside each other to form the composite score.                              |
|   | Postpartum Care                                |   |
| Proportion of Days Covered  | Diabetes All Class                             | Three indicators will be treated as three distinct measures. Each will be weighted equally alongside the measures within their composite to form the composite score. |
|   | Renin Angiotensin System (RAS) Antagonists     |   |
|   | Statins  |   |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents | Body Mass Index (BMI) Percentile Documentation | Three indicators combined as weighted averages to create the measure score.   |
|   | Counseling for Nutrition                       |   |
|   | Counseling for Physical Activity               |   |

The weighted average equation is as follows:

$$X = \frac{\sum_1^i n_i * x_i}{\sum_1^i n_i}$$

where X is the final measure score that is the weighted average, x<sub>i</sub> is the indicator score, and n<sub>i</sub> is the indicator denominator. Exhibit 12 shows an example of this weighted average calculation for a measure score.

Exhibit 12. Example of Weighted Average of Indicator Scores

| Name of Indicator/Measure   | Example Denominator Size | Example Score |
|---|--------------------------|---------------|
| ACE Inhibitors or ARBs (Indicator)  | 100                      | 0.40          |
| Digoxin (Indicator)   | 200                      | 0.60          |
| Diuretics (Indicator)   | 150                      | 0.50          |
| <b>Annual Monitoring for Patients on Persistent Medications (Measure)</b> | <b>450</b>               | <b>0.52</b>   |

$$\begin{aligned} \text{Annual Monitoring for Patients on Persistent Medications} &= \\ &= \frac{((\text{ACE Inhibitors or ARBs} * \text{Denominator}) + \\ &+ (\text{Digoxin} * \text{Denominator}) + (\text{Diuretics} * \text{Denominator}))}{\text{Total Denominator}} \\ &= \frac{((0.40 * 100) + (0.60 * 200) + (0.50 * 150))}{450} = \frac{235}{450} = 0.52 \end{aligned}$$

Several of the QRS survey measures are also composed of two or more indicators (or QHP Enrollee Survey questions, in this case). For these CAHPS®-based measures, questions that assess similar topics will be grouped together to form a single QRS measure to simplify the interpretation of the data and enhance the reliability of the results. In keeping with this CAHPS® framework, a number of QRS measures that are based on the QHP Enrollee Survey response data will be formed by combining two or more survey indicators (e.g., see the Access to Care measure in Appendix B). The individual indicator values will be averaged to create the measure score. CMS will determine the weighting approach to be used for QRS survey measure indicators (based on the QHP Enrollee Survey) once 2015 beta test data have been analyzed.

**2. Determine if the measure’s denominator size is sufficient for including the measure in scoring.**

While QHP issuers will submit measure data to CMS regardless of denominator size, measures with an insufficient denominator size will be excluded from QRS scoring. QHP issuers that do not meet the minimum denominator size requirement for a measure will not receive a score for that measure. CMS will establish the minimum denominator size in 2015, when beta test data are available, and will publish these details in future technical guidance.

CMS will determine for all QHP issuers if their respective measure’s denominator size meets the minimum denominator size criteria for QRS scoring.

For measures with multiple indicators, CMS anticipates making this determination based on the maximum denominator size among the measure’s indicators. For example, the Follow-up Care for Children Prescribed ADHD Medication measure has two indicators. If the Initiation Phase indicator’s denominator is 50 enrollees, and the Continuation and Maintenance Phase indicator’s denominator is 25 enrollees, CMS will reference the denominator size of 50 to determine whether the measure can be used for QRS scoring.

Exhibit 13 shows examples of how QRS scoring could be affected by observed denominator sizes in comparison to a minimum denominator size requirement of 30.

**Exhibit 13. Example of Observed Denominator Size in Comparison to a Hypothetical Minimum Denominator Size Requirement**

| Measure | Measure’s Observed Denominator Size   | Hypothetical Minimum Denominator Size Required for Inclusion in QRS Scoring | Measure Included in QRS Scoring? |
|---------|---|---|----------------------------------|
| A       | 45  | 30  | Yes                              |
| B       | 30  | 30  | Yes                              |
| C       | 20  | 30  | No                               |
| D       | 50 for indicator X<br>25 for indicator Y<br>(assume the maximum denominator size of 50) | 30  | Yes                              |

## STEP 2: STANDARDIZE MEASURE SCORES

CMS will standardize measure scores by calculating national percentile ranks<sup>39</sup> before calculating composite and higher-level QRS component scores. For each measure with a reportable rate, CMS will use the calculable QHP product's rate to create national percentile ranks. QRS percentile ranks will be based on one national, all-product reference group. For example, across all products (e.g., HMOs), CMS will take all rates for the Cervical Cancer screening measure and rank them using the distribution of values. A QHP issuer's HMO product with a rate that corresponds to the 50<sup>th</sup> percentile among all product types receives a Cervical Cancer Screening score of 50. National standardization helps consumers compare the QRS ratings for QHPs offered through the Marketplaces using a uniform standard. CMS intends to provide the national percentile ranks each year, so QHP issuers may use them to calculate their own standardized measure scores.

## STEP 3: CALCULATE COMPOSITE SCORES AND RATINGS

Composites, like all other QRS components (i.e., domains, summary indicators, and global), are calculated using equally weighted score averages. CMS will calculate composite scores and ratings based on combinations of standardized QRS measure scores. The steps include:

1. **Determine if the composite score can be calculated.** CMS will use a *half-scale rule* to determine if each composite score can be calculated. The half-scale rule indicates that only if at least half of the associated measures in the composite have a score, the composite can be calculated. Otherwise, the composite cannot be calculated and will not reflect a score.
2. **Calculate the composite score.** CMS will average the associated and available measure scores with equal weighting. Exhibit 14 includes an example of how the Cardiovascular Care composite will be calculated from three measure scores.

Exhibit 14. Example Composite Score Calculation

| Measure   | Example Score<br>(Standardized Measure Percentile Rank) |
|---|---|
| Controlling High Blood Pressure   | 30  |
| Proportion of Days Covered (RAS Antagonists)  | 90  |
| Proportion of Days Covered (Statins)  | 60  |
| <b>Cardiovascular Care Composite Score (Average of Available Measure Scores, Not a Percentile Rank)</b> | <b>60</b>   |

<sup>39</sup> To standardize measure scores, CMS will use SAS PROC RANK with the number of groups fixed at 100. CMS will exclude measures that do not meet the minimum denominator criterion before calculating percentile ranks. This approach calculates the rank as  $n / (N+1)$ , where  $n$  is the QHP's position in the rank order and  $N$  is the number of QHPs with calculable data. The SAS PROC UNIVARIATE procedure, with percentile definition 4 (PCTLDEF=4), is an alternative method that will produce equivalent results.

$$\begin{aligned} & \text{Cardiovascular Care} = \\ & \frac{(\text{Controlling High Blood Pressure} + \text{Proportion of Days Covered (RAS Antagonists)} + \\ & \quad \text{Proportion of Days Covered (Statins)})}{3} \\ & = \frac{(30 + 90 + 60)}{3} = 60 \end{aligned}$$

Composite scores (and all component scores) are averages of percentile ranks; they are not percentile ranks. A composite score value of 60, for example in Exhibit 14, means “this QHP has an average percentile rank of 60 based on the measure scores for this composite.” It does not mean “this QHP is at the 60<sup>th</sup> percentile rank for this composite.”

3. **Convert the composite score to a rating.** Using *non-standardized* composite scores, CMS will convert each composite score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5. The distribution of composite scores are each divided into rating categories for display on a star scale that ranges from 1 star to 5 stars. CMS will determine the score value cut points to create the rating categories based on 2015 beta test data. No fixed percent of QHPs will have any individual star rating. See Exhibit 15 for the score and rating classifications using example score value cut points.

Exhibit 15. Conversion of a Component Score to a Rating

| Example Score Value Cut Points | Categorical Rating |
|--------------------------------|--------------------|
| 0 < Score Value < 25           | 1 ★                |
| 25 ≤ Score Value < 50          | 2 ★★               |
| 50 ≤ Score Value < 75          | 3 ★★★              |
| 75 ≤ Score Value < 90          | 4 ★★★★             |
| 90 ≤ Score                     | 5 ★★★★★            |

CMS will use a five-category scale, as it provides a reasonable balance of appropriate precision with minimal misclassification. Setting score value cut points for categorical ratings balances the desire for granular categories against the risk of misclassification. For example, QRS component scores may not be sufficiently reliable to discriminate QHPs’ performances when using a larger number of categories (e.g., 10 categories) to achieve finer demarcations for the levels of performance (e.g., QHPs within the 7<sup>th</sup> category versus QHPs within the 8<sup>th</sup> category). If there are several small categories or ranges applied, the QRS would be susceptible to QHPs shifting categories from year to year, even if the QHPs’ true performances were relatively stable each year.

#### STEP 4: CALCULATE DOMAIN SCORES AND RATINGS

CMS will calculate domain scores and ratings based on equally weighted, non-standardized composite score averages. CMS will take similar types of steps used with composite calculations. The steps include:

- **Determine whether the domain score can be calculated.** CMS will use a *half-scale rule* to determine if each domain score can be calculated. The half-scale rule indicates that only if half or more of the associated composites have a score, the domain score can

be calculated. Otherwise, the domain score cannot be calculated and will not reflect a score.

- **Calculate the domain score.** CMS will average the available composite scores using equal weighting as shown in Exhibit 16.

Exhibit 16. Example Domain Score Calculation

| Composite   | Example Score <sup>40</sup><br>(Average of Available Measure Scores) |
|---|--|
| Checking for Cancer   | 20   |
| Maternal Health   | 40   |
| Staying Healthy Adult   | 80   |
| Staying Healthy Child   | 60   |
| <b>Prevention Domain Score (Average of Available Composite Scores, Not a Percentile Rank)</b> | <b>50</b>  |

$$\begin{aligned} \text{Prevention} &= \\ \text{Checking for Cancer} + \text{Maternal Health} + \text{Staying Healthy Adult} + \text{Staying Healthy Child} \\ &= \frac{20 + 40 + 80 + 60}{4} = 50 \end{aligned}$$

- **Convert the domain score to a rating.** As with all component scores, the domain scores will not be standardized before being converted into a rating. Also, CMS will use the same cut point values (used for previous component scoring) to create domain ratings. No fixed percent of QHPs will have any individual star rating.

Example: The domain score of 50 for Prevention in Exhibit 16 lies within the limits of the third category in Exhibit 15 ( $50 \leq \text{Score Value} < 75$ ) and converts to a 3-star rating (★★★).

## STEP 5: CALCULATE SUMMARY INDICATOR SCORES AND RATINGS

CMS will calculate summary indicator scores and ratings based on equally weighted, non-standardized domain score averages (not domain ratings). CMS will take similar types of steps used with domain calculations. The steps include:

1. **Determine whether the summary indicator score can be calculated.** CMS will use a *full-scale rule* to determine whether the summary indicator score can be calculated. The rule indicates that only if all of the associated domain scores for a summary indicator are present, the summary indicator score is calculated. Otherwise, the summary indicator score cannot be calculated and will not reflect a score.
2. **Calculate the summary indicator score.** CMS will average the available domain scores using equal weighting as shown in Exhibit 17.

<sup>40</sup> Composite scores are not standardized before averaging.

Exhibit 17. Example Summary Indicator Score Calculation

| Domain   | Example Score<br>(Average of Available Composite Scores) |
|--|--|
| Access   | 65   |
| Care Coordination  | 50   |
| Doctor and Care  | 35   |
| <b>Enrollee Experience Summary Indicator Score<br/>(Average of Available Domain Scores, Not a Percentile Rank)</b> | <b>50</b>  |

$$\begin{aligned} \text{Enrollee Experience} &= \\ &= \frac{\text{Access} + \text{Care Coordination} + \text{Doctor and Care}}{3} \\ &= \frac{65 + 50 + 35}{3} = 50 \end{aligned}$$

- Convert the summary indicator score to a rating.** As with all component scores, the summary indicator scores will not be standardized before being converted into a rating. CMS will also use the same cut point values (used for previous component scoring) to create summary indicator ratings. No fixed percent of QHPs will have any individual star rating.

Example: The Enrollee Experience summary indicator score of 50 in Exhibit 16 lies within the limits of the third category in Exhibit 15 ( $50 \leq \text{Score Value} < 75$ ) and converts to a 3-star rating (★★★).

## STEP 6: CALCULATE GLOBAL SCORE AND RATING

CMS will calculate the global score and rating based on equally weighted, non-standardized summary indicator score averages (not summary indicator ratings). CMS will take similar types of steps used with summary indicator calculations. The steps include:

- Determine whether the global score can be calculated.** CMS will use a *full-scale rule* to determine whether the global score can be calculated. The rule indicates that only if all of the associated summary indicator scores are present, the global score is calculated. Otherwise, the global score cannot be calculated and will not reflect a score.
- Calculate the global score.** CMS will average the available summary indicator scores using equal weighting as shown in Exhibit 18.

Exhibit 18. Example Global Score Calculation

| Summary Indicator  | Example Score<br>(Average of Available Domain Scores) |
|--|---|
| Clinical Quality Management  | 65  |
| Enrollee Experience  | 35  |
| Plan Efficiency, Affordability, and Management                                   | 50  |
| <b>Global Score (Average of Summary Indicator Scores, Not a Percentile Rank)</b> | <b>50</b>   |

$$\begin{aligned} \text{Global Score} &= \\ & \frac{\text{Clinical Quality Management} + \text{Enrollee Experience} + \\ & \quad \text{Plan Efficiency, Affordability, and Management}}{3} \\ &= \frac{65 + 35 + 50}{3} = 50 \end{aligned}$$

- 3. Convert the global score to a rating.** As with all component scores, the global score will not be standardized before being converted into a global rating. CMS will also use the same cut point values (used for previous component scoring) to create a global rating. No fixed percent of QHPs will have any individual star rating.

Example: The global score of 50 in Exhibit 18 lies within the limits of the third category in Exhibit 13 ( $50 \leq \text{Score Value} < 75$ ) and converts to a 3-star rating (★★★).

## Appendix E. Glossary

The table below includes definitions for key terms used in this document.

| Term   | Definition  |
|--|---|
| <b>Administrative data collection method</b>   | 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.  |
| <b>Average</b>                                 | A single value obtained by adding several quantities together and then dividing this total by the number of quantities.   |
| <b>Benefit Not Offered (NB)</b>                | Data validation result assigned for a measure if the QHP issuer did not offer the health benefit required by the measure.   |
| <b>Biased Rate (BR)</b>                        | Data validation result assigned for a measure if the QHP issuer's calculated rate was materially biased.  |
| <b>Component</b>                               | 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.   |
| <b>Composite</b>                               | 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 question items (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.   |
| <b>Cut point</b>                               | 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.   |
| <b>Continuous score</b>                        | An integer of the numerical value. Numbers do not represent ranks (relative position) or categories.  |
| <b>Data validation</b>                         | A process by which an independent third party validates a QHP issuer's QRS measure data, including their data systems and processes. The data validator will verify completeness, accuracy, and comparability of the measure results. For 2016, CMS requires QHP issuers to contract with a HEDIS® Compliance Organization (National Committee for Quality Assurance [NCQA]-licensed). A HEDIS® Compliance Auditor, employed or contracted by that organization, will validate all QRS clinical measure results and the sampling frame for the QHP Enrollee Survey using the HEDIS Compliance Audit™ standards, policies, and procedures. |
| <b>Data validator</b>                          | An independent third party that validates the QRS clinical measure data and the sampling frame for the QHP Enrollee Survey prior to data submission. For 2016, QHP issuers must contract with a HEDIS® Compliance Auditor, who will serve as the data validator.  |
| <b>Domain</b>                                  | A component of the QRS hierarchy. A score for this component is created by combining scores from associated composites.   |
| <b>Exclusive Provider Organization (EPO)</b>   | 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.   |
| <b>Federally-facilitated Marketplace (FFM)</b> | The Marketplace model operated by HHS for individual and small group market coverage. For QHP issuers operating in the FFMs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov alongside other QHP information to inform consumers.   |

| Term   | Definition  |
|--|---|
| <b>Full-scale rule</b>   | 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.   |
| <b>Global</b>  | A component of the QRS hierarchy. A score or rating for this component is created by combining scores from summary indicators.  |
| <b>Half-scale rule</b>   | 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.   |
| <b>Health Insurance Marketplace (Marketplace)</b>                                  | A resource in each state where qualified individuals, families, and small businesses can learn about their health insurance options; compare QHPs based on quality, costs, benefits, and other important features; choose a QHP; and enroll in coverage. In some states, the Marketplace is operated by the state. In others, it is operated by the federal government.   |
| <b>Health Maintenance Organization (HMO)</b>                                       | 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.   |
| <b>HealthCare.gov</b>  | The consumer-facing website developed and operated by CMS/CCIIO that provides eligibility information, enrollment instructions, and QHP information for consumers looking to enroll in a health insurance plan through the FFMs. QRS ratings for QHP issuers operating in both the FFMs and states performing plan management functions will be displayed on HealthCare.gov to support consumers as they search for and enroll in a QHP.  |
| <b>Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™</b> | 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 <i>HEDIS Compliance Audit: Standards, Policies, and Procedures</i> that is available for purchase can be accessed at the following link: <a href="http://store.ncqa.org/index.php/performance-measurement.html">http://store.ncqa.org/index.php/performance-measurement.html</a> |
| <b>HEDIS® Compliance Auditor</b>   | An individual certified by NCQA to validate QRS clinical measure data and the QHP Enrollee Survey sampling frame using the standardized HEDIS Compliance Audit™ program.  |
| <b>Hybrid data collection method</b>   | Uses data obtained from both administrative and medical record/ electronic medical record sources to identify the eligible population and numerator compliance. The denominator consist of a systematic sample of enrollees drawn from the measure's eligible population. QHP issuers then: a) review administrative data to determine numerator compliance, and b) review medical record data for enrollees who do not meet numerator criteria based on administrative data, in order to identify additional numerator compliance for the measure. Details on the collection method are included in a measure's technical specifications (see <i>2016 Quality Rating System Measure Technical Specifications</i> ).              |
| <b>Indicator</b>   | A rate that forms a measure. Some QRS measures have multiple indicators.  |
| <b>Interactive Data Submission System (IDSS)</b>                                   | 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.   |
| <b>Measure</b>   | 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).   |

| Term   | Definition   |
|--|--|
| <b>Multi-State Plan (MSP)</b>  | A Multi-State Plan (MSP) is a private health insurance plan offered through the Marketplaces under contract with the Office of Personnel Management (OPM). MSP options are recognized as QHPs, per 45 CFR 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. |
| <b>National Committee for Quality Assurance (NCQA)</b>   | The organization that developed and maintains the system through which QHP issuers will submit validated QRS clinical measure data to CMS, the Interactive Data Submission System (IDSS).<br>NCQA is the measure steward for HEDIS® measures. NCQA also manages the HEDIS Compliance Audit™ program.   |
| <b>National Quality Forum (NQF)</b>  | 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.  |
| <b>National Quality Strategy (NQS)</b>   | Mandated by the Patient Protection and Affordable Care Act, the National Quality Strategy (NQS) was first published in March 2011. The NQS established a set of three overarching aims that builds on the Institute for Healthcare Improvement's Triple Aim®, supported by six priorities that address the most common health concerns that Americans face.  |
| <b>Not Applicable (NA)</b>   | 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.   |
| <b>Not Reported (NR)</b>   | Data validation result assigned for a measure if the QHP issuer chose not to report the measure rate.  |
| <b>Office of Personnel Management (OPM)</b>  | OPM administers the Federal Employees Health Benefits (FEHB) Program. The Affordable Care Act directs OPM to contract with private health insurers in each state to offer high-quality, affordable health insurance options (Multi-State Plan options) through the Multi-State Plan (MSP) Program to drive competition and choice in the Marketplaces.   |
| <b>Pharmacy Quality Alliance (PQA)</b>   | The measure steward for the Proportion of Days Covered (PDC) measure.  |
| <b>Point of Service (POS)</b>  | 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.   |
| <b>Preferred Provider Organization (PPO)</b>   | 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).  |
| <b>Product type</b>  | 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.  |
| <b>2016 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications</b> | A document published on <a href="http://qhpcahps.cms.gov">http://qhpcahps.cms.gov</a> that includes detailed specifications and protocols for HHS-approved survey vendors to conduct the QHP Enrollee Survey.  |

| Term  | Definition   |
|---|--|
| <b>QHP Enrollee Survey score</b>  | 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 item or a combination of several items on a similar topic that are combined to form a single measure.  |
| <b>QHP Enrollee Survey vendor</b>   | 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.   |
| <b>QRS clinical measures</b>  | QRS measures calculated using clinical data from a QHP issuer's administrative and medical record sources.   |
| <b>QRS hierarchy</b>  | The organization of the QRS measures into information categories ranging from the most granular information (measure scores) to a global rating.   |
| <b>QRS rating methodology</b>   | The rules for combining measures and converting scores into performance ratings for the QRS.   |
| <b>QRS survey measures</b>  | QRS measures calculated using enrollee responses to a subset of specified questions in the QHP Enrollee Survey. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to the CMS Health Insurance Marketplace Quality Initiatives website ( <a href="https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system">https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system</a> )   |
| <b>Qualified Health Plan (QHP)</b>  | A health insurance plan that has in effect a certification that it meets the standards established by the Affordable Care Act and supporting regulation, issued or recognized by each Marketplace through which such plan is offered.  |
| <b>Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)</b> | A survey tool developed, as directed by the Affordable Care Act section 1311 (c)(4), that includes a comprehensive set of questions related to enrollee experience with their QHP offered through the Marketplace. CMS will use enrollee response data for a specified subset of the questions to calculate the QRS survey measures.   |
| <b>Qualified Health Plan (QHP) issuer</b>                                     | A health insurance issuer that offers a QHP in accordance with a certification from a Marketplace, as defined by 45 CFR § 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.   |
| <b>2016 Quality Rating System Measure Technical Specifications</b>            | A document published on the CMS Health Insurance Marketplace Quality Initiatives website ( <a href="http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html">http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html</a> ) that includes detailed measure specifications and general guidelines for QRS measure data collection. |
| <b>QHP quality rating information</b>   | Information that includes QRS scores and ratings, as well as QHP Enrollee Survey results.  |
| <b>Quality Rating System (QRS)</b>  | As directed by the Affordable Care Act section 1311 (c)(3), the Quality Rating System (QRS) is a system of rating QHPs offered through the Marketplace 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.  |
| <b>QRS rating</b>   | 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.   |
| <b>QRS score</b>  | A numerical value that indicates the level of QHP performance for QRS measures and hierarchy components (composites, domains, summary indicators, and global).<br>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.   |
| <b>Reference group</b>  | 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.   |

| Term   | Definition  |
|--|---|
| <b>Reporting unit</b>  | 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.   |
| <b>Standardized score</b>                                      | A rank value ranging from 0 to 99 that indicates the percentage of reporting 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. |
| <b>States performing plan management functions in the FFMs</b> | A hybrid Marketplace model in which a state operates plan management functions (and some also operate consumer assistance functions), while the remaining Marketplace functions are operated by HHS. For QHP issuers operating in states performing plan management functions in the FFMs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov.   |
| <b>State-based Marketplace (SBM)</b>                           | A Marketplace model in which a state operates its own Health Insurance Marketplace, for both the individual and small group markets. An SBM is responsible for certifying QHP issuers, overseeing QHP issuer compliance with federal Marketplace quality standards as a condition of certification, and, starting with the Open Enrollment Period for 2017 that begins in the fall of 2016, displaying QHP quality rating information to help consumers compare QHPs.                               |
| <b>Summary indicator</b>                                       | A component of the QRS hierarchy. A score for this component is created by combining scores from associated domains.  |
| <b>Summary-level measure data</b>                              | 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 <i>2016 Quality Rating System Measure Technical Specifications</i> , and include elements such as eligible population (denominator), numerator, and the rate.   |
| <b>Survey sampling frame</b>                                   | 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.  |
| <b>Unstandardized Score</b>                                    | The original, raw, measure score value.   |
| <b>Weighted average</b>  | An average that is calculated in which some data points (values) contribute more than others to the final average.  |