2015 Beta Test of the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2015

September 2014

Technical Assistance and Contact Information

The following links and contact information should be used to obtain additional details and technical assistance related to the 2015 beta test of the Quality Rating System (QRS) and the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) established under sections 1311(c)(3) and (c)(4) of the Patient Protection and Affordable Care Act.

Website Links

- Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html
- CMS QHP Enrollee Survey website: http://qhpcahps.cms.gov
- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audit™ website: http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx

Contact Information

- QRS and QHP Enrollee Survey implementation and reporting requirements: Exchange Operations Support Center (XOSC) Help Desk via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Please reference the "Marketplace Quality Initiative" or "MQI" when contacting the XOSC Help Desk.

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

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1. Document Purpose

This document provides technical guidance regarding the 2015 beta tests of the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey). It specifies QRS and QHP Enrollee Survey requirements for Qualified Health Plan (QHP) issuers offering coverage through the Health Insurance Marketplaces (Marketplaces).[2] The 2015 beta test of the QRS and QHP Enrollee Survey requirements outlined in this document are based on statute and CMS regulation, including the "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" Final Rule.[3] On or before December 1, 2014, CMS will post a summary of comments received on the draft QRS scoring specifications published in March 2014, including a summary of how CMS addressed the comments within this document.

The guidance primarily targets QHP issuers, but it also includes information relevant to other stakeholders involved with QRS and QHP Enrollee Survey implementation (e.g., State-based Marketplaces, third-party data validators and HHS-approved survey vendors). This document includes the following information:

- *Implementation schedule for the 2015 beta test of the QRS and QHP Enrollee Survey*: This section provides a snapshot of the 2015 implementation process, key dates, and the stakeholder(s) with primary responsibility for critical action(s).
- *Entities that must comply with QRS and QHP Enrollee Survey requirements*: This section outlines the criteria for determining which QHP issuers must collect and submit validated QRS and QHP Enrollee Survey data to the Centers for Medicare & Medicaid Services (CMS) (e.g., minimum enrollment size), and the level at which data must be collected. It also describes Marketplace responsibilities related to the QRS and QHP Enrollee Survey.
- *QRS and QHP Enrollee Survey requirements*: This section includes the QRS measure set, which includes a subset of measures from the QHP Enrollee Survey, in addition to clinical quality measures. This section details the requirements for data collection, data validation, and data submission for the QRS and the QHP Enrollee Survey.
- *QRS scoring specifications and rating methodology*: This section provides an overview of the scoring specifications and methodology that CMS will use to produce the QRS ratings for QHPs offered through the Marketplaces. It describes the statistical methods that will be applied and the process by which QRS scores and ratings will be calculated. This section is not intended to provide the level of detail necessary to replicate CMS' calculations; rather, this section is intended to provide transparent details about the methodology.
- *QRS and QHP Enrollee Survey data preview process*: This section describes the process by which QHP issuers and Marketplaces will be able to review QRS and QHP Enrollee Survey data and submit any inquiries to CMS related to the data.

[2] The references to "Marketplace" and/or "Marketplaces" in this document include Federally-facilitated Marketplaces (FFMs), State Partnership Marketplaces (SPMs), and State-Based Marketplaces (SBMs).
[3] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 FR 30240 at 30352 (May 27, 2014) (45 CFR Parts 144, 146, 147, et al.).

- *QHP quality rating information display and marketing use*: Marketplaces are required to display quality rating information[4] (i.e., QRS scores and ratings and QHP Enrollee Survey results) for the open enrollment period that begins in the fall of 2016. CMS does not plan on displaying quality rating information in 2015 for QHPs operating in SPMs and in the FFM. CMS would not require nor restrict a State-based Marketplace from posting this information on its website but would encourage inclusion of appropriate disclaimers to inform the consumer about the limitations of the beta test data, and that the results are part of a first year process improvement and quality rating development process. This section indicates that CMS will issue future guidance related to the display of quality rating information on Marketplace websites. CMS will also issue future guidance for QHP issuers related to the use of quality rating information in marketing materials.

2. Background

Section 1311(c)(3) of the Affordable Care Act[5] directs the Secretary of Health and Human Services (HHS) to develop a quality rating system for QHPs 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 system that will evaluate the level of enrollee satisfaction of members in QHPs offered through a Marketplace, for each QHP with more than 500 enrollees in the previous year.

Based on this authority, CMS issued a regulation in May of 2014 to establish standards and requirements related to QHP issuer data collection and public reporting of quality rating information in every Marketplace.[6] CMS requires that QHP issuers report this information for its QHPs offered through a Marketplace as a condition of certification and participation in the Marketplaces.[7] Appendix A includes relevant statutory and regulatory citations for the QRS and QHP Enrollee Survey.

3. Overview

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

- To provide comparable and useful information regarding the quality of health care services and enrollee experience of QHPs offered through Marketplaces to inform consumers;
- To facilitate regulatory oversight of QHPs offered through Marketplaces with regard to the quality standards set forth in the Affordable Care Act; and
- To provide actionable information that QHP issuers can use to improve performance.

[4] Within this document, the term "quality rating information" refers to the QRS scores and ratings, and QHP Enrollee Survey results, collectively.
[5] 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. 111–309) (collectively referred to as the Affordable Care Act).
[6] 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.).
[7] 45 CFR § 156.200(b)(5); § 156.1120(a),(d); and § 156.1125(b),(e).

CMS aims to align 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.[8] States have the option to build upon the federal quality standards by setting additional standards for QHPs that reflect state priorities and population-based needs.

QHP issuers and Multi-State Plan (MSP) issuers[9] that offered coverage through a Marketplace in the previous 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.[10] SBMs are responsible for QHP certification in their respective Marketplaces and the Office of Personnel Management (OPM) is responsible for MSP certification in all Marketplaces. Therefore, SBMs and OPM must assist with oversight to ensure compliance with QRS and QHP Enrollee Survey requirements.

Using the validated QRS clinical measure data and a subset of the QHP Enrollee Survey response data (survey measures),[11] CMS will calculate quality ratings for each QHP offered through the Marketplaces. CMS will apply the QRS rating methodology to aggregate clinical measure data and survey response data to produce quality performance ratings on a 1- to 5- star rating scale.

For the 2015 beta test and in the initial years, CMS anticipates collecting data and calculating quality rating information for each QHP issuer's product type (e.g., Health Maintenance Organization [HMO]) and applying these ratings to each product's respective QHPs. CMS will explore data collection at a more granular level of QHP issuer coverage (e.g., HMO Bronze level) in the future, keeping in mind the need to balance the value of this information for consumers with QHP issuer data collection, validation, and reporting efforts.

CMS anticipates performing the following steps for the 2015 beta test, which may result in refinements to the QRS and QHP Enrollee Survey for 2016:

1. Test the distinct QRS phases including data collection, data validation, data submission, scoring and rating, and data preview.
2. Test survey vendor processes using the same specifications and conditions planned for the national implementation of the survey in 2016, repeat analyses from earlier psychometric testing to verify findings and check for effects of variation in survey methods, and calculate survey scores to provide input to the 2015 test of the QRS.
3. Refine the QRS scoring specifications and rating methodology using QHP issuer data.

[8] NQS was first published by the Agency for Healthcare Quality and Research (AHRQ) in March 2011 as the National Strategy for Quality Improvement in Health Care. It established a framework for coordinating quality improvement efforts of health care payers, purchasers, providers, and consumers. The NQS established a set of three overarching aims that builds on the Institute for Healthcare Improvement's Triple Aim®, supported by six priorities**.** See http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.htm for additional information.

[9] A Multi-State Plan, certified by and under contract with the U.S. Office of Personnel Management (OPM), is recognized as a QHP per 45 CFR §155.1010. Therefore, when describing requirements for "QHP issuers" within this document, it is assumed the same requirements apply to issuers offering MSPs, unless otherwise noted by the OPM in guidance issued to MSP issuers.

[10] 45 CFR § 156.200(b)(5); § 156.1120(a),(d); and § 156.1125(b),(e).

[11] 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.

Beginning in 2016, Marketplaces will be required to prominently display QHP quality rating information on their websites to help consumers compare QHPs.[12] The quality rating information will reflect the quality of health care services including health outcomes, enrollee experience, and accessibility of care.

CMS anticipates refining the QRS over time, based on its experience with measuring and reporting quality performance for QHPs offered through the Marketplaces. CMS also anticipates assessing the validity of questionnaire items and the effectiveness of survey procedures for the QHP Enrollee Survey each year to identify any needed improvements. CMS intends to propose modifications in a transparent manner with opportunities for the public to provide feedback. CMS anticipates issuing updated guidance annually to reflect any adjustments made to QRS and QHP Enrollee Survey requirements.

4. Implementation Schedule for 2015 Beta Test of the QRS and QHP Enrollee Survey

Exhibit 1 highlights key events and dates associated with 2015 QRS and QHP Enrollee Survey implementation. The initial year will serve as the "beta test" for both the QRS and the QHP Enrollee Survey; therefore, Marketplaces are not required to publicly display QHP quality rating information in 2015. Details are addressed in the sections that follow.

Exhibit 1. Implementation Schedule for 2015 Beta Test of the QRS and QHP Enrollee Survey

Event	Stakeholder Responsible	Date
Contract with a HEDIS Compliance Auditor for validation of the QHP Enrollee Survey sampling frame and of the QRS clinical measure data	QHP Issuer	September-December 2014
Contract with a HHS-approved QHP Enrollee Survey vendor to conduct the QHP Enrollee Survey and authorize the survey vendor to submit survey response data to HHS	QHP Issuer	October – December 2014
Complete QHP Enrollee Survey sampling frame validation	QHP Issuer, HEDIS Compliance Auditor	January 31, 2015
Complete the HEDIS Compliance Audit™	QHP Issuer, HEDIS Compliance Auditor	January – June 2015
Conduct the QHP Enrollee Survey, based on the validated survey sampling frame	HHS-approved QHP Enrollee Survey Vendor	February – April 2015
Submit the QHP Enrollee Survey response data to CMS (on behalf of the QHP issuer) via a secure data submission function on the QHP Enrollee Survey website (http://qhpcahps.cms.gov)	HHS-approved QHP Enrollee Survey Vendor	May 31, 2015
Submit the validated QRS clinical measure data to CMS via NCQA's Interactive Data Submission System (IDSS)	QHP Issuer	June 15, 2015
Preview the QRS and QHP Enrollee Survey data[13]	QHP Issuer, SBMs, CMS (on behalf of SPMs and FFMs)	Fall 2015

[12] 45 CFR § 155.1400 and §155.1405.

[13] In the fall of 2015, CMS will provide the referenced stakeholders with the opportunity to preview QRS scores and ratings and QHP Enrollee Survey results. CMS intends to submit the relevant QRS and QHP Enrollee Survey data extract for MSP issuers on an annual basis beginning in the summer of 2015, to OPM, the certifying authority for those issuers.

5. Entities that Must Comply with QRS and QHP Enrollee Survey Requirements

QHP Issuers

QRS and QHP Enrollee Survey requirements apply to QHP issuers offering family and/or adult-only health insurance coverage through the Marketplaces as a condition of certification, regardless of the Marketplace model in which they operate (i.e., Federally-facilitated Marketplace [FFM], State Partnership Marketplace [SPM], or State-based Marketplace [SBM]). A QHP issuer must meet QRS and QHP Enrollee Survey requirements for QHPs that have been offered through a Marketplace in the previous year.

QRS and QHP Enrollee Survey requirements apply to QHP product types that are offered through the Marketplaces, including, but not limited to: Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point of Service (POS), and Preferred Provider Organization (PPO). Requirements also apply to all of the following categories of coverage within those product types: bronze, silver, gold, platinum, and catastrophic.

CMS requires data collection and submission by QHP issuer product type (e.g., HMO, PPO). For both the QRS and QHP Enrollee Survey, QHP issuers are required to collect and submit data for those QHPs offered through a Marketplace that have more than 500 enrollees as of July 1, 2014 in a given product type.[14] For the QHP Enrollee Survey, a QHP issuer that is required to submit data must contract with an HHS-approved survey vendor to conduct the survey for those products. QHP issuers may not combine product types for purposes of collecting and submitting QRS and QHP Enrollee Survey data. QRS and QHP Enrollee Survey requirements also apply to MSP issuers. Additional MSP quality reporting requirements, if required, will be specified by the OPM.

An issuer that offers both a QHP and an MSP option of the same product type in the same Marketplace must include enrollees in both plan types when determining product enrollment size. QHP issuers must include enrollees from coverage in the individual market offered through a Marketplace, as well as enrollees from the Small Business Health Options Program (SHOP). In the event that a QHP issuer offers an identical QHP through and outside of the Marketplace, the QHP issuer may include enrollees in the version of the QHP that is offered outside of the Marketplace only if it is certified as a QHP and has the same standard component ID (SCID) as the version offered through the Marketplace. CMS will not assign QRS scores and ratings and QHP Enrollee Survey results to QHPs offered outside of the Marketplace.

[14] 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 QHP Enrollee Survey minimum enrollment requirement and to contribute to a sufficient size for credible and reliable results.

At this time, child-only plans[15] and stand-alone dental plans are not included in the QRS and QHP Enrollee Survey requirements. CMS will continue to monitor these plan types and will consider developing a quality rating system and QHP Enrollee Survey for these in the future.

Exhibit 2 summarizes considerations for determining when QRS and QHP Enrollee Survey requirements apply for the 2015 beta test.

Exhibit 2. Applicability of the 2015 QRS and QHP Enrollee Survey Requirements

Consideration	QRS and QHP Enrollee Survey Applicability
Marketplace type	FFM, SPM, SBM
QHP coverage type	Family and adult-only (child-only and stand-alone dental plans excluded for 2015)
QHP product type	HMO, PPO, EPO, POS
QHP product's category of coverage	Bronze, Silver, Gold, Platinum, Catastrophic
Minimum number of enrollees required during the 2014 coverage year	More than 500 enrollees per product as of July 1, 2014

State-based Marketplaces

An SBM is responsible for overseeing its QHP issuers' compliance with certification standards and overseeing compliance with reporting of federal quality rating information for the Marketplaces.[16] Thus, Marketplaces will monitor QHP issuers' ongoing compliance with QRS and QHP Enrollee Survey requirements. To assist with this process, CMS anticipates providing SBMs with a list of the QHP issuers that meet the established criteria, and are therefore required to submit QRS and QHP Enrollee Survey data (e.g., certified; offered through the Marketplace in the previous coverage year; meet minimum enrollment threshold). SBMs can use this information to monitor their QHP issuers' compliance with QRS and QHP Enrollee Survey requirements.

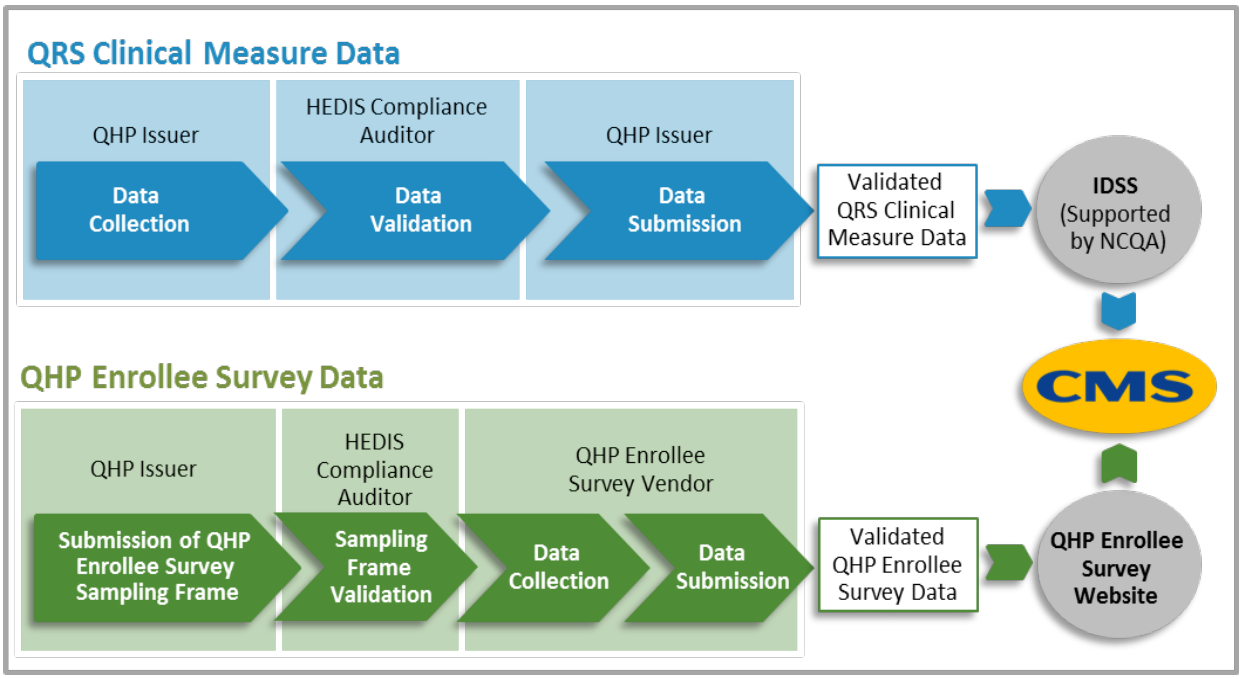
An SBM may also choose to impose additional quality reporting requirements for QHPs offered through its Marketplace, in addition to the federal requirements established by HHS. QHP issuers operating in an SBM should confirm any additional quality reporting requirements with the respective Marketplace.

6. QRS and QHP Enrollee Survey Requirements

The following sections address the QRS and QHP Enrollee Survey requirements, including the protocols for data collection, data validation, and data submission. Exhibit 3 illustrates the process and stakeholders with primary responsibility for the associated steps, which are detailed in subsequent sections.

[15] 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.
[16] 45 CFR § 155.1010(a)(2) and § 155.200(d).

Exhibit 3. QRS and QHP Enrollee Survey Data Process Flow



6.1 QRS Measure Set

The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Exhibit 4 includes the list of QRS measures required for the 2015 beta test. The remaining measures in the QRS measure set require at least two years of data collection and, therefore, will not be reportable until 2016 or 2017 (see Exhibit 5).

The survey measures in the QRS measure set, noted with an asterisk (*) in Exhibits 4 and 5, 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[17] (CAHPS®) surveys. See Section 6.2 for details on the QHP Enrollee Survey.

QHP issuers are required to report all associated measure indicator data, unless a specific indicator is shown in parentheses next to the measure in the exhibits below.

Appendix B includes summaries of each measure. For detailed measure specifications for the 2015 beta test, refer to the *QRS Measure Technical Specifications.* 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.

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

Exhibit 4. 2015 QRS Measures

Measure Title	National Quality Forum (NQF) ID[18]
Access to Care *	0006[19]
Access to Information *	0006[19]
Annual Dental Visit	1388
Annual Monitoring for Patients on Persistent Medications	Not Endorsed[20]
Appropriate Testing for Children With Pharyngitis	0002
Appropriate Treatment for Children With Upper Respiratory Infection	0069
Care Coordination *	Not Endorsed
Cervical Cancer Screening	0032
Chlamydia Screening in Women	0033
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
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004
Plan Administration *	0006[19]
Prenatal and Postpartum Care	1517
Proportion of Days Covered	0541
Rating of All Health Care *	0006[19]
Rating of Health Plan *	0006[19]
Rating of Personal Doctor *	0006[19]
Rating of Specialist *	0006[19]
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 Third, Fourth, Fifth, and Sixth Years of Life	1516

[18] Definitions of NQF-endorsed measures can be found here: http://www.qualityforum.org/Home.aspx

[19] NQF ID #0006 reflects NQF endorsement for the CAHPS® Health Plan 4.0 Survey. The QHP Enrollee Experience Survey and associated QRS survey measures largely align with items from the CAHPS® Health Plan 5.0 Surveys, which have not yet been submitted for endorsement upon publication of this guidance. Further, the Plan Administration survey measure includes one survey item developed by CMS; this survey item is not included in the CAHPS® Survey.

[20] Measure not NQF-endorsed upon publication of this guidance, but it was submitted for endorsement in early 2014.

Exhibit 5. Additional QRS Measures for 2016 and 2017

Measure Title	NQF ID
Adult BMI Assessment	Not Endorsed
Antidepressant Medication Management	0105
Aspirin Use and Discussion*	Not Endorsed
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058
Breast Cancer Screening	Not Endorsed[21]
Childhood Immunization Status (Combination 3)	0038
Colorectal Cancer Screening	0034
Follow-Up Care for Children Prescribed ADHD Medication	0108
Human Papillomavirus Vaccination for Female Adolescents	1959
Immunizations for Adolescents (Combination 1)	1407
Medical Assistance With Smoking and Tobacco Use Cessation*	0027
Medication Management for People With Asthma (75% of Treatment Period)	1799
Plan All-Cause Readmissions	1768
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	1392

6.2 QHP Enrollee Survey

The QHP Enrollee Survey draws heavily from CAHPS® Health Plan Surveys used widely to assess Medicare, Medicaid, and other commercial health plan performance. It assesses enrollee experience with a QHP offered through a Marketplace on the topics presented in Exhibit 6. As indicated in the previous section, a subset of survey questions is incorporated into the QRS measure set and accompanying ratings.

Exhibit 6. QHP Enrollee Survey Topics

[21] Measure not NQF-endorsed upon publication of this guidance, but it was submitted for endorsement in early 2014. As currently specified, the Breast Cancer Screening measure requires three years of data to report and will, therefore, not be required until 2017.

In order to adjust for any systematic biases with the enrollee response data, CMS will apply case-mix adjustment to the QHP Enrollee Survey data, including the response data used for the QRS survey measures. It is common in survey-based applications to case-mix adjust scores for factors such as overall health status, age, and education to account for biases due to survey response tendencies. For example, it may be that enrollees in better health, older enrollees, and enrollees with less education tend to give higher ratings. In such instances, QHPs with higher concentrations of such enrollees 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.

The calculation of QHP Enrollee Survey scores, including those used in QRS, will be done using the CAHPS® Analysis Program ("CAHPS® Macro"), which was developed by the CAHPS® Consortium under the auspices of the Agency for Healthcare Research and Quality (AHRQ), and is commonly used for scoring in CAHPS®-related applications. A comprehensive description of calculations performed by the CAHPS® Analysis Program can be found in "Instructions for Analyzing Data from CAHPS Surveys" (Document No. 15), which is included in the *CAHPS® Survey and Reporting Kit*. These materials are available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015_instructions_for_analyzing_data.pdf.

The content of the QHP Enrollee Survey will undergo psychometric testing before being finalized for the 2016 implementation of the survey.

6.3 Data Collection Requirements

QHP issuers must collect QRS clinical measure data and QHP Enrollee Survey response data for each product offered through a Marketplace (e.g., HMO, PPO) in the previous year that meets the minimum enrollment size threshold for data collection.[22] Details related to the data collection protocols are summarized below. For additional data collection guidance on the QRS clinical measure set, including the required data elements for each QRS measure, refer to *QRS Measure Technical Specifications*. For additional guidance and protocols related to the QHP Enrollee Survey, refer to the *QHP Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications.*

6.3.1 QRS Clinical Measure Data Collection

QHP issuers will collect data for the clinical measures using administrative sources or a hybrid of administrative and medical record sources. The data collection methods are described below. QHP issuers must refer to the measure's technical specification to determine which method is allowed for the measure.

- **Administrative Method:** Uses data obtained from administrative sources (e.g., claims data) to identify the eligible population (denominator) and numerator compliance.

[22] 45 CFR § 156.1120(a) and § 156.1125(b).

- **Hybrid Method:** Uses data obtained from both administrative and medical record/ electronic medical record sources to identify the eligible population (denominator) and numerator compliance. The QHP issuer will draw a systematic sample of enrollees from the measure's eligible population, and 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.

6.3.2 QHP Enrollee Survey Data Collection

Prior to survey administration, each QHP issuer will develop a sampling frame of enrollees for each of its products (e.g., HMO, PPO) offered through a Marketplace that has more than 500 enrollees as of July 1, 2014. QHP issuers must contract with a HHS-approved QHP Enrollee Survey vendor to administer the QHP Enrollee Survey to a sample of the QHP issuer's eligible enrollees using different modes of administration (e.g., mail, phone, or web). These vendors will collect enrollee responses to the survey questions on behalf of the QHP issuer. The QHP Enrollee Survey website (http://qhpcahps.cms.gov) will include a list of HHS-approved survey vendors and general instructions for QHP issuers about the QHP Enrollee Survey data collection process.

Each QHP issuer must formally authorize its chosen survey vendor to collect and submit QHP Enrollee Survey data to CMS on its behalf.[23] In the fall of 2014, each QHP issuer will receive a QHP Enrollee Survey Reporting Requirements memo. The memo will include the step-by-step process for authorizing a survey vendor, including information on how to log into the QHP Enrollee Survey website, the timeline for authorizing a survey vendor, and the list of QHP products (associated with the QHP issuer) that must comply with the survey requirements.

6.4 Data Validation Requirements

Each QHP issuer must have its clinical measure data and the QHP Enrollee Survey sampling frame validated by an independent third-party data validator, in accordance with measure stewards' protocols prior to data submission.[24] For the 2015 beta test, CMS requires that QHP issuers use a HEDIS Compliance Auditor and follow the HEDIS Compliance Audit standards to validate all QRS measures, including the QHP Enrollee Survey sampling frame.[25] The sections below contain details related to these data validation requirements.

6.4.1 Data Validators

For the 2015 beta test, QHP issuers must contract with a HEDIS Compliance Auditor, who will perform the HEDIS Compliance Audit (i.e., validation of QRS measure data) for all clinical measures and the survey sampling frame. Each QHP issuer is responsible for selecting the HEDIS Compliance Organization, determining fees, and entering into a data validation contract (as may be necessary).

[23] 45 CFR § 156.1125(a).
[24] 45 CFR § 156.1120(a)(2) and § 156.1125(b)(2).
[25] Pharmacy Quality Alliance (PQA) does not have a defined measure validation strategy for the Proportion of Days Covered measure. For 2015, CMS requires this measure to be validated using the HEDIS Compliance Audit process.

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

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

6.4.2 Data Validation Standards

Currently, QHP issuers must comply with the data validation standards included in the *HEDIS Compliance Audit: Standards, Policies, and Procedures*. Auditors will use this uniform set of data validation standards to assess each QHP issuer's information system characteristics and capabilities, as well as its compliance with the measure technical specifications. The HEDIS Compliance Auditors will also use the standards to assess the QHP issuer's sampling frame for the QHP Enrollee Survey.

QHP issuers should refer to the *HEDIS Compliance Audit: Standards, Policies, and Procedures*, available for purchase on the following website:
http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx.

6.4.3 Data Validation Results

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

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

- **A rate:** The QHP issuer followed the specifications and produced a reportable rate (numeric result) for the measure.
- **Benefit Not Offered (NB):** The QHP issuer did not offer the health benefit required by the measure.
- **Not Reportable (NR):** The QHP issuer did not report the measure rate, or the calculated rate is materially biased.

For the QHP Enrollee Survey sampling frame, the QHP issuer is responsible for sending the validated sampling frame and validator's approval notice to the survey vendor before the QHP Enrollee Survey is administered.

6.5 Data Submission Requirements

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

6.5.1 QRS Clinical Measure Data Submission

QHP issuers must submit summary-level QRS clinical measure data via NCQA's IDSS (at no cost to access/use the system), once the data have been validated by a HEDIS Compliance Auditor. The summary-level data are specific to each measure and will include elements such as eligible population or denominator, numerator, and the reported rate. Patient-level data are not required for QRS clinical measures. QHP issuers must prepare and submit separate data submissions for each product offered through the Marketplace (e.g., HMO, PPO) in the previous year that meets the minimum enrollment size threshold for data submission.

QHP issuers must submit the validated QRS clinical measure data by June 15, 2015.

6.5.2 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 data are found on the QHP Enrollee Survey website and in the *QHP Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications.*

QHP Enrollee Survey vendors must submit the QHP Enrollee Survey data by May 31, 2015.

7. QRS Scoring Specifications and Rating Methodology

The following sections describe how CMS will calculate quality ratings based on the QRS clinical measure and QHP Enrollee Survey response data.[26]

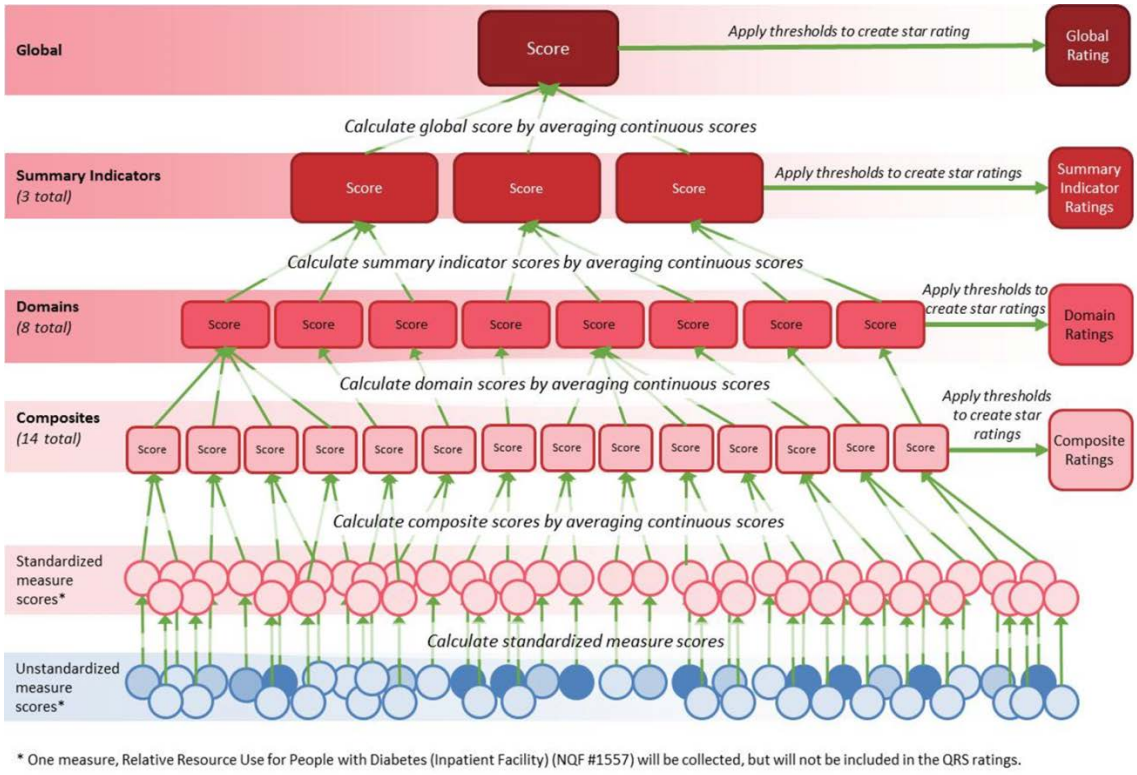
7.1 QRS Hierarchy

The QRS measures outlined in Section 6.1 are organized into a hierarchical structure designed to make the quality rating information more understandable to stakeholders (e.g., consumers, QHP issuers, Marketplaces). The measures are the building blocks of the hierarchical structure and are grouped into hierarchy components (composites, domains, summary indicators) that are used to

[26] The information in this section incorporates stakeholder feedback (including public comments on the *Quality Rating System Scoring Specifications* draft published on March 28, 2014 and input from the QRS Technical Expert Panel) and additional CMS analysis on the QRS scoring specifications and rating methodology. The following includes some of the substantive changes made to the draft March 2014 methodology: 1) Removed previous references to the un-weighted average approach for measure scoring; 2) Removed the down-weighting approach for the Antidepressant Medication Management measure indicators; 3) Specified measures (Prenatal and Postpartum Care; Proportion of Days Covered) where measure indicators will be treated as distinct measures (vs. use of indicator weighting); 4) Removed the full-scale rule exception for the Patient Safety domain as it relates to the scoring approach for summary indicators; as well as several revisions to the hierarchy.

form a single global score and rating. Appendix C includes a list of the measures organized by their hierarchy components. Exhibit 7 provides an illustration of how the measures and components formulate scores and ratings. The following sections include details related to this process.

Exhibit 7. 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.

7.2 Process for Calculating QRS Scores and Ratings

Exhibit 8 outlines the process for calculating QRS scores and ratings. The subsections that follow describe the steps in greater detail.

Exhibit 8. Steps for Calculating the QRS Scores and Ratings

Step	Sub-steps
Step 1. Prepare Data for Scoring	▪ *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. ▪ *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.
Step 2. Standardize Measure Scores	▪ *Standardize the measure scores.* Using 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.

Step	Sub-steps
Step 3. Calculate Composite Scores and Ratings	▪ *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. ▪ *Calculate the score.* Average available measure scores using equal weights. ▪ *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.
Step 4. Calculate Domain Scores and Ratings	▪ *Determine if the score can be calculated.* 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. ▪ *Calculate the score.* Average available composite scores using equal weights. ▪ *Convert the score to a rating*. Convert each domain score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.
Step 5. Calculate Summary Indicator Scores and Ratings	▪ *Determine if the score can be calculated.* Apply the full-scale rule, meaning that the summary indicator score can be calculated only if all of the associated domains have a score. ▪ *Calculate the score.* Average available domain scores using equal weights. ▪ *Convert the score to a rating*. Convert each summary indicator score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.
Step 6. Calculate Global Score and Rating	▪ *Determine if the score can be calculated*. Apply the full-scale rule, meaning that the global score can be calculated only if all of the associated summary indicators have a score. ▪ *Calculate the score*. Average available summary indicator scores using equal weights. ▪ *Convert the score to a rating.* Convert the global score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.

7.3 Prepare Data for Scoring

Prior to scoring, CMS will prepare the available measure data[27] 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. Details related to these steps include:

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. Appendix D identifies the QRS measures with multiple indicators where the scores will be calculated as weighted averages.

[27] 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.

The weighted average equation is as follows:

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

where X is the final measure score that is the weighted average, x_i is the indicator score, and n_i is the indicator denominator. Exhibit 9 shows an example of this weighted average calculation for a measure score.

Exhibit 9. 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
Annual Monitoring for Patients on Persistent Medications (Measure)	**450**	**0.52**

$$\textbf{Annual Monitoring for Patients on Persistent Medications} = \frac{\begin{array}{c}((\textbf{ACE Inhibitors or ARBs} * \textbf{Denominator}) + \\ + (\textbf{Digoxin} * \textbf{Denominator}) + (\textbf{Diuretics} * \textbf{Denominator}))\end{array}}{\textbf{Total Denominator}}$$

$$= \frac{((\mathbf{0.40} * \mathbf{100}) + (\mathbf{0.60} * \mathbf{200}) + (\mathbf{0.50} * \mathbf{150}))}{\mathbf{450}} = \frac{\mathbf{235}}{\mathbf{450}} = \mathbf{0.52}$$

Several of the QRS survey measures also are comprised 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 in order 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 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 these measures 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, Follow-up Care for Children Prescribed ADHD Medication 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 10 shows examples of how QRS scoring could be impacted by observed denominator sizes in comparison to a minimum denominator size requirement of 30.

Exhibit 10. 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 25 for indicator Y (assume the maximum denominator size of 50)	30	Yes

7.4 Standardize Measure Scores

CMS will standardize measure scores by calculating national percentile ranks[28] 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 50th 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 that QHP issuers may use them to calculate their own standardized measure scores.

7.5 Calculate Composite Scores and Ratings

Composites, like all 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:

[28] 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.

1. **Determine if the composite score can be calculated.**[29] 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 11 includes an example of how the Cardiovascular Care composite will be calculated from three measure scores.

Exhibit 11. Example Composite Score Calculation

Measure	Example Score (Standardized Measure Percentile Rank)
Controlling High Blood Pressure	30
Proportion of Days Covered (RAS Antagonists)	90
Proportion of Days Covered (Statins)	60
Cardiovascular Care Composite Score (Average of Available Measure Scores, Not a Percentile Rank)	**60**

$$\textbf{Cardiovascular Care} = \frac{(\textbf{Controlling High Blood Pressure} + \textbf{Proportion of Days Covered (RAS Antagonists)} + \textbf{Proportion of Days Covered (Statins)})}{\textbf{3}} = \frac{(\textbf{30} + \textbf{90} + \textbf{60})}{\textbf{3}} = \textbf{60}$$

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 11, 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 60th 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 12 for the score and rating classifications using example score value cut points.

[29] This document differs from the March 28, 2014 draft *Quality Rating System Scoring Specifications* in how it describes the steps in the QRS process. Specifically, this document discusses "calculating" the scores and ratings, as opposed to "reporting" the scores and ratings, in recognition of the fact that the 2015 QRS beta test results will not be publicly reported.

Exhibit 12. 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 7th category versus QHPs within the 8th 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 performance is relatively stable each year.

7.6 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:

1. **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.

2. **Calculate the domain score.** CMS will average the available composite scores using equal weighting as shown in Exhibit 13.

Exhibit 13. Example Domain Score Calculation

Composite	Example Score[30] (Average of Available Measure Scores)
Checking for Cancer	20
Maternal Health	40
Staying Healthy Adult	80
Staying Healthy Child	60
Prevention Domain Score (Average of Available Composite Scores, Not a Percentile Rank)	**50**

[30] Composite scores are not standardized before averaging.

$$\textbf{Prevention} = \frac{\textbf{Checking for Cancer} + \textbf{Maternal Health} + \textbf{Staying Healthy Adult} + \textbf{Staying Healthy Child}}{\textbf{4}}$$
$$= \frac{\textbf{20} + \textbf{40} + \textbf{80} + \textbf{60}}{\textbf{4}} = \textbf{50}$$

3. **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 13 lies within the limits of the third category in Exhibit 12 (50 ≤ Score Value < 75) and converts to a 3-star rating (★★★).

7.7 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 14.

Exhibit 14. Example Summary Indicator Score Calculation

Domain	Example Score (Average of Available Composite Scores)
Access	65
Care Coordination	50
Doctor and Care	35
Enrollee Experience Summary Indicator Score (Average of Available Domain Scores, Not a Percentile Rank)	**50**

$$\textbf{Enrollee Experience} = \frac{\textbf{Access} + \textbf{Care Coordination} + \textbf{Doctor and Care}}{\textbf{3}}$$
$$= \frac{\textbf{65} + \textbf{50} + \textbf{35}}{\textbf{3}} = \textbf{50}$$

3. **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 14 lies within the limits of the third category in Exhibit 12 (50 ≤ Score Value < 75) and converts to a 3-star rating (★★★).

7.8 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:

1. **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.

2. **Calculate the global score.** CMS will average the available summary indicator scores using equal weighting as shown in Exhibit 15.

Exhibit 15. Example Global Score Calculation

Summary Indicator	Example Score (Average of Available Domain Scores)
Clinical Quality Management	65
Enrollee Experience	35
Plan Efficiency, Affordability, and Management	50
Global Score (Average of Summary Indicator Scores, Not a Percentile Rank)	**50**

$$\textbf{Global Score} = \frac{\textbf{Clinical Quality Management} + \textbf{Enrollee Experience} + \textbf{Plan Efficiency, Affordability, and Management}}{3} = \frac{65 + 35 + 50}{3} = 50$$

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 15 lies within the limits of the third category in Exhibit 12 (50 ≤ Score Value < 75) and converts to a 3-star rating (★★★).

8. QRS and QHP Enrollee Survey Data Preview Process

Each year, beginning with the 2015 beta test, CMS anticipates providing QHP issuers in all Marketplaces the opportunity to preview their respective quality rating information, including QRS scores and ratings and QHP Enrollee Survey results, and to submit any related inquiries to CMS.

In addition, CMS will provide SBMs with the quality rating information for the QHP issuers operating within their respective Marketplaces. An SBM may choose to conduct an additional ratings preview for QHP issuers operating in that Marketplace, and CMS encourages 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.

In the fall of 2015, CMS anticipates testing the preview and inquiry reconciliation process for QHP issuers, though quality rating information is not required to be publicly displayed in 2015. During the preview and reconciliation process, CMS intends to work with QHP issuers and states to address any inquiries from issuers about their ratings and to resolve discrepancies, if necessary. CMS will coordinate with SBMs throughout the process to mitigate duplicative efforts.

In 2016, CMS intends to post public use data files that include QRS and QHP Enrollee Survey data to make these data files available to the general public. This would be in addition to the public display of the quality rating information on Marketplace websites.

9. QHP Quality Rating Information Display and Marketing Use

As noted earlier in this guidance, 2015 will be a beta test year for both the QRS and the QHP Enrollee Survey, and Marketplaces are not required to publicly display QHP quality rating information in 2015. While SBMs will have the opportunity to display beta test results in 2015 with appropriate disclaimers, CMS does not plan on displaying this information in 2015 for QHPs operating in the SPMs and in the FFM because of limitations with the beta test data given this first year. The first year results are part of a first year process improvement and quality ratings development process.

In future guidance, CMS will specify guidelines related to public display of quality rating information by Marketplaces to inform consumer QHP selection, which will begin in 2016 (for the 2017 coverage year). The guidance will establish requirements for all Marketplaces to prominently display the HHS-calculated quality rating information on the Marketplace website, in addition to specifying the form and manner in which CMS will display quality rating information on HealthCare.gov for each QHP operating in the FFM.

CMS will also issue marketing guidelines in the future regarding the use of QRS and QHP Enrollee Survey information by QHP issuers in their marketing materials.

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
QHP certification standards: Public reporting of quality information	(c) RESPONSIBILITIES OF THE SECRETARY.— (1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum— (H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable. (I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act. [*As added by section 10203(a)*]"	Section 1311 (c)(1)(H),(I)
Marketplace standards: Public reporting of QRS and QHP Enrollee Survey information	(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).	Section 1311 (c)(3)
	(4) ENROLLEE SATISFACTION SYSTEM.—The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.	Section 1311 (c)(4)
	(5) INTERNET PORTALS.—The Secretary shall — (B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices. Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.	Section 1311 (c)(5)(B)
	(d) REQUIREMENTS.— (4) FUNCTIONS.—An Exchange shall, at a minimum— (D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3); (E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act;	Section 1311 (d)(4)(D),(E)

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT; PROGRAM INTEGRITY: EXCHANGE, PREMIUM STABILIZATION PROGRAMS, AND MARKET STANDARDS; AMENDMENTS TO THE HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2014; FINAL RULE, 78 FED. REG. 65046-65105 (OCTOBER 30, 2013)

Topic	Provisions	Citation
Application & Standards for QHP Enrollee Survey vendors; List of HHS-approved vendors	(a) *Application for approval.* An enrollee satisfaction survey vendor must be approved by HHS, in a form and manner to be determined by HHS, to administer, on behalf of a QHP issuer, enrollee satisfaction surveys to QHP enrollees. HHS will approve enrollee satisfaction survey vendors on an annual basis, and each enrollee satisfaction survey vendor must submit an application for each year that approval is sought. (b) *Standards.* To be approved by HHS, an enrollee satisfaction survey vendor must meet each of the following standards: (1) Sign and submit an application form for approval in accordance with paragraph (a) of this section; (2) Ensure, on an annual basis, that appropriate staff participate in enrollee satisfaction survey vendor training and successfully complete a post-training certification exercise as established by HHS; (3) Ensure the accuracy of their data collection, calculation and submission processes and attest to HHS the veracity of the data and these processes; (4) Sign and execute a standard HHS data use agreement, in a form and manner to be determined by HHS, that establishes protocols related to the disclosure, use and reuse of HHS data; (5) Adhere to the enrollee satisfaction survey protocols and technical specifications in a manner and form required by HHS; (6) Develop and submit to HHS a quality assurance plan and any supporting documentation as determined to be relevant by HHS. The plan must describe in adequate detail the implementation of and compliance with all required protocols and technical specifications described in paragraph (b)(5) of this section; (7) Adhere to privacy and security standards established and implemented under § 155.260 of this subchapter by the Exchange with which they are associated; (8) Comply with all applicable state and federal laws; (9) Become a registered user of the enrollee satisfaction survey data warehouse to submit files to HHS on behalf of its authorized QHP contracts; (10) Participate in and cooperate with HHS oversight for quality-related activities, including, but not limited to: review of the enrollee satisfaction survey vendor's quality assurance plan and other supporting documentation; analysis of the vendor's submitted data and sampling procedures; and site visits and conference calls; and, (11) Comply with minimum business criteria as established by HHS. (c) *Approved list.* A list of approved enrollee satisfaction survey vendors will be published on an HHS Web site.	45 CFR § 156.1105(a)-(c) Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges

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
Marketplace standards for public display of QRS ratings	The Exchange must prominently display the quality rating information assigned to each QHP on its Web site, in accordance with § 155.205(b)(1)(v), as calculated by HHS and in a form and manner specified by HHS.	45 CFR § 155.1400 Quality rating system
Marketplace standards for public display of QHP Enrollee Survey information	The Exchange must prominently display results from the Enrollee Satisfaction Survey for each QHP on its Web site, in accordance with § 155.205(b)(1)(iv), as calculated by HHS and in a form and manner specified by HHS.	45 CFR § 155.1405 Enrollee satisfaction survey system
QHP certification standards: Public reporting of QHP quality rating information[31]	(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. (b) *QHP issuer requirement.* A QHP issuer must— (5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Affordable Care Act consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act; (h) As a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements described in subparts D, E, H, K, L, and M of this part.	45 CFR § 156.200(a),(b)(5),(h) QHP issuer participation standards
Monitoring of QHP Enrollee Survey vendors and vendor appeals	(d) *Monitoring.* HHS will periodically monitor HHS-approved enrollee satisfaction survey vendors to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS determines that an HHS-approved enrollee satisfaction survey vendor is non-compliant with the standards required in paragraph (b) of this section, the survey vendor may be removed from the approved list described in paragraph (c) of this section and/or the submitted survey results may be ineligible to be included for ESS results. (e) *Appeals.* An enrollee satisfaction survey vendor that is not approved by HHS after submitting the application described in paragraph (a) of this section may appeal HHS's decision by notifying HHS in writing within 15 days from receipt of the notification of not being approved and submitting additional documentation demonstrating how the vendor meets the standards in paragraph (b) of this section. HHS will review the submitted documentation and make a final approval determination within 30 days from receipt of the additional documentation.	45 CFR § 156.1105(d),(e) Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges

[31] 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 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
Standards for QRS data submission, data validation, implementation timeline, and marketing of QRS ratings; Multi-State Plan requirements	(a) *Data submission requirement.* (1) A QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP that has been offered in an Exchange for at least one year. (2) In order to ensure the integrity of the data required to calculate the QRS, a QHP issuer must submit data that has been validated in a form and manner specified by HHS. (3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS. (b) *Timeline.* A QHP issuer must annually submit data necessary to calculate the QHP's quality ratings to HHS and Exchanges, on a timeline and in a standardized form and manner specified by HHS. (c) *Marketing requirement.* A QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS. (d) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (a) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.	45 CFR § 156.1120 (a)–(d) Quality rating system
Standards for administering the QHP Enrollee Survey and marketing survey results; Multi-State Plan requirements	(a) *General requirement.* A QHP issuer must contract with an HHS-approved enrollee satisfaction survey (ESS) vendor, as identified by § 156.1105, in order to administer the Enrollee Satisfaction Survey of the QHP's enrollees. A QHP issuer must authorize its contracted ESS vendor to report survey results to HHS and the Exchange on the issuer's behalf. (b) *Data requirement.* (1) A QHP issuer must collect data for each QHP, with more than 500 enrollees in the previous year that has been offered in an Exchange for at least one year and following a survey sampling methodology provided by HHS. (2) In order to ensure the integrity of the data required to conduct the survey, a QHP issuer must submit data that has been validated in a form and manner specified by HHS, and submit this data to its contracted ESS vendor. (3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS. (c) *Marketing requirement.* A QHP issuer may reference the survey results for its QHPs in its marketing materials, in a manner specified by HHS. (d) *Timeline.* A QHP issuer must annually submit data necessary to conduct the survey to its contracted ESS vendor on a timeline and in a standardized form and manner specified by HHS. (e) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (b) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.	45 CFR § 156.1125 (a)–(e) Enrollee satisfaction survey system

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 is first required. Some measures require a look-back period greater than one year, and will therefore not be required until 2016 or 2017. For detailed QRS clinical measure specifications, refer to the *QRS Measure Technical Specifications*. 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.

2015 QRS MEASURES

Measure Name:	**Access to Care**
Measure Steward:	AHRQ
NQF Endorsement ID:	0006[32]
Description:	Enrollee experience related to the following: • Got care for illness/injury as soon as needed • Got non-urgent appointment as soon as needed • Easy to get care after regular office hours • How often it was easy to get necessary care, tests, or treatment • Got appointment with specialists as soon as needed
Data Source(s):	QHP Enrollee Survey

Measure Name:	**Access to Information**
Measure Steward:	AHRQ
NQF Endorsement ID:	0006[32]
Description:	Enrollee experience related to the following: • Written materials or Internet provided information needed about how plan works • Found out from health plan about cost for health care service or equipment • Found out from health plan about cost for specific prescriptions
Data Source(s):	QHP Enrollee Survey

Measure Name:	**Annual Dental Visit**
Measure Steward:	NCQA
NQF Endorsement ID:	1388
Description:	The percentage of members 2-21 years of age who had at least one dental visit during the measurement year.
Data Source(s):	Administrative Data

[32] NQF ID #0006 reflects NQF endorsement for the CAHPS® Health Plan 4.0 Survey. The QHP Enrollee Experience Survey and associated QRS survey measures largely align with items from the CAHPS® Health Plan 5.0 Surveys, which have not yet been submitted for endorsement upon publication of this guidance.

Measure Name:	Annual Monitoring for Patients on Persistent Medications
Measure Steward:	NCQA
NQF Endorsement ID:	None (Submitted in early 2014 for endorsement)
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).[33]
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 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

[33] 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
NQF Endorsement ID:	None
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 Medical Record Data

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 Medical Record Data

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 Medical Record Data

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 Medical Record Data

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 had evidence of nephropathy during the measurement year.
Data Source(s):	Administrative Data and Medical Record Data

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):	Administrative and Medical Record Data (Hybrid Method must be used)

Measure Name:	Cultural Competence
Measure Steward:	AHRQ
NQF Endorsement ID:	Not currently endorsed[34]
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 patients 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. One rate is reported: • The percentage of discharges for which the patient received follow-up within 7 days of discharge.
Data Source(s):	Administrative Data

[34] The question related to Forms in Preferred Language was modified from the question included in CAHPS Clinician and Group 2.0, Adult Supplemental (NQF #1904). The How Often Got an Interpreter question is new in CAHPS Health Plan 5.0, Adult Supplemental.

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:	0006[35]
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 Medical Record Data

[35] NQF ID #0006 reflects NQF endorsement for the CAHPS® Health Plan 4.0 Survey. The QHP Enrollee Experience Survey and associated QRS survey measures largely align with items from the CAHPS® Health Plan 5.0 Surveys, which have not yet been submitted for endorsement upon publication of this guidance.

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[36]
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[36]
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[36]
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[36]
Description:	Enrollee experience related to the following: • Rating of specialist
Data Source(s):	QHP Enrollee Survey

[36] NQF ID #0006 reflects NQF endorsement for the CAHPS® Health Plan 4.0 Survey. The QHP Enrollee Experience Survey and associated QRS survey measures largely align with items from the CAHPS® Health Plan 5.0 Surveys, which have not yet been submitted for endorsement upon publication of this guidance.

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

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

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

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

2016 QRS MEASURES

Measure Name:	Adult BMI Assessment
Measure Steward:	NCQA
NQF Endorsement ID:	None
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 Medical Record Data

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

Measure Name:	Aspirin Use and Discussion
Measure Steward:	NCQA
NQF Endorsement ID:	None

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:
	  o Women 56–79 years of age with at least two risk factors for cardiovascular disease.
	  o Men 46–65 years of age with at least one risk factor for cardiovascular disease.
	  o 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:
	  o Women 56–79 years of age.
	  o Men 46–79 years of age.

Data Source(s):	QHP Enrollee Survey

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

Measure Name:	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").
Data Source(s):	Administrative and Medical Record Data

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

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

Measure Name:	Human Papillomavirus Vaccination for Female Adolescents
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 Medical Record Data

Measure Name:	Immunizations for Adolescents (Combination 1)
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 Medical Record Data

Measure Name:	Medical Assistance With Smoking and Tobacco Use Cessation
Measure Steward:	NCQA
NQF Endorsement ID:	0027
Description:	The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: • *Advising Smokers and Tobacco Users to Quit*: A rolling average represents the percentage of patients 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 patients 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 patients 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 patients 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 patients 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

2017 QRS MEASURES

Measure Name:	Breast Cancer Screening
Measure Steward:	NCQA
NQF Endorsement ID:	None (Submitted in early 2014 for endorsement)
Description:	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
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, and summary indicators, and which contributes to a single global rating.

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	NQF #
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	Not Endorsed*
			Plan All-Cause Readmissions	1768
	Prevention	Checking for Cancer	Breast Cancer Screening	Not Endorsed*
			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 18-84	0039
			Medical Assistance With Smoking and Tobacco Use Cessation	0027
		Staying Healthy Child	Annual Dental Visit	1388
			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 (6 or More Visits)	1392
			Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516

* Measure not NQF endorsed upon publication of this guidance, but was submitted in early 2014 for endorsement.

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	NQF #
Enrollee Experience	Access	Access to Care	Access to Care	0006**
	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	0006**
			Plan Administration	0006**
			Rating of Health Plan	0006**
Collected But Not Included for Purposes of QRS Scoring and Ratings				
N/A	N/A	N/A	Relative Resource Use for People with Diabetes (Inpatient Facility)	1557

**NQF ID #0006 reflects NQF endorsement for the CAHPS® Health Plan 4.0 Survey. The QHP Enrollee Experience Survey and associated QRS survey measures largely align with items from the CAHPS® Health Plan 5.0 Surveys, which have not yet been submitted for endorsement upon publication of this guidance. Further, the Plan Administration survey measure includes one survey item developed by CMS; this survey item is not included in the CAHPS® Survey.

Appendix D. Weighting Approach for QRS Clinical Measures with Multiple Indicators

The table below lists QRS clinical measures that are composed of multiple indicators and the weighting approach used for these indicators. Most measures are scored using weighted averages where the "weights" are based on the respective denominator sizes (see Section 7.3). The exception is for two measures, Prenatal and Postpartum Care and Proportion of Days Covered, whose indicators are treated as unique measures. Note that CMS will determine the weighting approach associated with the QRS survey measure indicators (based on the QHP Enrollee Survey) once 2015 beta test data have been analyzed.

Measure	Indicator	Weighting Approach
Annual Monitoring for Patients on Persistent Medications	Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs) Digoxin Diuretics	Three indicators combined as weighted averages to create the measure score.
Antidepressant Medication Management	Effective Acute Phase Treatment Effective Continuation Phase Treatment	Two indicators combined as weighted averages to create the measure score.
Chlamydia Screening in Women	16-20 Years 21-24 Years	Two indicators combined as weighted averages to create the measure score.
Follow-Up Care for Children Prescribed ADHD Medication	Initiation Phase Continuation and Maintenance (C&M) Phase	Two indicators combined as weighted averages to create the measure score.
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence	Initiation of AOD Treatment Engagement of AOD Treatment	Two indicators combined as weighted averages to create the measure score.
Prenatal and Postpartum Care	Timeliness of Prenatal Care Postpartum Care	Two indicators will be treated as two distinct measures. Each will be weighted equally alongside each other to form the composite score.
Proportion of Days Covered	Diabetes All Class Renin Angiotensin System (RAS) Antagonists Statins	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.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Body Mass Index (BMI) Percentile Documentation Counseling for Nutrition Counseling for Physical Activity	Three indicators combined as weighted averages to create the measure score.

Appendix E. Glossary

This appendix includes definitions for key terms used in this document.

Term	Definition
Administrative Data Collection Method	Method of data collection that obtains data from administrative sources (e.g., claims data) to help identify a measure's eligible population (denominator) and numerator compliance.
Average	A single value obtained by adding several quantities together and then dividing this total by the number of quantities.
Benefit Not Offered (NB)	Data validation result assigned at the measure or indicator level by the data validator if the organization did not offer the health benefit required by the measure, indicating that the measure is not publicly reportable.
Component	The QRS hierarchy includes the following components, listed from the lowest to the highest level of the hierarchy: composites, domains, summary indicators, and global. These components represent levels of scores and ratings. Scores for a component are composed of averages of scores of components in the lower level of the hierarchy. Thus, the global score is an average of summary indicator scores, summary indicator scores are averages of associated domain scores, and domain scores are averages of associated composite scores.
Composite	A component of the QRS hierarchy. A score or rating for this component is created by a combination of two or more measures. A composite may also consist of a 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.
Cut point	A numeric score value that serves as a threshold to delineate a category, or level of performance, for each component. These levels of performance produce the 5-star rating scale.
Continuous score	An integer of the numerical value. Numbers do not represent ranks (relative position) or categories.
Data validation	A process by which an independent third party validates a QHP issuer's QRS measure data, including their data systems and processes. CMS requires QHP issuers to contract with a data validator who will verify completeness, accuracy, and comparability of the measure results. The data validator will validate both clinical measure results for the QRS and the sampling frame for the QHP Enrollee Survey. For the 2015 QRS measure set, CMS requires that QHP issuers follow the HEDIS Compliance Audit™ standards to validate all QRS clinical measure data.
Data validator	An independent third party that validates the QRS clinical measure data and the sampling frame for the QHP Enrollee Survey prior to data submission. For 2015, QHP issuers must contract with a HEDIS Compliance Auditor, who will serve as the data validator.
Domain	A component of the QRS hierarchy. A score or rating for this component is created by combining scores from associated composites.
Exclusive Provider Organization (EPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO enrollees will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.
Federally-facilitated Marketplace (FFM)	The Marketplace model operated by HHS for individual and small group market coverage. For QHP issuers operating in the FFM, CMS/CCIIO will display quality rating information on HealthCare.gov alongside other QHP information to inform consumers.
Full-scale rule	A scoring rule that requires all component scores that form a higher level component score to be present in order for the component score to be calculated. For example, all summary indicator scores must be present in order to calculate the global score. This rule is intended for component scores to be comparable across QHPs.

Term	Definition
Global	A component of the QRS hierarchy. A score or rating for this component is created by combining scores from summary indicators.
Half-scale rule	A scoring rule that requires at least half of the component scores that form a higher level component score to be present in order for the component score to be calculated. For example, at least half of the composite scores must be present in order to calculate the domain score. This rule is intended for component scores to be comparable across products.
Health Insurance Marketplace (Marketplace)	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.
Health Maintenance Organization (HMO)	A type of health insurance product that usually limits coverage to care from providers who work for or contract with the HMO and generally will not cover out-of-network care except in an emergency. In this type of organization, enrollees must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.
HealthCare.gov	The consumer-facing website developed and operated by CMS/CCIIO that provides eligibility information, enrollment instructions, and QHP information for consumers looking to enroll in a health insurance plan through the FFMs and SPMs. QRS ratings for QHP issuers operating in both the FFM and SPMs will be displayed on HealthCare.gov to support consumers as they search for and enroll in a QHP.
Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit ™	The HEDIS Compliance Audit™ is a data validation process that consists of a standardized review of an organization's data management processes and algorithmic compliance with measure technical specifications. This process verifies the integrity of QRS measure data and allows for comparability across organizations. An overview of the HEDIS Compliance Audit, the list of NCQA-Certified HEDIS Compliance Auditors, and a link to the HEDIS Compliance Audit: Standards, Policies, and Procedures that is available for purchase can be accessed at the following link: http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx.
HEDIS Compliance Auditor	An individual certified by NCQA to validate HEDIS measure data and the QHP Experience Survey sampling frame using the standardized HEDIS Compliance Audit™ methodology.
Hybrid data collection method	A method of data collection that obtains data from both administrative sources and medical record/electronic medical record sources for reporting QRS clinical measure data. The issuer will draw a systematic sample of enrollees from the measure's eligible population, and 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 *QRS Measure Technical Specifications).*
Indicator	A rate that forms a measure. Some QRS measures have multiple indicators.
Interactive Data Submission System (IDSS)	The web-based system, owned and managed by the National Committee for Quality Assurance (NCQA), which QHP issuers will use to submit QRS clinical measure data.
Measure	Rate variables that serve as the fundamental building blocks of the QRS hierarchy. Each measure is assigned to a composite and contributes to the scoring for the higher components of the hierarchy (i.e., domains, summary indicators, and global).
Multi-State Plan (MSP)	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.

Term	Definition
National Committee for Quality Assurance (NCQA)	The organization that developed and maintains the system through which QHP issuers will submit validated QRS clinical measure data to CMS, the Interactive Data Submission System (IDSS). NCQA is the measure steward for HEDIS measures. NCQA also manages the HEDIS Compliance Audit program.
National Quality Forum (NQF)	NQF reviews, endorses, and recommends use of standardized healthcare performance measures. NQF issues an endorsement identification number (ID) for measures that they endorse. This ID is cited for QRS measures where applicable.
Not Reportable (NR)	The data validation result assigned at the measure level by the data validator if the organization calculated the measure but the rate was materially biased, or the organization did not report the measure.
Office of Personnel Management (OPM)	OPM administers the Federal Employees Health Benefits (FEHB) Program. The Affordable Care Act directs the OPM to contract with private health insurers in each state to offer high-quality, affordable health insurance options called Multi-State Plans (MSPs) via the Multi-State Plan Program (MSPP) to drive competition in the Marketplaces.
Pharmacy Quality Alliance (PQA)	The measure steward for the Proportion of Days Covered (PDC) measure.
Point of Service (POS)	A type of health insurance product modeled after an HMO, but with an opt-out option. In this type of product, enrollees may choose to receive services either within the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner). The level of benefits or reimbursement is generally determined by whether the enrollee uses in-network or out-of-network services.
Preferred Provider Organization (PPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. PPO enrollees may use providers outside of this network, but out-of-network services are usually covered at a reduced rate (e.g., reduced reimbursement percentages, higher deductibles, higher co-payments).
Product type	Also referred to as "product." 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.
QHP Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications	A document published on http://qhpcahps.cms.gov that includes detailed specifications and protocols for HHS-approved survey vendors to conduct the QHP Enrollee Survey.
QHP Enrollee Survey score	The average value for a measure from the QHP Enrollee Survey calculated for survey respondents in a given QHP issuer product. 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.
QHP Enrollee Survey Vendor	A HHS-approved survey vendor with which a QHP issuer contracts to administer the QHP Enrollee Survey to a sample of the QHP issuer's enrollees and that is authorized to submit the survey data on the QHP issuer's behalf.
QRS clinical measures	QRS measures calculated using clinical data from a QHP issuer's administrative and medical record sources.
QRS hierarchy	The organization of the QRS measures into information categories ranging from the most granular information (measure scores) to a global rating.

Term	Definition
QRS Measure Technical Specifications	A document published on the CMS Health Insurance Marketplace Quality Initiatives website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html) that includes detailed measure specifications and general guidelines for QRS measure data collection and reporting.
QRS rating methodology	The rules for combining measures and converting scores into performance ratings for the QRS.
QRS survey measures	QRS measures calculated using enrollee responses to a subset of specified questions in the QHP Enrollee Survey. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to the CMS Health Insurance Marketplace Quality Initiatives website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html).
Qualified Health Plan (QHP)	A QHP is 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.
Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)	A survey tool developed, as directed by the Affordable Care Act section 1311 (c)(4), that includes a comprehensive set of questions related to enrollee experience with their QHP offered through the Marketplace. CMS will use enrollee response data for a specified subset of the questions to calculate the QRS survey measures.
Qualified Health Plan (QHP) issuer	A health insurance issuer that offers a QHP in accordance with a certification from 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.
Quality rating information	Quality information that includes QRS scores and ratings, as well as QHP Enrollee Survey results. This information will be publicly displayed for each QHP offered through a Marketplace to support consumer plan selection beginning in 2016.
Quality Rating System (QRS)	As directed by the Affordable Care Act section 1311 (c)(3), the Quality Rating System (QRS) is a system of rating QHPs offered through the Marketplace based on quality and price. The quality rating information will be provided to individuals and employers to inform their selection of a QHP and will provide a system for monitoring of QHP quality by regulators.
QRS rating	Also referred to as “categorical rating” or “star rating”. A value based on a score for QRS components (composites, domains, summary indicators, and global), which facilitates consumer understanding of QHP performance.
QRS score	A numerical value that indicates the level of QHP performance for QRS measures and hierarchy components (composites, domains, summary indicators, and global). For component scores, composite scores are averages of percentile ranks for a QHP; domain scores are averages of associated composite scores for a QHP; summary indicator scores are averages of associated domain scores for a QHP; and the global score is an average of summary indicator scores for a QHP.
Reference group	A population of QHP products that is defined based on specification of a geographical region and/or time period. A QHP product’s level of performance is its ranking among all products within the defined group.
Standardized score	A rank value ranging from 0 to 99 that indicates the percentage of QHP issuer products 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 QHP issuer products nationally. Standardizing the measure scores allows for comparisons of a QHP issuer’s product relative to all other QHP issuer products. Only QRS measure scores are standardized; component scores are not standardized.

Term	Definition
State Partnership Marketplace (SPM)	A hybrid Marketplace model in which a state operates plan management functions and/or consumer assistance functions, while the remaining Marketplace functions are operated by HHS. For QHP issuers operating in all SPMs (regardless of whether the SPM operates plan management functions), CMS/CCIIO will display quality rating information on HealthCare.gov.
State-based Marketplace (SBM)	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 that begins in the fall of 2016, displaying quality rating information on the SBM website for consumer access.
Summary indicator	A component of the QRS hierarchy. A score or rating for this component is created by combining scores from associated domains.
Summary-level measure data	The level of QRS clinical measure data that QHP issuers will submit to CMS. Summary-level data elements are specified for each QRS clinical measure in the *QRS Measure Technical Specifications*, and include elements such as eligible population (denominator), numerator, and the rate.
Survey sampling frame	The QHP issuer's eligible population source file that contains a list of the eligible enrollees for which the QHP Enrollee Survey can be administered. The data validator will validate the survey sampling frame, and the HHS-approved QHP Enrollee Survey vendor will generate a member sample based on the validated sampling frame.
Unstandardized Score	The original, raw, measure score value.
Weighted average	An average that is calculated in which some data points (values) contribute more than others to the final average.