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

January 2016

Version 2.0

Document Change Log

Description	Date
Initial release of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016.* This guidance addresses requirements for 2016, which include data submission in the 2016 calendar year for ratings to be displayed for the 2017 plan year. Please see Section 1.1 for a summary of key differences between this document and the *2015 Beta Test for the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2015.*	9/16/2015
Version 2.0 is the final version of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016.* This version of the 2016 Guidance is the final Guidance to communicate 2016 QRS requirements and supersedes the initial version of the Guidance, which was published in September 2015. This guidance includes the finalized QRS rating methodology along with additional details regarding preview and public display of the quality rating information. Please see Section 1.1 for a summary of key differences between this document and the September 2015 release.	1/27/2016

Table of Contents

List of Exhibits

Technical Assistance

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

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

Accompanying Documents

The accompanying document, the *2016 Quality Rating System Measure Technical Specifications* (QRS Measure Technical Specifications), details QRS clinical measure specifications and guidelines for data collection. The document can be found on the Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives (MQI) website (link below). For questions on individual measures, please contact the appropriate measure stewards via the contact information listed in the technical specifications.

Website Links

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

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

Website	Description	Link
CMS QHP Enrollee Survey website	As the central website for the QHP Enrollee Survey, this website includes detailed information on the survey questionnaire, a list of the Department of Health and Human Services (HHS)-approved QHP Enrollee Survey vendors, and survey protocols for vendors (including the *2016 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications*).	http://qhpcahps.cms.gov
National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audit™ website	This website provides additional information related to data validation, including the data validator contracting process, as well as HEDIS® Compliance Audit™ standards, policies, and procedures.	http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditors SoftwareVendors/HEDISComplianceAuditProgram.aspx
Registration for Technical Assistance Portal (REGTAP)	This website serves as an information hub for CMS technical assistance related to Marketplace and Premium Stabilization Program requirements. Registered users can access the library, frequently asked questions, training resources, and the inquiry tracking and management system. Use key word search "Quality Rating System" to identify any resources related to the QRS.	https://www.REGTAP.info
State Exchange Resource Virtual Information System (SERVIS)	This website serves as an information hub for CMS technical assistance related to State-based Marketplace requirements. Registered State users can access relevant resources organized by the Center for Consumer Information and Insurance Oversight (CCIIO) State Exchange Group.	https://servis.cms.gov/resources/

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

1. Document Purpose and Scope

This *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016* (2016 Guidance) document provides technical guidance regarding the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) for 2016. It specifies QRS and QHP Enrollee Survey requirements for QHP issuers offering coverage through the Health Insurance Marketplaces (Marketplaces). Unless the context indicates otherwise, the term "Marketplaces" refers to the Federally-facilitated Marketplaces (FFMs) (inclusive of FFMs where the State performs plan management functions) and the State-based Marketplaces (SBMs).

This subsequent version of the 2016 Guidance, version 2.0, communicates 2016 QRS requirements and supersedes the initial version of the Guidance that was published in September 2015. Specifically, version 2.0 includes the final rating methodology, based on the analysis of the 2015 beta test results, and additional details regarding the preview process and the Marketplace display guidelines for QHP quality rating information. Section 1.1 highlights all key updates made since the initial version of the 2016 Guidance. CMS anticipates issuing guidance at least annually in the fall before the year of data submission.

The primary audience for the 2016 Guidance is QHP issuers, but it also includes information relevant to other stakeholders involved with QRS and QHP Enrollee Survey implementation (e.g., SBMs, data validators, Department of Health and Human Services [HHS]-approved survey vendors). The 2016 Guidance addresses requirements for 2016, which includes data submission in the 2016 calendar year for ratings to be displayed for the 2017 plan year.[1]

The requirements outlined in this document are based on statute and Centers for Medicare & Medicaid Services (CMS) regulation, including the "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" final rule.[2]

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

1.1 Section Guide

In addition to the initial background sections, this document includes the information noted below. Where applicable, the section descriptions highlight key differences between the initial version of the 2016 guidance, released in September 2015, and this final version, as well as differences in QRS and QHP Enrollee Survey requirements between the 2016 Guidance and the 2015 Beta Test Guidance.[3]

[1] All references to "coverage year" have been changed to "plan year" since the initial version of 2016 Guidance. The year referenced is the same year, but the term has been revised to reflect most common usage.
[2] "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.).
[3] The guidance for the 2015 beta test was titled *2015 Beta Test for the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2015.*

- ***Section 4. Implementation Schedule for the QRS and QHP Enrollee Survey*:** This section provides a snapshot of the implementation process, key dates, and the stakeholder(s) with primary responsibility for critical action(s).
- ***Section 5. Marketplace Oversight Responsibilities*:** This section describes Marketplace responsibilities related to the QRS and QHP Enrollee Survey.
- ***Section 6. QRS and QHP Enrollee Survey Requirements*:** This section outlines the criteria for determining which QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS. This section also describes the QRS measure set and details the requirements for data collection, data validation, and data submission for the QRS and the QHP Enrollee Survey.
  - **As compared to the initial version of the 2016 Guidance**, this section includes more details regarding determining which enrollees to include in the reporting unit.

Key Differences in Requirements Between the 2015 Beta Test Guidance and the 2016 Guidance
For 2015, QHP issuers were given the option to include enrollees from identical QHPs offered outside the Marketplace. For 2016, enrollees in QHPs that are offered outside the Marketplace (off-Marketplace) and non-QHPs are not included. For 2015, QHP issuers were required to collect and submit validated data for 29 of the 43 measures in the QRS measure set. For 2016, QHP issuers are required to collect and submit validated data for all 43 measures in the QRS measure set.

- ***Section 7. QRS Rating Methodology*:** This section provides an overview of the rating methodology used to produce the QRS scores and ratings from QRS measure data.
  - **As compared to the initial version of the 2016 Guidance**, the details shown here reflect the *finalized* rating methodology for 2016, based on the results of the 2015 beta test data analysis. This section includes expanded details in referenced Appendices, including detailed scoring specifications for QRS survey measures.
- ***Section 8. Quality Rating Information Preview Process*:** This section describes the process by which QHP issuers and Marketplaces will be able to review QRS ratings and QHP Enrollee Survey results in advance of public display.
  - **As compared to the initial version of the 2016 Guidance**, this final version includes additional details about the process and timing for the preview period.
- ***Section 9. Marketplace Display Guidelines for QHP Quality Rating Information*:** This section gives an overview of the guidelines for display of QHP quality rating information on Marketplace websites to help consumers compare QHPs.
  - **As compared to the initial version of the 2016 Guidance**, this final version includes additional details about the content, process, and timing of the required display of QHP quality rating information.

Key Differences in Display Between the 2015 Beta Test Guidance and the 2016 Guidance
In 2016, Marketplaces are required to publicly display QHP quality rating information for the first time, making the ratings available for consumers in time for the individual market open enrollment period for 2017.

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

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

2. Background

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

Based on this authority, CMS issued a regulation in May 2014 to establish standards and requirements related to QHP issuer data collection and public reporting of quality rating information in every Marketplace.[5] CMS requires that QHP issuers submit this information (QRS clinical measure data and QHP Enrollee Survey response data) for their respective QHPs offered through a Marketplace in accordance with CMS guidelines as a condition of certification and participation in the Marketplaces.[6] Marketplaces are also required to display the QHP quality rating information on their respective websites.[7] Appendix A includes relevant statutory and regulatory citations for the QRS and QHP Enrollee Survey.

3. Overview

The goals of the QRS and QHP Enrollee Survey are:

- To provide comparable and useful information to consumers about the quality of health care services and enrollee experience of QHPs offered through the Marketplaces;

[4] The Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively referred to as the Affordable Care Act).
[5] "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 §§ 156.1120; 1125.
[6] 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125).
[7] 45 CFR § 155.1400 and § 155.1405.

- To facilitate oversight of QHP issuer compliance with quality reporting standards set forth in the Affordable Care Act and implementing regulations; and
- To provide actionable information that QHP issuers can use to improve quality and performance.

CMS has aligned federal quality reporting standards for QHP issuers with other federal and State quality reporting program standards, while continuing to reflect the National Quality Strategy (NQS) priorities for improving the quality of health and health care.[8] States have the flexibility to build upon the federal quality reporting standards by setting additional standards for QHPs that reflect State priorities and population-based needs.

QHP issuers and Multi-State Plan (MSP) issuers that offered coverage through a Marketplace in the prior year are required to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS as a condition of certification.[9] An MSP option, certified by and under contract with the U.S. Office of Personnel Management (OPM), is recognized as a QHP for purposes of 45 CFR §155.1010. Therefore, the QHP issuer requirements as described in this 2016 Guidance also apply to QHP issuers offering MSP options. Additional MSP quality reporting requirements, if required, will be specified by OPM.

CMS will calculate the quality performance ratings for QHPs offered through all Marketplaces, regardless of the Marketplace model. CMS will apply the QRS rating methodology to validated QRS clinical measure data and a subset of the QHP Enrollee Survey response data (QRS survey measures) to produce quality ratings on a 5-star rating scale.[10] CMS will collect data and calculate quality ratings for each QHP issuer's product type (i.e., exclusive provider organization [EPO], health maintenance organization [HMO], point of service [POS], and preferred provider organization [PPO]) within each State and apply these ratings to each product type's QHPs in that State. Beginning with the individual market open enrollment period for 2017, Marketplaces are required to prominently display QHP quality rating information on their websites to help consumers compare QHPs.[11]

CMS anticipates issuing guidance at least annually and also expects to refine the QRS and QHP Enrollee Survey over time, based on experience with measuring and reporting quality performance for QHPs offered through the Marketplaces.

[8] The NQS was first published by the Agency for Healthcare Research and Quality (AHRQ) in March 2011 as the *National Strategy for Quality Improvement in Health Care*. It established a framework for coordinating quality improvement efforts of health care payers, purchasers, providers, and consumers. The NQS established a set of three broad aims, building on the Institute for Healthcare Improvement's Triple Aim®, supported by six priorities**.** See http://www.ahrq.gov/workingforquality/ for additional information.
[9] 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125.
[10] 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.
[11] 45 CFR § 155.1400 and § 155.1405.

4. Implementation Schedule for the QRS and QHP Enrollee Survey

Exhibit 1 highlights key events and dates associated with 2016 QRS and QHP Enrollee Survey implementation. Adherence to this schedule enables timely data submission and ratings calculations. CMS expects QHP issuers to meet the following deadlines so that data validators (Healthcare Effectiveness Data and Information Set [HEDIS®] Compliance Auditors™) and survey vendors can effectively support QHP issuers in complying with the data collection and submission requirements. Details are addressed in the sections that follow.

Exhibit 1. Implementation Schedule for the 2016 QRS and QHP Enrollee Survey

Event	Date
QHP issuer contracts with a HEDIS® Compliance Organization (National Committee for Quality Assurance [NCQA]-licensed) for validation of the QHP Enrollee Survey sampling frame and the QRS clinical measure data.	**Deadline:** December 1, 2015
QHP issuer contracts with an HHS-approved QHP Enrollee Survey vendor and authorizes vendor to conduct the QHP Enrollee Survey and submit survey response data to CMS.	**Deadline:** January 5, 2016
QHP issuer and HEDIS® Compliance Auditor (employee of or contracted by of the HEDIS® Compliance Organization) complete validation of QHP Enrollee Survey sampling frame.	**Deadline:** January 29, 2016
QHP issuer completes NCQA's Healthcare Organization Questionnaire (HOQ) to prepare for QRS clinical measure data submission.	**Deadline:** February 29, 2016
QHP issuer and HEDIS® Compliance Auditor complete the HEDIS® Compliance Audit.	January – June 2016[12]
HHS-approved QHP Enrollee Survey vendor conducts the QHP Enrollee Survey on the validated survey sampling frame.	February – May 2016
HHS-approved QHP Enrollee Survey vendor submits the QHP Enrollee Survey response data to CMS (on behalf of the QHP issuer) via a secure data submission function on the QHP Enrollee Survey website (http://qhpcahps.cms.gov).	**Deadline:** May 25, 2016
QHP issuer submits the validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS).[13] Note: Each QHP issuer must submit and plan-lock its QRS clinical measure data by June 8 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit-lock all submissions by the June 15 deadline.	**Deadline:** June 15, 2016
QHP issuers, Marketplace administrators, and CMS preview the QHP quality rating information.	Anticipated August 2016
The FFMs and SBMs publicly display QHP quality rating information.	**Deadline:** Individual market open enrollment period for 2017[14]

[12] Please see the general guidelines in the *2016 Quality Rating System Measure Technical Specifications* for a more detailed timeline for the HEDIS® Compliance Audit.
[13] There are no fees for QHP issuers associated with accessing and using the IDSS.
[14] Based on the Notice of Benefit and Payment Parameters for 2017 proposed rule, CMS anticipates the individual market open enrollment period for 2017 will begin on November 1, 2016. This date will be finalized in the final rule.

5. Marketplace Oversight Responsibilities

Marketplaces are responsible for QHP certification and oversight of compliance with certification standards by QHP issuers operating in their respective Marketplaces. This responsibility includes a requirement to oversee QHP issuer implementation and compliance with the QRS and QHP Enrollee Survey.[15] As a function of this responsibility, CMS (on behalf of the FFMs) and the SBMs will monitor and enforce compliance with QRS and QHP Enrollee Survey requirements with respect to QHP issuers operating in their respective Marketplaces. Similarly, OPM is responsible for MSP certification and MSP issuer oversight and, therefore, will oversee MSP issuer compliance with these requirements. Since CMS is responsible for calculating quality ratings for all QHPs and MSP options in every Marketplace, CMS will coordinate with the SBMs and OPM as needed to support their oversight efforts.[16]

CMS will provide the SBMs[17] with: (1) a list of QHP issuers that have eligible reporting units (as defined in Section 6.1) and are, therefore, required to submit QRS clinical measure and QHP Enrollee Survey response data; and (2) a status update following the data submission deadline with a list of QHP issuers that submitted data for their eligible reporting units. The SBMs can use this information to support oversight of their respective QHP issuers' compliance with QRS and QHP Enrollee Survey requirements. CMS will also provide this information to OPM for MSP issuer oversight.

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

6. QRS and QHP Enrollee Survey Requirements

This section outlines which QHP issuers must comply with QRS and QHP Enrollee Survey requirements (i.e., collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS). This section also describes the QRS measure set, which includes both clinical measures and survey measures derived from a subset of questions in the QHP Enrollee Survey. Lastly, this section details the requirements for data collection, data validation, and data submission for the QRS and the QHP Enrollee Survey.

6.1 Participation Criteria for QHP Issuers

QRS and QHP Enrollee Survey requirements apply to QHP issuers offering QHPs, for at least one year, through the Marketplaces[18] that meet participation criteria defined in this section.

[15] 45 C.F.R. § 155.200(d).
[16] 45 CFR § 155.1010(a)(2) and § 155.200(d).
[17] SBMs, unless otherwise noted, include State-based Marketplaces – Federal Platform (SBM-FP) states (i.e., the SBM states that use HealthCare.gov).
[18] Marketplaces refer to the FFMs (inclusive of States performing plan management functions in State Partnership States) and the SBMs.

QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data by product type with separate submissions by State.[19] QHP issuers may not combine product types. Therefore, the reporting unit for the QRS and QHP Enrollee Survey is defined by the unique State-product type for each QHP issuer. Product types subject to the QRS and QHP Enrollee Survey requirements include EPOs, HMOs, POSs, and PPOs. Indemnity plans should not be included.

QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data for each of the above noted product types offered through a Marketplace in the previous year. For 2016 reporting, validated data must be submitted for each of the above noted product types offered through a Marketplace in 2016 that had more than 500 enrollees as of July 1, 2015.[20, 21] Reporting units (i.e., State-product type) that are discontinued before June 15, 2016, are exempt. When determining which enrollees to include in each reporting unit, QHP issuers must consider the following requirements:

- Include enrollees in QHPs offered through the Marketplace in the 2016 QRS and QHP Enrollee Survey data submissions *regardless of how they enrolled in these QHPs*. For example, an eligible enrollee who does not have access to a Marketplace website could enroll in a Marketplace QHP directly with a QHP issuer; such an enrollee is to be included in 2016 QRS and QHP Enrollee Survey data submissions. These QHPs will be designated by Health Insurance Oversight System (HIOS) ID variants -01 through -06.
- Do not include enrollees in QHPs offered outside the Marketplace (off-Marketplace health plans) and non-QHPs in the 2016 QRS and QHP Enrollee Survey data submissions. Off-Marketplace health plans include those that mirror QHPs offered through a Marketplace due to guaranteed availability requirements (Section 147.104(a) of the Affordable Care Act), and are designated with a HIOS variant ID -00.
- Include enrollees in QHPs that provide family and/or adult-only medical coverage (unless noted otherwise in the *2016 Quality Rating System Measure Technical Specifications*). At this time, QRS and QHP Enrollee Survey requirements do not apply to child-only plans or stand-alone dental plans.[22]
- Combine enrollees from both QHP and MSP products if the QHP issuer offers both a QHP and an MSP option of the same product type in the same State.
- Combine enrollees from both the individual market and Small Business Health Options Program (SHOP) if the QHP issuer offers the same product type in the individual market as well as the SHOP within a State.

[19] Pursuant to 45 C.F.R. 156.1120(a)(3) and 156.1125(b)(3), QHP issuers participating in the Marketplaces must include information in their respective QRS and QHP Enrollee Survey data submissions only for those enrollees at the level specified by HHS.
[20] 45 CFR § 156.1120(a) and § 156.1125(b).
[21] The QHP Enrollee Survey minimum enrollment requirement aligns with standards set forth in 45 CFR § 156.1125(b)(1). CMS established the minimum enrollment requirement for QRS to align with the QHP Enrollee Survey minimum enrollment requirement and to support a sufficient size for credible and reliable results.
[22] A limited number of child-only QHPs and enrollees may prohibit reliable child-only QRS rating calculations and QHP Enrollee Survey results. CMS will continue to monitor child-only plans and stand-alone dental plans, and will consider developing a quality rating system and QHP Enrollee Survey for these plan types in the future.

Example:

A fictional QHP issuer is certified to offer family medical coverage in two states: West Virginia (WV) and Maryland (MD). Exhibit 2 shows the characteristics of its reporting units. In accordance with the participation criteria defined above, this QHP issuer must collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS for only the following reporting units: WV PPO, and MD EPO. The other reporting units either did not have sufficient number of enrollees as of July 1, 2015, or were discontinued before June 15, 2016.

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

Reporting Unit	Number of enrollees in the reporting unit as of July 1, 2015 (total and per individual market vs. SHOP)	Offered in 2016 as of June 15, 2016	Meets 2016 participation criteria? (i.e., required to submit QRS and QHP Enrollee Survey measure data)?
WV PPO	505 (505 individual, 0 SHOP)	Yes	Yes
WV HMO	601 (501 individual, 100 SHOP)	No	No
MD PPO	100 (55 individual, 45 SHOP)	Yes	No
MD HMO	500 (300 individual, 200 SHOP)	Yes	No
MD EPO	700 (600 individual, 100 SHOP)	Yes	Yes

QHP issuers should seek guidance from CMS via the Exchange Operations Support Center (XOSC) Help Desk for specific questions related to the eligibility of a reporting unit to meet the QRS and QHP Enrollee Survey participation criteria. Details on addressing membership changes in measure data collection are provided in the General Guidelines for Data Collection section of the *2016 Quality Rating System Measure Technical Specifications* under "Membership Changes."

6.2 QRS Measure Set

QHP issuers that meet the participation criteria as defined in Section 6.1 are required to collect and submit validated data for all measures as listed in Exhibit 3 below. The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Some measures have multiple indicators (or rates). QHP issuers are required to submit validated data for all indicators within a measure, unless a specific indicator is shown in parentheses next to the measure, in which case only the indicator must be reported (e.g., for Childhood Immunization Status [Combination 3], only Combination 3 must be reported) . QHP issuers should refer to each measure's technical specifications, which specify criteria for determining the eligible population and ability to submit data for the measure (e.g., a measure may require multiple years of continuous enrollment and, therefore, a new QHP issuer or reporting unit may be unable to report a numeric rate for this measure).

The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[23] surveys. See Section 6.2.1 for details on the QHP Enrollee Survey.

Appendix B includes summaries of each measure. For detailed measure specifications, refer to the QRS Measure Technical Specifications. Note that all QRS survey measures (except for the three HEDIS-based measures[24]), as well as the QRS clinical measure, Plan All-Cause Readmissions, are case-mix adjusted.[25] For additional information on how measures are used for scoring, please see Section 7.1.

Exhibit 3. QRS Measure Set

Measure Title	National Quality Forum (NQF) ID[26]	QRS Measure Type
Access to Care	Not Endorsed[27]	Survey
Access to Information	Not Endorsed	Survey
Adult BMI Assessment	Not Endorsed	Clinical
Annual Dental Visit	Not Endorsed	Clinical
Annual Monitoring for Patients on Persistent Medications	2371	Clinical
Antidepressant Medication Management	0105	Clinical
Appropriate Testing for Children With Pharyngitis	Not Endorsed	Clinical
Appropriate Treatment for Children With Upper Respiratory Infection	0069	Clinical
Aspirin Use and Discussion	Not Endorsed	Survey
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058	Clinical
Breast Cancer Screening[28]	2372	Clinical
Care Coordination	Not Endorsed	Survey
Cervical Cancer Screening	0032	Clinical
Childhood Immunization Status (Combination 3)	0038	Clinical
Chlamydia Screening in Women	0033	Clinical
Colorectal Cancer Screening	0034	Clinical
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055	Clinical
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575	Clinical
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057	Clinical
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	Clinical

[23] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The CAHPS® surveys are available at https://cahps.ahrq.gov.
[24] The three HEDIS-based measures collected via the QHP Enrollee Survey are Aspirin Use and Discussion, Flu Vaccinations for Adults Ages 18 – 64, and Medical Assistance with Smoking and Tobacco Use Cessation.
[25] See Appendix F for more information on case-mix adjustments.
[26] Definitions of NQF-endorsed measures can be found here: http://www.qualityforum.org/Home.aspx
[27] The QRS Access to Care measure includes two separate NQF-endorsed measures (Getting Needed Care and Getting Care Quickly) along with an additional CAHPS® Health Plan Supplemental question regarding getting after-hours care.
[28] The Breast Cancer Screening measure requires three years of continuous member enrollment. Therefore, QHP issuers may be unable to report a numerical rate for this measure, given coverage was first offered in the Marketplaces for 2014.

Measure Title	National Quality Forum (NQF) ID[26]	QRS Measure Type
Controlling High Blood Pressure	0018	Clinical
Cultural Competence	Not Endorsed	Survey
Flu Vaccinations for Adults Ages 18-64	0039	Survey
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	0576	Clinical
Follow-Up Care for Children Prescribed ADHD Medication	0108	Clinical
Human Papillomavirus Vaccination for Female Adolescents	1959	Clinical
Immunizations for Adolescents (Combination 1)	1407	Clinical
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	Clinical
Medical Assistance With Smoking and Tobacco Use Cessation*	0027	Clinical
Medication Management for People With Asthma (75% of Treatment Period)	1799	Clinical
Plan Administration	Not Endorsed	Survey
Plan All-Cause Readmissions	1768	Clinical
Prenatal and Postpartum Care	1517	Clinical
Proportion of Days Covered	0541	Clinical
Rating of All Health Care	0006	Survey
Rating of Health Plan	0006	Survey
Rating of Personal Doctor	0006	Survey
Rating of Specialist	0006	Survey
Relative Resource Use for People with Diabetes (Inpatient Facility Index)	1557	Clinical
Use of Imaging Studies for Low Back Pain	0052	Clinical
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024	Clinical
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	1392	Clinical
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516	Clinical

6.2.1 QHP Enrollee Survey

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

Exhibit 4. QHP Enrollee Survey Topics

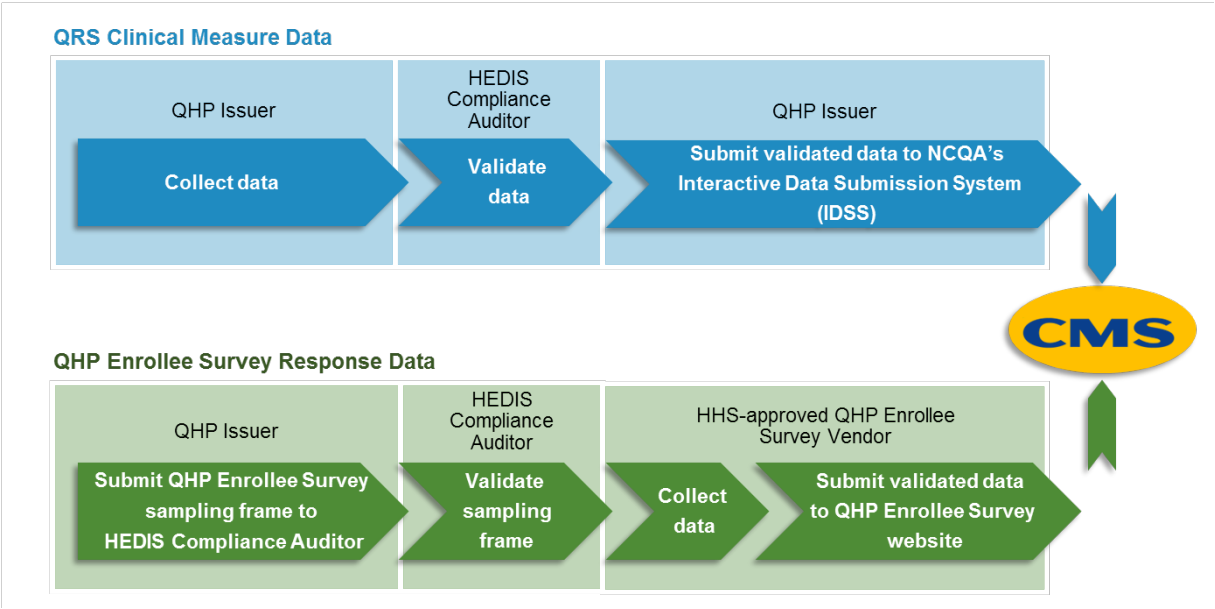
QHP Enrollee Survey Topics *(Asterisk [*] indicates survey questions within this topic are not included in QRS survey measures)*
Access to Care
Access to Information
Care Coordination
Cost*

QHP Enrollee Survey Topics *(Asterisk [*] indicates survey questions within this topic are not included in QRS survey measures)*
Cultural Competence
Doctor Communication *
Plan Administration
Prevention

6.3 Data Collection, Validation, and Submission

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

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



6.3.1 Data Collection

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

6.3.1.1 QRS Clinical Measure Data Collection

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

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

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

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

6.3.1.2 QHP Enrollee Survey Data Collection

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

Each QHP issuer must formally authorize its chosen survey vendor to collect and submit QHP Enrollee Survey response data to CMS on its behalf.[29] In the fall of 2015, QHP issuers received instructions on the survey vendor authorization process. These instructions include the step-by-step process for authorizing a survey vendor, including information on how to log in to the QHP Enrollee Survey website, the timeline for authorizing a survey vendor, and the list of reporting units that the QHP issuer must include to comply with the survey requirements.

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

6.3.2 Data Validation

Each QHP issuer must have its clinical measure data and the QHP Enrollee Survey sampling frame validated by a data validator, in accordance with measure stewards' protocols, prior to data submission.[30] For 2016, 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.[31] The sections below contain details related to these data validation requirements.

[29] 45 CFR § 156.1125(a).
[30] 45 CFR § 156.1120(a)(2) and § 156.1125(b)(2).
[31] The Pharmacy Quality Alliance (PQA) does not have a defined measure validation strategy for the Proportion of Days Covered measure. CMS requires this measure to be validated using the HEDIS Compliance Audit™ standards, policies, and procedures.

6.3.2.1 Data Validators

QHP issuers must use 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 (if necessary).

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

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

6.3.2.2 Data Validation Standards

The data validation standards are specified in the *HEDIS® Compliance Audit: Standards, Policies, and Procedures*. Auditors will use this uniform set of data validation standards to assess each QHP issuer's information system characteristics and capabilities, as well as its compliance with the *2016 Quality Rating System 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://store.ncqa.org/index.php/performance-measurement.html.

6.3.2.3 Data Validation Results

All QRS measures must have a final, validated result that indicates data are complete, accurate, and comparable. Using the HEDIS® 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.

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

- **A rate:** The QHP issuer followed the specifications and produced a reportable rate (numeric result) for the measure.
- **Benefit Not Offered (NB):** The QHP issuer did not offer the health benefit required by the measure.
- **Biased Rate (BR):** The QHP issuer's calculated rate was materially biased.
- **Not Reported (NR):** The QHP issuer chose not to report the measure.

- **Not Applicable (NA):** The QHP issuer followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. The QHP issuer did not have sufficient data to fulfill the continuous enrollment criteria for the measure. For example, a QHP issuer that has operated for only one year may be unable to meet the continuous enrollment criteria for Breast Cancer Screening, which requires multi-year continuous enrollment as outlined in the *2016 Quality Rating System Measure Technical Specifications*.

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

See Section 7 for information on how non-numerical audit results (i.e., BR, NA, NB, and NR results) will be handled by the QRS rating methodology. See Section 9 for additional information about what will be displayed publicly on Marketplace websites in the case that a reporting unit is unable to receive a rating.

6.3.2.3.1 Compliance Reviews

CMS may conduct targeted compliance reviews under 45 CFR 156.715 to examine QHP issuer compliance with the federal data submission and reporting requirements for the QRS and QHP Enrollee Survey (subsequent to data validation of QRS clinical measure and QHP Enrollee Survey response data). These reviews could occur in cases where CMS suspects QHP issuers' mishandling of data, inappropriate processing, or implementation of incorrect practices has resulted in erroneous data, scores, or ratings. Examples would include, but are not limited to: a QHP issuer's failure to adhere to QRS and QHP Enrollee Survey reporting requirements and a QHP issuer's failure to pass data validation directly related to data reported for specific measures. Based on the findings of this compliance review or other evidence received by CMS, CMS may take enforcement action, such as civil money penalties and/or decertification of the affected QHPs.[32]

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

6.3.3 Data Submission

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

6.3.3.1 QRS Clinical Measure Data Submission

All QHP issuers submitting QRS clinical measure data must complete the Healthcare Organization Questionnaire (HOQ) to gain access to NCQA's web-based tool, the Interactive Data Submission System (IDSS). There are no fees for QHP issuers associated with accessing

[32] 45 C.F.R. 156.800.

and using the IDSS. Upon completion of the HOQ, a QRS-specific submission ID will be created in the IDSS. NCQA opens the annual HOQ completion process in early January 2016 and closes access at the end of February 2016. The HOQ can be accessed at: http://CustomerCenter.ncqa.org once opened by NCQA. For more information regarding the HOQ, visit http://www.ncqa.org/tabid/219/Default.aspx. QHP issuers should submit questions about the HOQ to the NCQA portal at: https://my.ncqa.org/.

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

QHP issuers must work with their HEDIS® Compliance Auditors to submit the validated QRS clinical measure data and signed attestations (i.e., data are accurate and reflect plan performance) by 11:59 p.m. Eastern Time (ET), June 15, 2016. QHP issuers should submit questions regarding the IDSS to the NCQA portal at: https://my.ncqa.org/.

6.3.3.2 QHP Enrollee Survey Data Submission

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

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

7. QRS Rating Methodology

This section describes how CMS will calculate 2016 QRS quality ratings based on the QRS clinical measure and QHP Enrollee Survey response data submitted in 2016. The final QRS rating methodology for 2016, presented below, is consistent with the final rating methodology for the 2015 beta test (detailed in the *QRS Rating Methodology for 2015).* CMS made refinements to the content presented in the *QRS Rating Methodology for 2015* for improved clarity only.

7.1 Measures and Scoring

For 2016, QHP issuers are required to collect and submit validated data for all 43 measures in the QRS measure set. CMS will use the same rating methodology that was used for the 2015 beta test, meaning, only 28 of the required 43 measures will be used for scoring. These measures are those that require only one year of data per the continuous enrollment criteria as defined in the measure technical specifications. [33] After scoring in 2016, CMS will use data from all measures

[33] Note that, in communicating total measure counts, the totals count a measure based on the perspective of the measure steward. If counting based on the number of measures in the QRS hierarchy, there are 31 measures used in scoring (rather than 28) and 46 measures collected in total (rather than 43). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care (NQF #1517) is split into two distinct measures for the QRS hierarchy (and, therefore, QRS scoring): Timeliness of Prenatal Care and Postpartum Care. Similarly, Proportion of Days Covered (NQF #0541) is split into three distinct measures: Diabetes All Class, Renin Angiotensin System (RAS) Antagonists, and Statins.

submitted in 2016 to conduct further analyses to inform refinements to the 2017 QRS rating methodology. This approach is summarized in Exhibit 6.

Exhibit 6. QRS Measures and Scoring

	2015 (beta test)	2016 (current year)
Number of measures required for QRS data submission	29	43 (all measures)*
Number of measures to be used for QRS scoring	28**	28**
* QHP issuers should refer to each measure's technical specifications, which specify criteria for determining the eligible population and ability to submit data for the measure (e.g., a measure may require multiple years of continuous enrollment and, therefore, a new QHP issuer or reporting unit may be unable to report a numeric rate for this measure). ****** CMS will use the same QRS measures in scoring for 2015 and 2016. For the complete list of measures used for scoring in 2016, please see Appendix D.		

While QHP issuers are required to submit QRS measure data beginning with their second year as a certified entity (as defined by Section 6.1), a QHP issuer is not eligible to receive QRS scores and ratings for its eligible reporting unit until its *third* consecutive year operating in the Marketplace. Therefore, a reporting unit that is eligible to be scored must meet the criteria for data submission (as defined by Section 6.1) *and have been in operation for at least three consecutive years.* For example, as shown in Exhibit 7, the QHP issuers eligible for receiving QRS scores and ratings in 2016 need to have had a reporting unit that operated in 2014, 2015, and 2016.

Exhibit 7. Reporting Unit Data Submission and Scoring Example

Criteria	Required to submit data?	Eligible to be scored?
Reporting unit operates in current year only (2016). ▪ Reporting unit was not decertified or discontinued before June 15 of current year (2016).	No	No
Reporting unit operates in current year and prior year (2016 and 2015). ▪ More than 500 enrollees as of July 1 of prior year (2015). ▪ Reporting unit was not decertified or discontinued before June 15 of current year (2016).	Yes	No
Reporting unit operates for at least three consecutive years (2016, 2015, and 2014). ▪ More than 500 enrollees as of July 1 of prior year (2015). ▪ Reporting unit was not decertified or discontinued before June 15 of current year (2016).	Yes	Yes

A reporting unit that is eligible for scoring means that the data submitted for this reporting unit is included in ratings calculation. To specify, this means the data are included with all other

submitted data to create the national all-product reference group and that QRS scores and ratings are calculated for that reporting unit.

A QHP issuer that was not required to submit QRS clinical measure and QHP Enrollee Survey response data for a given reporting unit (due to inability to meet participation criteria as defined by Section 6.1) can still submit validated data for that reporting unit. However, CMS will not include data from this reporting unit in QRS scoring as the reporting unit did not meet the participation/data submission criteria.

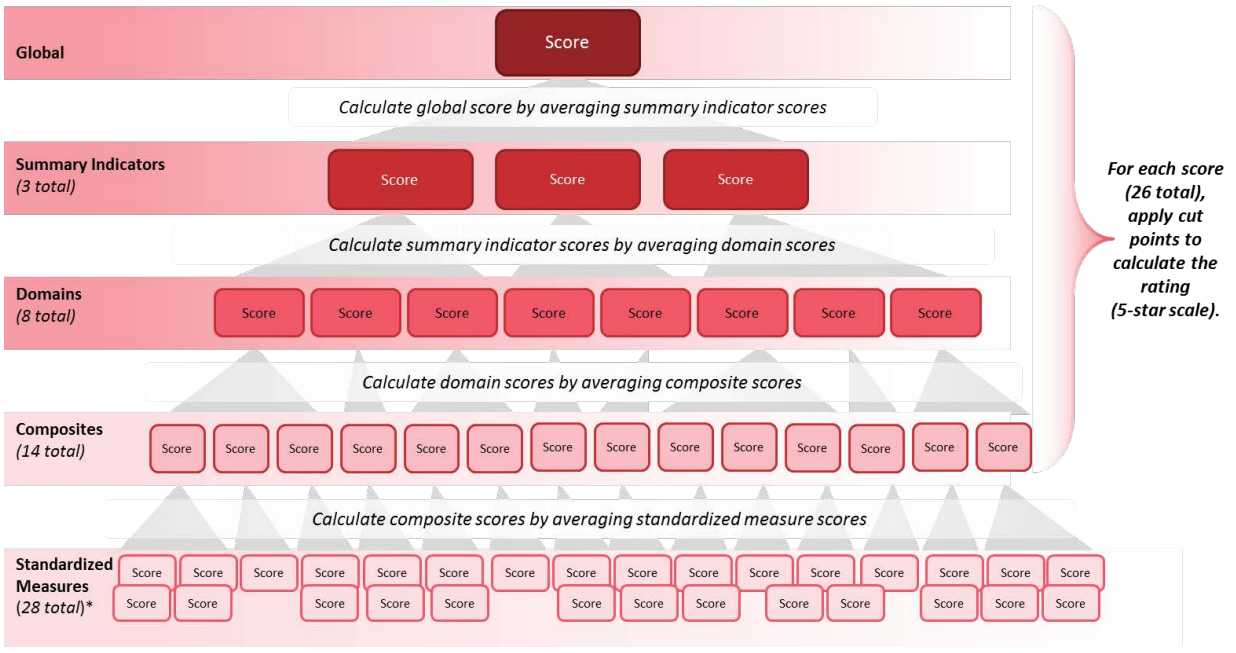
7.2 QRS Hierarchy

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

7.3 Overview of Process for Calculating QRS Scores and Ratings

Exhibit 8 is a visual depiction of how the QRS rating methodology converts standardized measure scores into higher-level QRS hierarchy component scores and ratings. Component scores are calculated by averaging scores of components in a lower level of the hierarchy. Thus, the global score is an average of summary indicator scores, summary indicator scores are averages of associated domain scores, and domain scores are averages of associated composite scores.

Exhibit 8. Overview of QRS Rating Methodology



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

7.4 Scoring Process in Detail

Exhibit 9 outlines the process for calculating QRS scores and ratings. Each step is described in greater detail in the Sub-steps column.

Exhibit 9. Steps for Calculating QRS Scores and Ratings

Step	Sub-steps
Step 1. Prepare Data	▪ *Combine the measure's indicator values 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*. The minimum denominator size is 30 observations for clinical measures and 100 for survey measures.
Step 2. Calculate Standardized Measure Scores	▪ *Calculate standardize measure scores.* Using a national reference group based on calculable measure rates from all reporting units, standardize each measure rate by assigning a percentile rank.
Step 3. Calculate Composite Scores	▪ *Determine if the score can be calculated.* Apply the half-scale rule, meaning the composite score can be calculated only if at least half of the associated measures have a score. ▪ *Calculate the score.* Average available standardized measure scores.
Step 4. Calculate Domain Scores	▪ *Determine if the score can be calculated.* Apply the half-scale rule, meaning the domain score can be calculated only if at least half of the associated composites have a score. ▪ *Calculate the score.* Average available composite scores.
Step 5. Calculate Summary Indicator Scores	▪ *Determine if the score can be calculated.* Apply the half-scale rule, meaning the summary indicator score can be calculated only if at least half of the associated domains have a score. ▪ *Calculate the score.* Average available domain scores.
Step 6. Calculate Global Score	▪ *Determine if the score can be calculated*. The global score can be calculated only if the Clinical Quality Management summary indicator has a score and at least one of the other two summary indicators has a score. ▪ *Calculate the score*. Average available summary indicator scores.
Step 7. Convert scores to ratings	▪ *Identify cut point values for each component using cluster analysis.* ▪ *Convert scores to ratings*. Convert each composite, domain, summary indicator, and global score into a rating using score value cut points that delineate rating categories of 1, 2, 3, 4, and 5.

8. Quality Rating Information Preview Process

CMS will provide QHP issuers and Marketplace administrators the opportunity to preview their respective QHP quality rating information (anticipated August 2016). QHP issuers in all Marketplaces will be able to preview their respective QRS quality ratings via the CMS Health Insurance Oversight System (HIOS)-Marketplace Quality Module (MQM) website and to submit any related inquiries to CMS during a two-week QRS preview period. CMS will provide further instructions in advance of the QRS preview period.

CMS anticipates providing 2016 proof sheets to QHP issuers during the QRS preview period. Each proof sheet will be specific to the given reporting unit and will provide the QHP issuer with the information required to replicate the QRS methodology calculations. The proof sheets will contain the output of the calculations for each step of the QRS methodology, from standardized measure scores through the global score and rating. The proof sheets will include the cut points

used to convert numeric scores to star ratings for each QRS hierarchy component. The proof sheets will include benchmark information for measure results and an associated definition/rationale for any invalid/non-numeric results (e.g., NR). The proof sheets will include results for all QRS measures, including those that were collected, but not included in scoring for 2016. The proof sheets will be accompanied by a user guide that describes the contents of the proof sheets and the QRS rating methodology.

QHP issuers will also receive a QHP Enrollee Survey Quality Improvement (QI) report for each reporting unit in late summer of 2016. Each report will include the reporting unit's results for all QHP Enrollee Survey composite measures and their component questions, as well as the results of individual survey questions. The reports will contain results from all QHP Enrollee Survey composite measures, including those not used in the QRS.

State Marketplace administrators will be able to preview the QRS ratings for reporting units in their respective Marketplaces via the MQM. CMS will also provide State Marketplace administrators with the QHP Enrollee Survey QI reports for the reporting units offered in their respective Marketplaces.

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

CMS will also provide OPM with the QRS results for the MSP options.

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

9. Marketplace Display Guidelines for QHP Quality Rating Information

Marketplaces are required to display the quality rating information assigned to each QHP as calculated by CMS on their respective websites. Ratings should be displayed for QHPs offered through the Marketplace in time for the individual market open enrollment period for 2017[34] to facilitate consumer shopping for the 2017 plan year. The QRS ratings reflect QHP performance by product-type, which includes QHPs in both the SHOP and individual market. Marketplaces should display the ratings for all QHPs in the product type, including QHPs in the SHOP and individual market, as applicable.

CMS will display the 2016 QRS global rating on the HealthCare.gov website for each QHP offered through HealthCare.gov. This includes the SBMs that rely on the federal eligibility and enrollment platform (i.e., State-based Marketplaces – Federal Platform [SBM-FPs]) as well as the FFMs, including FFMs where the State performs plan management functions. CMS is considering displaying additional QRS rating information (i.e., summary indicator ratings) on

[34] Based on the Notice of Benefit and Payment Parameters for 2017 proposed rule, CMS anticipates the individual market open enrollment period for 2017 will begin on November 1, 2016. The date will be finalized in the final rule.

HealthCare.gov. CMS will issue further communication to alert stakeholders if a decision is made to display QRS rating information in addition to the global rating.

SBMs that do *not* rely on the federal eligibility and enrollment platform (i.e., SBMs that do not use HealthCare.gov for eligibility and enrollment functions) are required to display QHP quality rating information in the form and manner dictated by CMS. In 2016, SBMs must display at least the QRS global rating directly on their websites by the start of the individual market open enrollment period for 2017. CMS will issue further communication to alert stakeholders if a decision is made to require display of QRS rating information (i.e., QRS summary indicator ratings) in addition to the global rating.

CMS will make the ratings data accessible for non-HealthCare.gov SBM display purposes via the Quality Ratings Application Program Interface (API). The API will provide a live system integration point for QRS ratings for each QHP down to the QRS summary indicator level (i.e., four ratings in total: one global and three summary indicators). The API approach will correspond with the quality ratings data that will be displayed on the FFM for the 2017 plan year. CMS will also issue technical details to facilitate non-HealthCare.gov SBMs' adherence with display requirements. For example, CMS will provide a prototype of the API along with sample data files to support ratings integration with SBM websites.

States that cannot facilitate an API will be given a State Ratings Data File for display purposes. The State Ratings Data File will include QRS ratings (for all components of the QRS hierarchy) for reporting units in their respective Marketplace. The purpose of the QHP quality rating information is to provide additional comparative information for consumers while shopping and selecting plans. In the initial years, however, if an SBM does not have the capability to include the QRS ratings directly on its plan selection website, the SBM can post the ratings to a static website for consumers to reference outside of the plan selection website. SBMs have the flexibility to display additional State or local quality information, but must prominently display the federally-calculated QRS ratings in the form and manner specified by CMS.

CMS will release additional details specifying the form and manner in which CMS will display QHP quality rating information at HealthCare.gov. For example, CMS anticipates referring to the QRS global rating as the "Quality Rating" on Marketplace websites. Additionally, CMS will be issuing details for what should be displayed in cases where a QHP did not receive a rating. The details of the API and the State Ratings Data Files will be presented and discussed in future webinars and communications. Test files, along with test data released via the API, will be available in February/March 2016.

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

10. Marketing Guidelines for QHP Quality Rating Information

QHP issuers may reference the QRS quality ratings and QHP Enrollee Survey results for its QHPs in its marketing materials, in a manner specified by CMS. [35] Any QHP issuer that elects to

[35] 45 CFR 156.1120(c), 156.1125(c)

include its QHP quality rating information, specifically QRS scores and ratings and QHP Enrollee Survey results, in its marketing materials (whether paper, electronic, or other media) must do so in accordance with the instructions below.[36]

The 2016 marketing guidelines are generally based on CMS guidance related to marketing QHPs as communicated in the *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces*.[37] A QHP issuer that elects to include QRS and QHP Enrollee Survey information in its marketing materials must do so in a manner that does not mislead consumers. The instructions that follow provide details as to the manner in which QRS and QHP Enrollee Survey information must be communicated in marketing materials:

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

[36] The scope of the definition for "marketing" extends beyond the public's general concept of advertising materials. CMS interprets the definition of marketing materials, as referenced here, is equivalent to what is described for the Medicare Advantage program in 42 CFR 422.2260.

[37] See Chapter 4, Section 5, "Oversight of Marketing Activities," in the *Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces*, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf. See also 45 CFR 156. 225 Marketing and Benefit Design of QHPs, 155.260 Privacy and Security, and 156.200(e) Non-discrimination.

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

- **Up-to-date information:** QHP issuers that choose to include QHP quality rating information in marketing materials must use the most up-to-date information. Changes must be made within 30 days of current year's QHP quality rating information becoming final[38] and discontinue marketing based on the previous year's information. CMS anticipates issuing the final QRS ratings to QHP issuers and Marketplace administrators annually prior to the start of the individual market open enrollment period.
- **Specificity of content:** Materials should reference specific QHPs or product types and their CMS-assigned quality rating information. QHP issuers may advertise a product type's quality rating information (e.g., a "5-star HMO") as QRS scores and ratings and QHP Enrollee Survey results are calculated for each product type (i.e., EPO, HMO, POS, PPO) and assigned to each QHP within the product type.
  - Materials should be specific as to the State to which the information applies.
  - QHP issuers with one or more QHPs (or product types) that were assigned a specific QRS global rating (e.g., 5-stars) should not create or disseminate marketing materials in a way that implies that all of their QHPs (or product types) achieved this rating.
  - QHP issuers are encouraged to advertise QRS ratings (i.e., stars) rather than scores (i.e., numerical value), which are less meaningful to consumers.
  - QHP issuers are encouraged to advertise the QRS global rating rather than the rating for other QRS components (i.e., summary indicators, domains, or composites). If QHP issuers choose to advertise ratings for QRS components, the QHP issuer may use only the component titles assigned by CMS without variation (e.g., Clinical Quality Management). Additionally, the QHP issuer must always include the QRS global rating alongside the QRS component rating.
  - The use of a general label in reference to the rating of a specific QHP (e.g., "a 5-star plan") can only be used to reference the QRS global rating, unless the component is specified (e.g., "a 5-star plan for [insert component name]"). QHP issuers may not use the rating for another QRS component (i.e., summary indicator, domain, composite, or measure) to imply a higher global quality rating than actually received. For example, a QHP issuer may not promote a QHP that received a global rating of three stars and a summary indicator rating of five stars as a "5-star plan."

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

  - QHP issuers should not use superlatives (e.g., "highest ranked," "one of the best") without additional context. For example, a QHP that is the only one in the State that received a 5-star rating for a specific QRS component, but received a 3-star global rating, may not be promoted as the highest ranked QHP in the State when other QHPs have a higher global rating.
  - QHP issuers may not claim that any of their product types or QHPs are recommended or endorsed by the Federal Government, HHS, CMS, CCIIO, or the Marketplaces. This includes, but is not limited to, use of the Department's name or logo; the Agencies' name and marks; or the Marketplaces' names, logos, and marks in a manner that would convey the false impression that any product type is recommended or endorsed by the Federal Government, HHS or its Agencies, or the Marketplaces.
- **Compliance with State law and regulations:** QHP issuers must comply with all applicable State laws and regulations on health plan marketing and must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[39]

Pursuant to 45 CFR 156.340(a)(1) and 156.225, a QHP issuer participating in an FFM maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, including affiliated agents and brokers, with the QRS and QHP Enrollee Survey marketing standards. As noted in both the 2015 and 2016 Letter to Issuers, States generally regulate health plan marketing practices and materials and related documents under State law, and CMS does not intend to review QHP marketing materials for compliance with State standards as described at 45 C.F.R. 156.225(a). In the FFMs, CMS may review QHP marketing materials for compliance with applicable federal regulations.[40] CMS will work with States to determine where additional monitoring and review of marketing activities may be needed.

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

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

[39] 45 C.F.R. § 156.225.
[40] 45 CFR 156.200(e); 45 CFR 156.225(b); 45 CFR 156.1120(c); 45 CFR 156.1125(c).

Appendix A. Relevant Statutory and Regulatory Citations

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

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

Topic	Provisions	Citation
QHP certification standards: Public reporting of quality information	(c) RESPONSIBILITIES OF THE SECRETARY.— (1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum— (H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable. (I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act. [*As added by section 10203(a)*]"	Section 1311 (c)(1)(H),(I)
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)

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

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

Topic	Provisions	Citation
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

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

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

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

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

Topic	Provisions	Citation
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

Topic	Provisions	Citation
QHP certification standards: public reporting of QHP quality rating information[41]	(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. (b) *QHP issuer requirement.* A QHP issuer must— (5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the 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

[41] 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 and Insurance Market Standards for the 2015 and Beyond" final rule (May 27, 2014) to cross-reference the QRS statutory provisions and correctly align it with the other quality standards originally listed in the regulation as part of the QHP certification standards.

Topic	Provisions	Citation
Standards for QRS data submission, data validation, implementation timeline, and marketing of QRS ratings; Multi-State Plan requirements	(a) *Data submission requirement.* (1) A QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP that has been offered in an Exchange for at least one year. (2) In order to ensure the integrity of the data required to calculate the QRS, a QHP issuer must submit data that has been validated in a form and manner specified by HHS. (3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS. (b) *Timeline.* A QHP issuer must annually submit data necessary to calculate the QHP's quality ratings to HHS and Exchanges, on a timeline and in a standardized form and manner specified by HHS. (c) *Marketing requirement.* A QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS. (d) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (a) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.	45 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

Exhibit 14 includes measure summaries for the final QRS measure set, organized alphabetically according to the year in which the measure was first required for reporting in the QRS. For detailed QRS clinical measure specifications, refer to the *2016 Quality Rating System Measure Technical Specifications* at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), see: https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system.

Exhibit 14. Measures First Required for Reporting in 2015

Measure Name:	Access to Care
Measure Steward:	AHRQ, CMS
NQF Endorsement ID:	Not Endorsed[42]
Description:	Enrollee experience related to the following: • Got care for illness/injury as soon as needed • Got non-urgent appointment as soon as needed • Easy to get care after regular office hours • How often it was easy to get necessary care, tests, or treatment • Got appointment with specialists as soon as needed
Data Source(s):	QHP Enrollee Survey

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

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

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

Measure Name:	Annual Monitoring for Patients on Persistent Medications
Measure Steward:	NCQA
NQF Endorsement ID:	2371
Description:	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the three rates separately and as a total rate. • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) • Annual monitoring for members on digoxin • Annual monitoring for members on diuretics • Total rate (the sum of the three numerators divided by the sum of the three denominators)[43]
Data Source(s):	Administrative Data

Measure Name:	Appropriate Testing for Children with Pharyngitis
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
Description:	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).
Data Source(s):	Administrative Data

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Measure Name:	Well-Child Visits in the 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

Exhibit 15. Measures first required for reporting in 2016

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

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

Measure Name:	Aspirin Use and Discussion
Measure Steward:	NCQA
NQF Endorsement ID:	Not Endorsed
Description:	The two components of this measure assess different facets of aspirin use management. • *Aspirin Use.* A rolling average represents the percentage of members who are currently taking aspirin. A single rate is reported for which the denominator includes: 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:	Breast Cancer Screening
Measure Steward:	NCQA
NQF Endorsement ID:	2372
Description:	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
Data Source(s):	Administrative Data

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

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

Measure Name:	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 Hybrid

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 Hybrid

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

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

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

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

Appendix C. Crosswalk of 2016 QHP Enrollee Survey Questions Included in the QRS

Exhibit 16. Crosswalk of 2016 QHP Enrollee Survey Questions Included in the QRS

2016 QRS Survey Measure	2016 QHP Enrollee Survey Composite	2016 QHP Enrollee Survey Question Number	Question Wording	Question Source
Access to Care	Getting Care Quickly	4	In the last 6 months, when you **needed care right away**, how often did you get care as soon as you needed?	CAHPS Health Plan 5.0
		6	In the last 6 months, how often did you get an appointment for a **check-up or routine care** at a doctor's office or clinic as soon as you needed?	CAHPS Health Plan 5.0
	Getting Needed Care	11	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	CAHPS Health Plan 5.0
		33	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	CAHPS Health Plan 5.0
	Single Item Measure	8	In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic **after** regular office hours?	CAHPS Health Plan 5.0 — Supplemental Items
Access to Information	Access to Information[44]	37	In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?	CAHPS Health Plan 4.0 — Supplemental Items (HEDIS)
		39	In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?	CAHPS Health Plan 4.0 — Supplemental Items (HEDIS)
		41	In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?	CAHPS Health Plan 4.0 — Supplemental Items (HEDIS)

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

2016 QRS Survey Measure	2016 QHP Enrollee Survey Composite	2016 QHP Enrollee Survey Question Number	Question Wording	Question Source
Care Coordination	Care Coordination[45]	20	When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?	CAHPS Health Plan 5.0 — Supplemental Items
		22	In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?	CAHPS Health Plan 5.0 — Supplemental Items
		23	In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?	CAHPS Health Plan 5.0 — Supplemental Items
		25	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	CAHPS Health Plan 5.0 — Supplemental Items
		28	In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?	CAHPS Health Plan 5.0 — Supplemental Items
		31	In the last 6 months, did you **get the help that you needed** from your personal doctor's office to manage your care among these different providers and services?	CAHPS Health Plan 5.0 — Supplemental Items
Cultural Competence	Cultural Competence	13	In the last 6 months, when you needed an interpreter at your doctor's office or clinic, how often did you get one?	CAHPS Health Plan 5.0— Supplemental Items
		49	In the last 6 months, how often were the forms that you had to fill out available in the language you prefer?	Modified from CG CAHPS 2.0, Adult Supplemental Items
		51	In the last 6 months, how often were the forms that you had to fill out available in the format you needed, such as large print or braille?	Modified from CG CAHPS 2.0, Adult Supplemental Items
Plan Administration	Plan Administration	43	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	CAHPS Health Plan 5.0
		44	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	CAHPS Health Plan 5.0

[45] This composite will be in the new CAHPS Health Plan 5.0 Care Coordination Supplemental Item set.

2016 QRS Survey Measure	2016 QHP Enrollee Survey Composite	2016 QHP Enrollee Survey Question Number	Question Wording	Question Source
Plan Administration	Single Item Measure (Plan Administration)	45	In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected?	New Question developed for QHP Enrollee Survey
		47	In the last 6 months, how often were the forms from your health plan easy to fill out?	CAHPS Health Plan 5.0
		48	In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?	CAHPS Health Plan 5.0—Supplemental Items
Rating of all Health Care	Single Item Measure	10	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	CAHPS Health Plan 5.0
Rating of Health Plan	Single Item Measure	52	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months?	CAHPS Health Plan 5.0
Rating of Personal Doctor	Single Item Measure	26	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	CAHPS Health Plan 5.0
Rating of Specialist	Single Item Measure	35	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?	CAHPS Health Plan 5.0
Flu Vaccinations for Adults Ages 18–64	Single Item Measure (Preventive Services)	60	Have you had either a flu shot or flu spray in the nose since July 1, [YYYY FILL THE MEASUREMENT YEAR (2015 FOR THE SURVEY FIELDED IN 2016)]?	CAHPS 5.0H[46] Survey

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

2016 QRS Survey Measure	2016 QHP Enrollee Survey Composite	2016 QHP Enrollee Survey Question Number	Question Wording	Question Source
Aspirin Use and Discussion	Single Item Measure (Preventive Services)	65	Do you take aspirin daily or every other day?	CAHPS 5.0H Survey
		66	Do you have a health problem or take medication that makes taking aspirin unsafe for you?	CAHPS 5.0H Survey
		67	Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?	CAHPS 5.0H Survey
		68	Are you aware that you have any of the following conditions? *Mark one or more*. High cholesterol, High blood pressure, Parent or sibling with heart attack before the age of 60	CAHPS 5.0H Survey
		69	Has a doctor ever told you that you have any of the following conditions? Mark one or more. Heart attack, Angina or coronary heart disease, Stroke, Any kind of diabetes or high blood sugar.	CAHPS 5.0H Survey
Medical Assistance With Smoking and Tobacco Use Cessation	Single Item Measure (Preventive Services)	62	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	CAHPS 5.0H Survey
		63	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	CAHPS 5.0H Survey
		64	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	CAHPS 5.0H Survey

Appendix D. QRS Hierarchy

Exhibit 17 illustrates the QRS hierarchy, which is the organization of measures into composites, domains, and summary indicators and, ultimately, a single global rating. The survey measures in the QRS measure set are noted with an asterisk (*). Shown in grey are measures (and composites) that are **not included in QRS scoring for 2016** (i.e., scores and ratings will not be calculated). Therefore, when CMS applies the half-scale rule to determine if higher-level component scores can be calculated, only measures that were required for scoring will be considered.

Exhibit 17. QRS Hierarchy

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
Clinical Quality Management	Clinical Effectiveness	Asthma Care	Medication Management for People With Asthma (75% of Treatment Period)	1799
		Behavioral Health	Antidepressant Medication Management	0105
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	0576
			Follow-Up Care for Children Prescribed ADHD Medication	0108
			Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004
		Cardiovascular Care	Controlling High Blood Pressure	0018
			Proportion of Days Covered (RAS Antagonists)	0541
			Proportion of Days Covered (Statins)	0541
		Diabetes Care	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062
			Proportion of Days Covered (Diabetes All Class)	0541
	Patient Safety	Patient Safety	Annual Monitoring for Patients on Persistent Medications	2371
			Plan All-Cause Readmissions	1768
	Prevention	Checking for Cancer	Breast Cancer Screening	2372
			Cervical Cancer Screening	0032
			Colorectal Cancer Screening	0034
		Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	1517
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517
		Staying Healthy Adult	Adult BMI Assessment	Not Endorsed
			Chlamydia Screening in Women	0033
			Aspirin Use and Discussion*	Not Endorsed
			Flu Vaccinations for Adults Ages 18-64*	0039
			Medical Assistance With Smoking and Tobacco Use Cessation*	0027
		Staying Healthy Child	Annual Dental Visit	Not Endorsed
			Childhood Immunization Status (Combination 3)	0038
			Human Papillomavirus Vaccination for Female Adolescents	1959
			Immunizations for Adolescents (Combination 1)	1407
			Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
			Well-Child Visits in the First 15 Months of Life (Six or More Visits)	1392
			Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516
Enrollee Experience	Access	Access to Care	Access to Care*	Not Endorsed
	Care Coordination	Care Coordination	Care Coordination*	Not Endorsed
	Doctor and Care	Doctor and Care	Cultural Competence*	Not Endorsed
			Rating of All Health Care*	0006
			Rating of Personal Doctor*	0006
			Rating of Specialist*	0006
Plan Efficiency, Affordability, & Management	Efficiency & Affordability	Efficient Care	Appropriate Testing for Children With Pharyngitis	Not Endorsed
			Appropriate Treatment for Children With Upper Respiratory Infection	0069
			Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058
			Use of Imaging Studies for Low Back Pain	0052
	Plan Service	Enrollee Experience with Health Plan	Access to Information*	Not Endorsed
			Plan Administration*	Not Endorsed
			Rating of Health Plan*	0006
Collected but not included for purposes of QRS scores or ratings				
N/A	N/A	N/A	Relative Resource Use for People with Diabetes (Inpatient Facility)	1557

Appendix E. Process for Calculating QRS Scores and Ratings (QRS Rating Methodology)

This appendix describes in detail the process for calculating QRS scores and ratings from measure data, which is summarized in Section 7. This is the final QRS rating methodology CMS will use to calculate quality ratings based on the measure data submitted for the QRS in 2016. This appendix is similar in content to the *QRS Rating Methodology for 2015* document released during the 2015 beta test preview period. As stated in that document, this document does not include all information needed for QHP issuers to replicate the calculations (including cut points). Additionally, this appendix does not include measure benchmarks (e.g., median, min/max), distributions across star ratings, or national percentile ranks.

STEP 1: PREPARE DATA

A measure cannot be scored if the reporting unit received a Not Applicable (NA), Benefit Not Offered (NB), Not Reported (NR), or Biased Rate (BR) audit designation for that measure.

For the measure data that are available, CMS will average each measure's indicators (for those measures with two or more indicators or rates), and then determine whether each measure's results can be included in QRS scoring, based on the measure's denominator size.[47] The two steps include the following details:

1. **Combine the measure's indicator values to create the measure score.**

   For QRS clinical measures that are composed of multiple indicators (see Exhibit 18), CMS will use a weighted average method (see equation below Exhibit 18) to average each measure's individual indicator rates and calculate a measure score. The "weights" placed on the measure's indicators are based on the respective denominator sizes. Indicators with larger denominators will contribute more to the measure's score than indicators with smaller denominators.

Exhibit 18. QRS Measures with Multiple Indicators with Weighted Average Scores

Measure	Indicator	Weighting Approach
Annual Monitoring for Patients on Persistent Medications	Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs) 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
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

[47] Note that for the 2015 beta test year, CMS rounded both QRS clinical measure and QRS survey measure data to two decimal places upon receipt. CMS did not round data when proceeding with data scoring.

Measure	Indicator	Weighting Approach
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
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

The weighted average equation is as follows:

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

where X is the final measure score (i.e., the weighted average), x_i is the indicator score, and n_i is the indicator denominator. The overall denominator is the sum of all the indicator denominators. Exhibit 19 shows an example of this weighted average calculation for a measure score.

Exhibit 19. Example of Weighted Average of Indicator Scores

Name of Indicator	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

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

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

For QRS survey measures composed of two or more QHP Enrollee Survey questions, please see Appendix F for the complete scoring specifications. For these Consumer Assessment of Healthcare Providers and Systems (CAHPS®)-based measures, questions that assess similar topics are grouped together to form a single QRS measure to simplify the interpretation of the data and enhance the reliability of the results.

2. Determine if the measure 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 (see Exhibit 20) will not receive a score for that measure (and will be assigned an NA measure result).

Exhibit 20. Minimum Denominator Size Required for Inclusion in QRS Scoring

Measure	Minimum Denominator Size Required for Inclusion in QRS Scoring
QRS Clinical Measure	30
QRS Survey Measure	100

For QRS clinical measures with multiple indicators (see Exhibit 18), CMS determines if the minimum denominator size is met based on the *maximum denominator size among the measure's indicators*. For example, the Follow-up Care for Children Prescribed ADHD Medication measure has two indicators. If the Initiation Phase indicator's denominator is 50 enrollees, and the Continuation and Maintenance Phase indicator's denominator is 25 enrollees, CMS will reference the denominator size of 50 to determine whether the measure can be used for QRS scoring.

Exhibit 21 shows examples of how QRS scoring could be affected by observed denominator sizes in comparison to a minimum denominator size requirement of 30.

Exhibit 21. Example of Observed Denominator Size in Comparison to the QRS Clinical Measure Minimum Denominator Size Requirement

Measure	Measure's Observed Denominator Size	QRS Clinical Measure 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
E	50 for indicator X 0 for indicator Y (assume the maximum denominator size of 50)	30	Yes
F	25 for indicator X 25 for indicator Y (assume the maximum denominator size of 25)	30	No

For QRS survey measures composed of two or more QHP Enrollee Survey questions, CMS determines if the minimum denominator size is met based on the *total denominator size*. For example, the QRS survey measure Access to Care is composed of five questions. The

denominator size for the measure is equal to the total number of respondents who provided a usable response to at least one of the questions. Therefore, there can be valid denominator sizes for each of the five questions that are lower than 100 and yet there can still be greater than 100 total usable observations for scoring. The enrollees who respond to one question do not nest within or completely overlap the enrollees who respond to other questions. As long as the reporting unit achieves a minimum denominator size of 100 for this measure, then the reporting unit will receive a score for the Access to Care measure. CMS then calculates the average of the case-mix adjusted mean across the five survey questions to calculate the score for the Access to Care measure.

STEP 2: CALCULATE STANDARDIZED MEASURE SCORES

CMS will calculate standardized measure scores by calculating national percentile ranks for submitted measure rates. CMS will calculate standardized measure scores before calculating composite and higher-level QRS component scores. Percentile ranks will be based on one national, all-product reference group. For example, across all products (i.e., EPOs, HMOs, POSs, and PPOs) and all Marketplaces, CMS will take all submitted rates for the Cervical Cancer screening measure and rank them using the distribution of rate 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.

If reporting units have tied measure rates, the reporting unit is assigned the value of the average/mean rank, as shown in Exhibit 22.

Exhibit 22. Handling Tied Values

Observation	Example Value	Rank
1	12345	1.0
2	**245**	**5.5**
3	**12**	**9.5**
4	2345	2.0
5	205	7.0
6	452	4.0
7	120	8.0
8	**12**	**9.5**
9	1555	3.0
10	**245**	**5.5**

CMS will use SAS PROC RANK with the percentile ranks ranging from 1 to 100 percentiles to standardize the measure rates. The code allows for as many percentile ranks allowed as there are reporting units (e.g., 1.5 percentile rank is valid). 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 reporting unit's position in the rank order and N is the number of reporting units with calculable data.

STEP 3: CALCULATE COMPOSITE SCORES

CMS calculates composites, like all other QRS components (i.e., domains, summary indicators, and global), using equally weighted score averages. CMS will calculate composite scores based on equally weighted averages of standardized QRS measure scores. The steps are as follows:

1. **Determine if the composite score can be calculated.** CMS will use a half-scale rule to determine if each composite score can be calculated. The half-scale rule indicates that only if at least half of the associated measures in the composite have a score, the composite can be calculated. Otherwise, the composite cannot be calculated and will not reflect a score. Note that when applying the half-scale rule for composite score calculation, CMS only considers measures that are included for scoring in 2016 and measures that did not receive the NA, NB, NR, or BR audit designations (see Appendix C for QRS hierarchy with measures not included for scoring highlighted in grey).

Exhibit 23. Example Application of the Half-Scale Rule for One Composite

Measure	Score Available for Reporting Unit?
Adult BMI Assessment	No, NR audit designation
Chlamydia Screening in Women	Yes, reported score
Aspirin Use and Discussion	No, data submitted, but measure not included in scoring for 2016 (for all reporting units)
Flu Vaccinations for Adults Ages 18-64	Yes, reported score
Medical Assistance With Smoking and Tobacco Use Cessation	No, data submitted, but measure not included in scoring for 2016 (for all reporting units)
Can the Staying Healthy Adult Composite be Calculated?	Yes, because at least one of the two available measures (Chlamydia Screening and Flu Vaccinations) in this composite can be scored.

2. **Calculate the composite score.** CMS will average the available measure scores with equal weighting. Exhibit 24 includes an example of how the Cardiovascular Care composite will be calculated from three measure scores.

Exhibit 24. Example Composite Score Calculation

Name	Type of QRS Component	Example Score
Controlling High Blood Pressure	Measure	30
Proportion of Days Covered (RAS Antagonists)	Measure	90
Proportion of Days Covered (Statins)	Measure	60
Cardiovascular Care	Composite	60 (Average of Available Measure Scores)

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

$$= \frac{(\mathbf{30 + 90 + 60})}{\mathbf{3}} = \mathbf{60}$$

Composite scores (and all component scores) are averages of percentile ranks; the ranking of the values only occurs once at the measure level. A composite score of 60, for example in Exhibit 24, 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."

STEP 4: CALCULATE DOMAIN SCORES

CMS will calculate domain scores and ratings based on equally weighted composite score averages. CMS will take similar types of steps used with composite calculations. The steps are as follows:

1. **Determine if 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 25.

Exhibit 25. Example Domain Score Calculation

Name	Type of QRS Component	Example Score
Checking for Cancer	Composite	20
Maternal Health	Composite	40
Staying Healthy Adult	Composite	80
Staying Healthy Child	Composite	60
Prevention	Domain	50 (Average of Available Composite Scores)

$$\textbf{Prevention} = \frac{\textbf{Checking for Cancer} + \textbf{Maternal Health} + \textbf{Staying Healthy Adult} + \textbf{Staying Healthy Child}}{\textbf{4}}$$

$$= \frac{\textbf{20} + \textbf{40} + \textbf{80} + \textbf{60}}{\textbf{4}} = \textbf{50}$$

STEP 5: CALCULATE SUMMARY INDICATOR SCORES AND RATINGS

CMS will calculate summary indicator scores and ratings based on equally weighted domain score averages. CMS will take similar types of steps used with domain calculations. The steps are as follows:

1. **Determine if the summary indicator score can be calculated.** CMS will use a half-scale rule to determine whether the summary indicator score can be calculated. The half-scale rule indicates that only if half or more 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 26 below.

Exhibit 26. Example Summary Indicator Score Calculation

Name	Type of QRS Component	Example Score
Access	Domain	65
Care Coordination	Domain	50
Doctor and Care	Domain	35
Enrollee Experience	Summary Indicator	50 (Average of Available Composite Scores)

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

$$= \frac{65 + 50 + 35}{3} = 50$$

STEP 6: CALCULATE GLOBAL SCORE AND RATING

CMS will calculate the global score and rating based on equally weighted summary indicator score averages. The steps are as follows:

1. **Determine if the global score can be calculated.** CMS will calculate the global score for the reporting unit only if the Clinical Quality Management summary indicator has a score and at least one of the other two summary indicators has a score.
2. **Calculate the global score.** CMS will average the available summary indicator scores using equal weighting as shown in Exhibit 27.

Exhibit 27. Example Global Score Calculation

Name	Type of QRS Component	Example Score
Clinical Quality Management	Summary Indicator	65
Enrollee Experience	Summary Indicator	35
Plan Efficiency, Affordability, and Management	Summary Indicator	50
Global	Global	50 (Average of Available Summary Indicator Scores)

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

$$= \frac{65 + 35 + 50}{3} = 50$$

STEP 7: CONVERT SCORES TO RATINGS

1. **Identify cut point values.** Once QHP issuers submit QRS measure data (summer of 2016), CMS will use cluster analysis of the submitted data to determine the score value of cut points

for each component to create the rating categories CMS will use a clustering analysis to take scores from each reporting unit and group them together based on similarity across five clusters. Data-driven cut points are different at each level of the hierarchy as the cluster analysis is conducted for each component of the hierarchy from composites through the global result (i.e., 26 independent clustering runs). CMS will release the cut point values along with the QRS scores and ratings during the QRS preview period.

2. **Converts scores to ratings.** CMS will convert each score (for composites, domains, summary indicators, and global score) into a rating using the cut points that delineate rating categories of 1, 2, 3, 4, and 5 stars. Scores fall into one of the five categories created by the cut points. Exhibit 28 shows an example of converting a global score to a global rating using global score cut points.

Exhibit 28. Conversion of a Global Score to a Global Rating

Example Cut Points	Categorical Rating
0 < Score < 31	1 ★
31≤ Score < 45	2 ★★
45 ≤ Score < 57	3 ★★★
57 ≤ Score < 69	4 ★★★★
69 ≤ Score	5 ★★★★★

Example: The global score of 50 in Exhibit 27 lies within the limits of the third category in Exhibit 28 (45 ≤ Score < 57) and converts to a 3-star rating (★★★).

Appendix F. Scoring Specifications For QRS Survey Measures

This document describes the scoring specifications for the QRS survey measures (i.e. methodology for calculating QRS survey measure scores from QHP Enrollee Survey questions). The QHP Enrollee Survey collects information on two general categories of measures: (1) consumers' experience of care measures based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and (2) selected HEDIS-based clinical measures based on the Healthcare Effectiveness Data and Information Set (HEDIS®). The scoring specifications for these two categories of QRS survey measures are described separately below.

Background information on how the 2016 QHP Enrollee Survey was conducted, including the survey questionnaire, sampling procedures, and data collection protocols, is presented in *2016 Qualified Health Plan Enrollee Experience Survey: Quality Assurance Guidelines and Technical Specifications* (https://qhpcahps.cms.gov/sites/default/files/upload/2016_QHP_Survey_QAG.pdf).

CAHPS-BASED MEASURES

The following QRS survey measures are CAHPS-based measures:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Access to Care
- Cultural Competence
- Care Coordination
- Access to Information
- Plan Administration

Scoring specifications for the CAHPS-based measures will follow the same general scoring approach as used by CMS in the Medicare Advantage-Prescription Drug Program (MA-PDP) quality measurement initiative for data collected through the MA-PDP CAHPS survey. This maintains consistency with scoring that CMS does in other health plan-related applications.

General background information about the scoring of CAHPS-based measures in the MA-PDP program is presented in the *MA-PDP CAHPS Survey: Quality Assurance Protocols and Technical Specifications*; see Chapter IX, Data Analysis and Public Reporting (http://www.ma-pdpcahps.org/Documents/MAPDP_CAHPS_Survey_QAPTS_V5 0.pdf).

CMS will calculate QRS survey measures scores from the QHP Enrollee Survey using the CAHPS® Analysis Program ("CAHPS® Macro"), which was developed by the CAHPS® Consortium under the auspices of the Agency for Healthcare Research and Quality (AHRQ). A comprehensive description of the calculations performed by the CAHPS® Analysis Program (version 4.1) can be found in *Instructions for Analyzing Data from CAHPS® Surveys* in the

CAHPS® Survey and Reporting Kit (https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf).

To adjust for any systematic biases with the enrollee response data, CMS will apply a case-mix adjustment to the QHP Enrollee Survey response data and use the adjusted data when calculating the QRS survey measures. It is common in survey-based applications to case-mix adjust scores for such factors as overall health status, age, and education to account for biases due to survey response tendencies. For example, QHPs with higher concentrations of enrollees with certain characteristics would tend to receive higher scores, even if they provided comparable quality of service as other QHPs.

Based on results from the 2015 beta test of the QHP Enrollee Survey, variables to be used in the case-mix adjustment include the following: general health rating, mental health rating, chronic conditions/medications, age, education, survey language, help with the survey, and survey mode. The final variables to be included in the case-mix adjustment will be determined based on psychometric testing and additional analysis of the 2016 survey data. More information about weighting and case-mix adjustment is available in *Instructions for Analyzing Data from CAHPS Surveys* (see link to this document at the top of this page).

All CAHPS-based measures are based on weighted, case-mix adjusted means that are transformed into a 0 – 100 metric. Person-level sampling weights that take into account differential selection probabilities will be used in the weighting.

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

Rating of Health Plan

Question 52 in the 2016 QHP Enrollee Survey asks, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months?" Use the following steps to calculate the QRS measure score for Rating of Health Plan:

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

Rating of All Health Care

Question 10 in the 2016 QHP Enrollee Survey asks, "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?" To calculate the QRS measure score for Rating of All Health Care measure, use the same steps that were used to calculate the score for Rating of Health Plan.

Rating of Personal Doctor

Question 26 in the 2016 QHP Enrollee Survey asks, "Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?" To calculate the score for Rating of Personal Doctor, use the same steps that were used to calculate the score for Rating of Health Plan.

Rating of Specialist

Question 35 in the 2016 QHP Enrollee Survey asks, "We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?" To calculate the score for Rating of Specialist, use the same steps that were used to calculate the score for Rating of Health Plan.

Access to Care

The QRS Access to Care measure is made up of five questions, all of which are coded on a 1 – 4 scale in the 2016 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS score for Access to Care:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Access to Care measure:
    - Question 4 from the 2016 QHP Enrollee Survey, which asks, "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?"
    - Question 6 from the 2016 survey, which asks, "In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?"
    - Question 8 from the 2016 survey, which asks, "In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic after regular office hours?"
    - Question 11 from the 2016 survey, which asks, "In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?"
    - Question 33 from the 2016 survey, which asks, "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?"
2. Calculate the average of the weighted, case-mix adjusted means across the five survey questions; use equal weighing of the questions.
3. Transform the average from Step 2 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the score for the Access to Care measure.

Cultural Competence

The QRS Cultural Competence measure is made up of three questions, all of which are coded on a 1 – 4 scale in the 2016 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS score for Cultural Competence:

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

- Question 13 from the 2016 survey, which asks, "In the last 6 months, when you needed an interpreter at your doctor's office or clinic, how often did you get one?"
- Question 49 from the 2016 survey, which asks, "In the last 6 months, how often were the forms that you had to fill out available in a language you prefer?"
- Question 51 from the 2016 survey, which asks, "In the last 6 months, how often were the forms that you had to fill out available in the format you needed, such as large print or braille?"

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

Care Coordination

The QRS Care Coordination measure is made up of six questions, all of which are coded on a 1 – 4 scale in the 2016 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS score for the Care Coordination measure:

1. Calculate the weighted, case-mix adjusted mean separately for each question included in the Care Coordination measure:
   - Question 20 in 2016 survey, which asks, "When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?"
   - Question 22 in the 2016 survey, which asks, "In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?"
   - Question 23 in the 2016 survey, which asks, "In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?"
   - Question 25 in the 2016 survey, which asks, "In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?"
   - Question 28 from the 2016 survey, which asks, "In the last 6 months, how often did you and your personal doctor talk about all of the prescriptions you were taking?"
   - Question 31 in the 2016 survey, which asks, "In the last 6 months, how often did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?"
2. Questions 22 and 23 are combined into a single measure to assess getting results after a blood test, x-ray, or other test. Calculate the average of the weighted, case-mix adjusted means for Questions 22 and 23 using equal weighting of the two questions. Use this average in Step 3.
3. Calculate the average of the weighted, case-mix adjusted means across the five survey questions (i.e., Questions 20, 25, 28, and 31, and the average of Questions 22 and 23 from Step 2); use equal weighting of the questions.
4. Transform the average from Step 3 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the score for the Care Coordination measure.

Access to Information

The QRS Access to Information measure is made up of three questions, all of which are coded on a 1 – 4 scale in the 2016 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS score for the Access to Information measure:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Access to Information measure:
    - Question 37 from the 2016 survey, which asks, "In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?"
    - Question 39 from the 2016 survey, which asks, "In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?"
    - Question 41 from the 2016 survey, which asks, "In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?"
2. Calculate the average of the weighted, case-mix adjusted means across the three survey questions; use equal weighing of the questions.
3. Transform the average from Step 2 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the score for the Access to Information measure.

Plan Administration

The QRS Plan Administration measure is made up of five questions, all of which are coded on a 1 – 4 scale in the 2016 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS score for the Plan Administration measure:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Plan Administration measure:
    - Question 43 from the 2016 QHP Enrollee Survey, which asks, "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?"
    - Question 44 from the 2016 survey, which asks, "In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?"
    - Question 45 from the 2016 survey, which asks, "In the last 6 months, how often did the time that you waited to talk with your health plan's customer service staff take longer than you expected?" Note: To make the direction of coding of Question 45 consistent with the other questions, Question 45 needs to be recoded so higher values represent a more positive response, as follows:

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

- Question 47 from the 2016 survey, which asks, "In the last 6 months, how often were the forms from your health plan easy to fill out?"
- Question 48 from the 2016 survey, which asks, "In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?"

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

HEDIS-BASED MEASURES

The following QRS survey measures are HEDIS-based measures.

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

Scoring specifications for the HEDIS-based measures collected through the 2016 QHP Enrollee Survey will follow the HEDIS specifications presented in the *Quality Rating System Measure Technical Specifications* (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2016-QRS-Measure-Technical-Specifications.pdf).

Appendix G. Glossary and List of Acronyms

Exhibit 29 includes definitions for key terms used in this document. Exhibit 30 provides definitions for acronyms that appear in this Guidance document.

Exhibit 29. Glossary

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

Term	Definition
Federally-facilitated Marketplace (FFM)	The Marketplace model operated by HHS for individual and small group market coverage. For QHP issuers operating in the FFMs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov alongside other QHP information to inform consumers.
Full-scale rule	A scoring rule that requires all component scores that form a higher level component score to be present in order for the component score to be calculated. For example, all summary indicator scores must be present in order to calculate the global score. This rule is intended for component scores to be comparable across reporting units.
Global	A component of the QRS hierarchy. A score or rating for this component is created by combining scores from summary indicators.
Half-scale rule	A scoring rule that requires at least half of the component scores that form a higher level component score to be present in order for the component score to be calculated. For example, at least half of the composite scores must be present in order to calculate the domain score. This rule is intended for component scores to be comparable across reporting units.
Health Insurance 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. QRS ratings for QHP issuers operating in both the FFMs, States performing plan management functions, and State-based Marketplaces – Federal Platform (SBM-FPs) will be displayed on HealthCare.gov to support consumers as they search for and enroll in a QHP.
Healthcare Effectiveness Data and Information Set (HEDIS)® Compliance Audit™	The HEDIS Compliance Audit™ is a data validation process that consists of a standardized review of an organization's data management processes and algorithmic compliance with measure technical specifications. This process verifies the integrity of QRS measure data and allows for comparability across organizations. An overview of the HEDIS Compliance Audit™, the list of NCQA-Certified HEDIS® Compliance Auditors, and a link to the *HEDIS Compliance Audit: Standards, Policies, and Procedures* that is available for purchase can be accessed at the following link: http://store.ncqa.org/index.php/performance-measurement.html
HEDIS® Compliance Auditor	An individual certified by NCQA to validate QRS clinical measure data and the QHP Enrollee Survey sampling frame using the standardized HEDIS Compliance Audit™ program.
Hybrid data collection method	Uses data obtained from both administrative and medical record/ electronic medical record sources to identify the eligible population and numerator compliance. The denominator consist of a systematic sample of enrollees drawn from the measure's eligible population. QHP issuers then: a) review administrative data to determine numerator compliance, and b) review medical record data for enrollees who do not meet numerator criteria based on administrative data, in order to identify additional numerator compliance for the measure. Details on the collection method are included in a measure's technical specifications (see *2016 Quality Rating System Measure Technical Specifications).*
Indicator	A rate that forms a measure. Some QRS measures have multiple indicators.
Interactive Data Submission System (IDSS)	The web-based system, owned and managed by the National Committee for Quality Assurance (NCQA), which QHP issuers will use to submit QRS clinical measure data.

Term	Definition
Measure	Rate variables that serve as the fundamental building blocks of the QRS hierarchy. Each measure is assigned to a composite and contributes to the scoring for the higher components of the hierarchy (i.e., domains, summary indicators, and global).
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.
National Committee for Quality Assurance (NCQA)	The organization that developed and maintains the system through which QHP issuers will submit validated QRS clinical measure data to CMS, the Interactive Data Submission System (IDSS). NCQA is the measure steward for HEDIS® measures. NCQA also manages the HEDIS Compliance Audit™ program.
National Quality Forum (NQF)	NQF reviews, endorses, and recommends use of standardized healthcare performance measures. NQF issues an endorsement identification number (ID) for measures that they endorse. This ID is cited for QRS measures where applicable.
National Quality Strategy (NQS)	Mandated by the Patient Protection and Affordable Care Act, the National Quality Strategy (NQS) was first published in March 2011. The NQS established a set of three overarching aims that builds on the Institute for Healthcare Improvement's Triple Aim®, supported by six priorities that address the most common health concerns that Americans face.
Not Applicable (NA)	Data validation result assigned for a measure if the QHP issuer followed the specifications but the denominator was too small (i.e. less than 30) to report a valid rate. The QHP issuer did not have sufficient data to fulfill the continuous enrollment criteria for the measure.
Not Reported (NR)	Data validation result assigned for a measure if the QHP issuer chose not to report the measure rate.
Office of Personnel Management (OPM)	OPM administers the Federal Employees Health Benefits (FEHB) Program. The Affordable Care Act directs OPM to contract with private health insurers in each State to offer high-quality, affordable health insurance options (Multi-State Plan options) through the Multi-State Plan (MSP) Program to drive competition and choice in the 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	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.

Term	Definition
2016 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications	A document published on http://qhpcahps.cms.gov that includes detailed specifications and protocols for HHS-approved survey vendors to conduct the QHP Enrollee Survey.
QHP Enrollee Survey score	The average value for a measure from the QHP Enrollee Survey calculated for survey respondents in a given reporting unit. A survey score can be for a single assessment question or a combination of several questions on a similar topic that are combined to form a single measure.
QHP Enrollee Survey vendor	A HHS-approved survey vendor with which a QHP issuer contracts to administer the QHP Enrollee Survey to a sample of the QHP issuer's enrollees and that is authorized to submit the survey response data on the QHP issuer's behalf.
QRS clinical measures	QRS measures calculated using clinical data from a QHP issuer's administrative and medical record sources.
QRS hierarchy	The organization of the QRS measures into information categories ranging from the most granular information (measure scores) to a global rating.
QRS rating methodology	The rules for combining measures and converting scores into performance ratings for the QRS.
QRS survey measures	QRS measures calculated using enrollee responses to a subset of specified questions in the QHP Enrollee Survey. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to the CMS Health Insurance Marketplace Quality Initiatives website (https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system)
Qualified Health Plan (QHP)	A health insurance plan that has in effect a certification that it meets the standards established by the Affordable Care Act and supporting regulation, issued or recognized by each 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.
2016 Quality Rating System Measure Technical Specifications	A document published on the CMS Health Insurance Marketplace Quality Initiatives website (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html) that includes detailed measure specifications and general guidelines for QRS measure data collection.
QHP quality rating information	Information that includes QRS scores and ratings, as well as QHP Enrollee Survey results.
Quality Rating System (QRS)	As directed by the Affordable Care Act section 1311 (c)(3), the Quality Rating System (QRS) is a system of rating QHPs offered through the Marketplace based on quality and price. The QHP quality rating information will be provided to individuals and employers to inform their selection of a QHP and will provide a system for monitoring of QHP quality by regulators.
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.

Term	Definition
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 reporting units that is defined based on specification of a geographical region and/or time period. A reporting unit's level of performance is its ranking among all reporting units within the defined group.
Reporting unit	The unit by which a QHP issuer groups their enrollees for purposes of QRS and QHP Enrollee Survey measure data collection and submission. The reporting unit for the QRS and QHP Enrollee Survey is defined by the unique State-product type for each QHP issuer.
Standardized score	A rank value ranging from 0 to 99 that indicates the percentage of reporting scoring at and below the given raw measure score value. For a given measure, all values are ranked from lowest to highest with 99 representing the highest raw measure value among all reporting units nationally. Standardizing the measure scores allows for comparisons of a reporting unit relative to all other reporting units. Only QRS measure scores are standardized; component scores are not standardized.
States performing plan management functions in the FFMs	A hybrid Marketplace model in which a State operates plan management functions (and some also operate consumer assistance functions), while the remaining Marketplace functions are operated by HHS. For QHP issuers operating in States performing plan management functions in the FFMs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov.
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 individual market open enrollment period for 2017 (that begins in the fall of 2016), displaying QHP quality rating information to help consumers compare QHPs.
Summary indicator	A component of the QRS hierarchy. A score for this component is created by combining scores from associated domains.
Summary-level measure data	The level of QRS clinical measure data that QHP issuers will submit to CMS for each eligible reporting unit. Summary-level data elements are specified for each QRS clinical measure in the *2016 Quality Rating System Measure Technical Specifications*, and include elements such as eligible population (denominator), numerator, and the rate.
Survey sampling frame	The QHP issuer's eligible population source file that contains a list of the eligible enrollees for which the QHP Enrollee Survey can be administered. The data validator will validate the survey sampling frame, and the HHS-approved QHP Enrollee Survey vendor will generate an enrollee sample based on the validated sampling frame.
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.

Exhibit 30. List of Acronyms

Acronym	Definition
ACE	Angiotensin Converting Enzyme
AHRQ	Agency For Healthcare Research and Quality

Acronym	Definition
AOD	Alcohol and Other Drug
API	Application Program Interface
ARB	Angiotensin Receptor Blockers
BMI	Body Mass Index
BR	Biased Rate
C&M	Continuation and Maintenance
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCIIO	Consumer Information and Insurance Oversight
CMS	Center for Medicare & Medicaid Services
EPO	Exclusive Provider Organization
ESS	Enrollee Satisfaction Survey
FEHB	Federal Employees Health Benefits
FFM	Federally-Facilitated Marketplace
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HIOS	Health Insurance Oversight System
HMO	Health Maintenance Organization
HOQ	Healthcare Organization Questionnaire
HPV	Human Papillomavirus
HTN	Diagnosis of Hypertension
IDSS	Interactive Data Submission System
IHS	Index Hospital Stays
IPV	Inactivated Polio Vaccine
MA-PDP	Medicare Advantage-Prescription Drug Program
MMR	Measles, Mumps and Rubella
MQI	Marketplace Quality Initiatives
MSP	Multi-State Plan
NA	Not Applicable
NB	Not Offered

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