Health Insurance Exchange

Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024

September 2023

Document Change Log

Description	Date
Release of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024.* This guidance addresses requirements for 2024, which include data submission in the 2024 calendar year for quality rating information that will be publicly reported by the Exchanges, beginning during the open enrollment period for the 2025 Plan Year.	09/18/2023

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List of Exhibits

Technical Assistance

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

- **QHP issuers:** Please submit questions to the Marketplace Service Desk (MSD) via email to CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Please reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.
- **State-based Exchanges (SBEs):** Please submit questions to your respective State Officers.
- **Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal Platform (SBE-FPs):** Please submit questions via email to the MSD at CMS_FEPS@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.
- **Other interested parties:** 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, *2024 Quality Rating System Measure Technical Specifications*, details QRS clinical measure and QRS survey measure specifications and guidelines for data collection.[1] The document can be found on the Centers for Medicare & Medicaid Services (CMS) Health Insurance MQI website (link in the table below). For questions on individual measures, please contact the appropriate measure stewards via the contact information listed in the technical specifications.

Website Links

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

Website	Description	Link
CMS MQI website	This website provides resources related to CMS MQI activities, including the QRS, the QHP Enrollee Survey, Quality Improvement Strategy (QIS) requirements, and patient safety standards. As the central site for QRS resources, this site contains instructional documents regarding QRS implementation and reporting, including this document, the *2024 Quality Rating System Measure Technical Specifications*, and the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications for 2024*.	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page

[1] Beginning with the 2022 ratings year, CMS aligned with the revised National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) timeline to publish the QRS Measure Technical Specifications annually in the spring. The *2024 QRS Measure Technical Specifications* released in March 2023 include the specifications for any measures and/or measure rates proposed for addition and removal in the Draft 2023 Call Letter, applicable beginning with the 2024 ratings year. CMS published an updated version of the 2024 *QRS Measure Technical Specifications* in the fall of 2023 to accompany this *2024 QRS and QHP Enrollee Survey Technical Guidance*. The updated *2024 QRS Measure Technical Specifications* reflect the final decisions applicable to the 2024 ratings year communicated via the Final 2023 Call Letter.

Website	Description	Link
National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[2] 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.	https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/
Registration for Technical Assistance Portal (REGTAP)	This website serves as an information hub for CMS technical assistance related to Exchange and Premium Stabilization Program requirements. Registered users can access the library, frequently asked questions, training resources, and the inquiry tracking and management system. Use key word search "Quality Rating System" to identify any resources related to the QRS.	https://www.REGTAP.info (registration required)
State Exchange Resource Virtual Information System (SERVIS)	This website serves as an information hub for CMS technical assistance related to SBE requirements. Registered state users can access relevant resources organized by the Center for Consumer Information and Insurance Oversight (CCIIO) State Marketplace and Insurance Programs Group.	https://portal.cms.gov/ (registration required)
QHP Enrollee Survey website	This website is intended for QHP issuers to attest to the QHP Enrollee Experience Survey Issuer Eligibility Criteria and select an approved vendor. This website also allows vendors to log in and securely submit data files to CMS on behalf of QHP issuers during the specified data submission periods.	https://qhpsurvey.cms.gov/ (registration required)

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

1. Document Purpose and Scope

This *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024* (2024 Guidance) document provides technical guidance regarding the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) for 2024. It specifies QRS and QHP Enrollee Survey requirements for QHP issuers offering coverage through the Health Insurance Exchanges (Exchanges) (also known as the Health Insurance Marketplace®).[3] Unless the context indicates otherwise, the term "Exchanges" refers to the Federally-facilitated Exchanges (FFEs) (inclusive of FFEs where the state performs plan management functions) and the State Exchanges. State Exchanges are inclusive of State-based Exchanges (SBEs), which operate their own eligibility and enrollment platform, and State-based Exchanges on the Federal Platform (SBE-FPs).

The 2024 Guidance communicates 2024 QRS requirements and includes QRS program refinements (including refinements to the QHP Enrollee Survey) described in the *Final 2023 Call Letter for the QRS and QHP Enrollee Survey* (Final 2023 Call Letter), published in June 2023,[4] as applicable. Section 1.1 of this document highlights all key differences between the 2023 Guidance[5] and 2024 Guidance. CMS anticipates issuing guidance annually in the fall before the year of data submission.

While the primary audience for the 2024 Guidance is QHP issuers, this document also includes information relevant to other interested parties involved with QRS and QHP Enrollee Survey implementation (e.g., SBEs, data validators, Department of Health & Human Services [HHS]-approved survey vendors). The 2024 Guidance addresses requirements for 2024, which include data submission in the 2024 calendar year for ratings for the 2025 Plan Year.

The requirements outlined in this document are based on statute and Centers for Medicare & Medicaid Services (CMS) regulations, including the "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" Final Rule.[6]

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 2023 Guidance and 2024 Guidance.

[3] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.
[4] The Final 2023 Call Letter is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.
[5] The term "2023 Guidance" refers to all CMS sub-regulatory guidance applicable to the 2023 ratings year, including the *Quality Rating System and Qualified Health Plan Enrollee Survey: Technical Guidance for 2023*; the May 2, 2023 *Quality Rating Information Bulletin*; the 2023 Quality Rating System Proof Sheet User Guide; and other CMS guidance (e.g., frequently asked questions [FAQs] available on REGTAP).
[6] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule; 79 FR 30240 at 30352 (May 27, 2014) (45 C.F.R. Parts 144, 146, 147, et al.).

- **Section 4. Implementation Schedule for the QRS and QHP Enrollee Survey:** This section provides a snapshot of the implementation process, key dates, and the interested parties with primary responsibility for critical action(s).
- **Section 5. Exchange Oversight Responsibilities:** This section describes Exchange responsibilities related to the QRS and QHP Enrollee Survey.
- **Section 6. QRS and QHP Enrollee Survey Requirements:** This section outlines the criteria for determining which QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS. This section also describes the QRS measure set and details the requirements for data collection, data validation, and data submission for the QRS and the QHP Enrollee Survey. The key differences outlined in the text boxes below reflect changes to the QRS and QHP Enrollee Survey program operations, including changes finalized in the *Final 2022 Call Letter for the QRS and QHP Enrollee Survey* (Final 2022 Call Letter) and the Final 2023 Call Letter.[7,8]

Key Differences in QRS and QHP Enrollee Survey Program Operations Between the 2023 Guidance and the 2024 Guidance

Removal of Measures:

In the Final 2023 Call Letter, CMS finalized the removal of three measures, *Annual Dental Visit, Flu Vaccinations for Adults Ages 18-64,* and *Appropriate Testing for Pharyngitis,* from the QRS measure set beginning with the 2024 QRS ratings year. QHP issuers are not required to submit data for these measures as part of the 2024 QRS data submission, and CMS will no longer include these measures in scoring.

Addition of New Measures:

In the Final 2023 Call Letter, CMS finalized the addition of two measures, *Oral Evaluation, Dental Services* and *Adult Immunization Status*, to the QRS measure set beginning with the 2024 QRS ratings year. QHP issuers are required to submit data for the *Oral Evaluation, Dental Services* and *Adult Immunization Status* measures as part of the 2024 QRS data submission. CMS anticipates including these measures in scoring beginning with the 2025 ratings year.

Transition of Measures:

In the Final 2023 Call Letter, CMS finalized the transition of the *Breast Cancer Screening* measure to Electronic Clinical Data Systems (ECDS)-only reporting beginning with the 2024 ratings year. QHP issuers are required to submit ECDS data for the *Breast Cancer Screening* measure as part of the 2024 QRS data submission. CMS anticipates including this measure in scoring beginning with the 2025 ratings year.

In the Final 2023 Call Letter, CMS finalized the transition of the *HbA1c Control for Patient with Diabetes: HbA1c Control (<8.0%)* measure to the *HbA1c Control for Patients*

[7] See the Final 2022 Call Letter, available at: https://www.cms.gov/files/document/final-2022-call-letter-qrs-qhp-enrollee-survey.pdf.
[8] See the Final 2023 Call Letter, available at: https://www.cms.gov/files/document/final-2023-call-letter-quality-rating-system-and-qualified-health-plan-enrollee-experience-survey.pdf.

Key Differences in QRS and QHP Enrollee Survey Program Operations Between the 2023 Guidance and the 2024 Guidance

with Diabetes: HbA1c poor control (>9.0%) measure beginning with the 2024 ratings year. QHP issuers are required to submit data for the *HbA1c Control for Patients with Diabetes: HbA1c poor control (>9.0%)* measure as part of the 2024 QRS data submission. QHP issuers will not collect or score the *HbA1c Control for Patient with Diabetes: HbA1c Control (<8.0%)* measure for the 2024 ratings year. CMS anticipates including the *HbA1c Control for Patients with Diabetes: HbA1c poor control (>9.0%)* measure in scoring beginning with the 2025 ratings year at the earliest.

Incorporation of Optional ECDS Reporting:

In the Final 2023 Call Letter, CMS finalized the incorporation of optional ECDS reporting for the *Cervical Cancer Screening* measure beginning with the 2024 ratings year. For the *Cervical Cancer Screening* measure and all measures that allow optional ECDS reporting, QHP issuers that submit optional ECDS reporting are required to do so alongside data reported via either the administrative or hybrid method. When optional ECDS data are reported, CMS will only score the measure data reported via traditional (i.e., administrative or hybrid) methods. QHP issuers must refer to the *2024 Quality Rating System Measure Technical Specifications* to determine which data collection method is appropriate for each measure.[9] For the *Cervical Cancer Screening* measure and all measures that allow optional ECDS reporting, CMS will not use ECDS reported measure data in scoring for 2024. CMS will continue to use *Cervical Cancer Screening* measure data reported using the administrative or hybrid method only for the 2024 ratings year.

Reporting of Stratified Race and Ethnicity Data[10]:

In the Final 2023 Call Letter, CMS finalized the requirement for QHP issuers to collect and report stratified race and ethnicity data for the *Breast Cancer Screening*, *Immunizations for Adolescents*, *Well-Child Visits in the First 30 Months of Life*, *Initiation and Engagement of Substance Use Disorder Treatment*, and *Asthma Medication Ratio* measures beginning with the 2024 ratings year (i.e., 2023 measurement year). QHP issuers will not be required to use a standardized method for reporting stratified race and ethnicity data when using indirect data sources to impute race or ethnicity data. CMS anticipates that QHP issuers will not be required to use direct data sources until the 2025 ratings year (i.e., 2024 measurement year), at the earliest.

[9] See the *2024 QRS Measure Technical Specifications,* available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.

[10] At this time, CMS will not display stratified race and ethnicity data during the 2024 ratings year. Instead, CMS will use the data for internal analyses to examine and better understand the quality of care provided to the Exchange population across different demographics. CMS will also not use the additional data or any analysis results to pursue changes to program policies until CMS confirms the response rate is adequate to support any analytical conclusions. CMS may also consider confidentially providing this information to QHP issuers (e.g., via QRS Proof Sheets) and would encourage issuers to adopt similar safeguards when analyzing these new data.

Key Differences in QRS and QHP Enrollee Survey Program Operations Between the 2023 Guidance and the 2024 Guidance

Measures Used for QRS Scoring:

In the Final 2022 Call Letter, CMS finalized the temporary removal of the *Initiation and Engagement of Substance Use Disorder Treatment* measure from 2023 scoring. QHP issuers were still required to submit data for the *Initiation and Engagement of Substance Use Disorder Treatment* measure as a part of the 2023 QRS data submission. CMS is reintroducing this measure in QRS scoring beginning with the 2024 ratings year.

In the Final 2022 Call Letter, CMS finalized the addition of the *Kidney Health Evaluation for Patients with Diabetes* measure. QHP issuers were required to submit data for the measure as part of the 2023 QRS data submission. However, CMS did not include this measure in scoring during its first year of data collection (i.e., 2023). CMS is introducing this measure in QRS scoring beginning with the 2024 ratings year.

Additionally, CMS finalized changes to the eligible population of the *Colorectal Cancer Screening* measure in the Final 2022 Call Letter. QHP issuers were required to report both the 45–49 and 50–75 age bands for the 2023 QRS data submission. However, CMS did not include the new eligible population (i.e., 45–49 years of age) in scoring for this measure in the 2023 ratings year. CMS is introducing the refined measure that includes the revised age range from 45–75 in QRS scoring beginning with the 2024 ratings year.

QHP Enrollee Survey Data Collection

Beginning with the 2024 ratings year, each QHP issuer must formally attest reporting eligibility for its reporting units and authorize a vendor to collect and submit QHP Enrollee Survey response data to CMS on its behalf by January 31, 2024.

- **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.
- **Section 8. Quality Rating Information and QHP Enrollee Survey Results and Preview:** This section describes the process by which QHP issuers and Exchanges will be able to review QHP quality rating information (i.e., QRS ratings and QHP Enrollee Survey results) in advance of public display.
- **Section 9. Exchanges Display Guidelines for QHP Quality Rating Information:** This section provides an overview of the guidelines for display of QHP quality rating information on Exchange websites.
- **Section 10. Marketing Guidelines for QHP Quality Rating Information:** This section describes guidelines for QHP issuers that elect to include QHP quality rating information in their marketing materials.

2. Background

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

Based on this authority, CMS finalized regulations in May 2014 to establish standards and requirements related to QHP issuer data collection and public reporting of quality rating information in every Exchange.[12] As a condition of certification and participation in the Exchanges, CMS requires that QHP issuers submit QRS clinical measure data and QHP Enrollee Survey response data for their respective QHPs offered through an Exchange in accordance with CMS guidelines.[13] Exchanges are also required to display QHP quality rating information on their respective websites.[14] Appendix A includes relevant statutory and regulatory citations for the QRS and QHP Enrollee Survey.

3. Overview

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

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

CMS aligned federal quality reporting standards for QHP issuers with other federal and state quality reporting program standards, as well as with the Meaningful Measures Initiative 2.0, aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess core quality of care issues that are most vital to advancing the agency's work to improve patient outcomes.[15] States have the flexibility to build upon the federal quality reporting

[11] The Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively referred to as the Patient Protection and Affordable Care Act).
[12] See 79 Fed. Reg. 30240 at 30352. Also see 45 C.F.R. §§ 155.1400, 155.1405, 156.1120 and 156.1125.
[13] 45 C.F.R. §§ 156.200(b)(5), (h); 156.1120; and 156.1125.
[14] 45 C.F.R. §§ 155.1400 and 155.1405.
[15] The Meaningful Measures Initiative, launched in 2017, is one of CMS' initiatives that identifies the highest priorities for quality measurement and improvement. Since its initial launch in 2017, there have been updated iterations such as the Meaningful Measures 2.0, as well as other new initiatives such as the CMS National Quality Strategy. The Meaningful Measures 2.0 involves assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes. The initiative focuses on eight quality priority areas: person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health. For additional information, please visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html.

standards for QHP issuers by setting additional standards that reflect state priorities and population-based needs.

QHP issuers that offered coverage through an Exchange in the prior year are required to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS as a condition of certification.[16]

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

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

4. Implementation Schedule for the QRS and QHP Enrollee Survey

Exhibit 1 highlights key events and dates associated with 2024 QRS and QHP Enrollee Survey implementation. CMS expects QHP issuers to meet the following deadlines so data validators (Healthcare Effectiveness Data and Information Set [HEDIS®] Compliance Auditors) and survey vendors can effectively support QHP issuers in complying with the data collection and submission requirements. Details are addressed in the sections that follow.

Exhibit 1. Implementation Schedule for the 2024 QRS and QHP Enrollee Survey

Event	Date
QHP issuer contracts with a HEDIS® Compliance Organization (NCQA-licensed) for validation of the QHP Enrollee Survey sample frame and the QRS clinical measure data.	**Deadline:** October 2, 2023
QHP issuer contracts with an HHS-approved QHP Enrollee Survey vendor to conduct the QHP Enrollee Survey and submit survey response data to CMS.	**Deadline:** January 31, 2024
QHP issuer pulls sample frame on or after January 5, 2024. HEDIS® Compliance Auditor (employee of or contracted by the HEDIS® Compliance Organization) completes validation of QHP Enrollee Survey sample frame by January 31, 2024.	**Deadline:** January 31, 2024

[16] 45 C.F.R. §§ 156.200(b)(5), (h); 156.1120; and 156.1125.
[17] The QHP Enrollee Survey includes a core question set that will be used to assess enrollee experience with health care services. Specific questions are grouped to form survey measures that will be used in the QRS.

Event	Date
QHP issuer completes attestation to the QHP Enrollee Experience Survey Issuer Eligibility Criteria via the QHP Enrollee Survey Website. QHP issuer authorizes a QHP Enrollee Survey vendor and communicates this information to CMS via the QHP Enrollee Survey Website if the QHP issuer determines that a reporting unit is required to collect and submit validated clinical measure data and QHP Enrollee Survey enrollee response data. QHP issuer reports ineligibility to CMS via the QHP Enrollee Survey Website if the QHP issuer determines that a reporting unit does not meet the January 1, 2024, enrollment threshold or any other eligibility requirement within 3 business days of discovery (but no later than January 31, 2024). **Note:** The *2024 QHP Enrollee Survey: Operational Instructions* are scheduled for distribution to QHP issuers in the fall of 2023 and will include detailed steps on how to complete the attestation and survey vendor authorization, as well as how to report eligibility or ineligibility of a reporting unit, via the QHP Enrollee Survey Website.	**Deadline:** January 31, 2024
QHP issuer completes NCQA's Healthcare Organization Questionnaire (HOQ) for the HEDIS® Compliance Auditor to prepare for QRS clinical measure data submission.	**Deadline:** February 2024
QHP issuer and HEDIS® Compliance Auditor complete the HEDIS® Compliance Audit™.	January–June 2024[18]
HHS-approved QHP Enrollee Survey vendor conducts the QHP Enrollee Survey on the validated survey sample frame.	February–May 2024
HHS-approved QHP Enrollee Survey vendor securely submits the QHP Enrollee Survey response data to CMS (on behalf of the QHP issuer).	**Deadline:** May 17, 2024
QHP issuer submits the validated QRS clinical measure data, with attestation, to CMS via NCQA's Interactive Data Submission System (IDSS).[19] **Note:** Each QHP issuer must submit and plan-lock its QRS clinical measure data by May 31 to allow the HEDIS® Compliance Auditor sufficient time to review, approve, and audit-lock all submissions by the June 14 deadline.	**Deadline:** June 14, 2024 by 9:00 pm ET
QHP issuers, Exchange administrators, and CMS preview the 2024 QHP quality rating information.	August/September 2024
Anticipated public display QHP quality rating information.	**Deadline:** Start of the 2025 individual market open enrollment period (OEP)[20]

[18] For a more detailed timeline for the HEDIS® Compliance Audit, see https://www.ncqa.org/wp-content/uploads/2023/03/MY2023-Audit-Timeline-for-March-Update.pdf.
[19] There are no fees for QHP issuers associated with accessing and using the IDSS.
[20] The 2025 individual market OEP is from November 1, 2024 to January 15, 2025 for FFE and SBE-FP states. States with State Exchanges that operate their own eligibility and enrollment platform have flexibility to set an end date no earlier than December 15. See 45 C.F.R. § 155.410(e)(4).

The annual timeline for finalizing the QRS measure set is shown in Exhibit 2.

Exhibit 2. Annual Timeline for Finalizing the QRS Measure Set

Anticipated Timeframe	Description
February	**Publication of Draft Call Letter:** CMS proposes changes to the QRS and QHP Enrollee Survey programs and provides interested parties with the opportunity to submit feedback via a 30-day public comment period. The Draft Call Letter may propose the addition or removal of measures from the QRS measure set for the upcoming ratings year (e.g., the Draft 2023 Call Letter included proposed measure set changes for the 2024 QRS measure set).
March	**Publication of QRS Measure Technical Specifications**: CMS provides measure specifications for all potential measures in the QRS measure set (i.e., any measures proposed for addition or removal in the Draft Call Letter).
June	**Publication of Final Call Letter:** CMS communicates final changes to the QRS and QHP Enrollee Survey programs and addresses the themes of the public comments. CMS finalizes the measure set changes proposed in the Draft Call Letter for the upcoming ratings year.
September/October	**Publication of QRS and QHP Enrollee Survey Technical Guidance:** CMS provides technical guidance regarding the QRS and QHP Enrollee Survey and specifies requirements for QHP issuers offering coverage through the Exchanges. The final measure set aligns with measure changes proposed in the Final Call Letter. **Publication of Updated QRS Measure Technical Specifications:**[21] CMS publishes an updated version of the QRS Measure Technical Specifications that indicates its final decisions regarding changes proposed to the measures (i.e., any measures finalized for addition or removal in Final Call Letter).

5. Exchange Oversight Responsibilities

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

For each Exchange, CMS will publish a list to the Health Insurance Oversight System Marketplace Quality Module (HIOS-MQM) of QHP issuers that have eligible reporting units (as defined in Section 6.1) and are required to submit QRS clinical measure and QHP Enrollee Survey response data. CMS will provide the SBEs with a status update following the data submission deadline with a list of QHP issuers that submitted data for their eligible reporting

[21] The *2024 QRS Measure Technical Specifications* are available on the CMS MQI website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page. The *2024 QRS Measure Technical Specifications* released in March 2023 include the specifications for any measures and/or measure rates proposed for addition and removal in the Draft 2023 Call Letter proposed to be applicable in the 2024 ratings year. CMS published an updated version of the annual *QRS Measure Technical Specifications* in fall 2023 that reflects the final decisions applicable to the 2024 ratings year communicated via the Final 2023 Call Letter.

[22] 45 C.F.R. § 155.200(d).

[23] 45 C.F.R. §§ 155.1010(a)(2) and 155.200(d). Also see 42 U.S.C. § 18031(c)(3).

units. The SBEs can use this information to support oversight of their respective QHP issuers' compliance with QRS and QHP Enrollee Survey requirements.

In addition to the federal requirements established by HHS, an SBE may choose to impose additional quality reporting requirements for QHPs offered through its Exchange. The SBE can use additional state quality information to supplement the HHS-calculated QRS ratings. QHP issuers operating in an SBE should confirm any additional quality reporting requirements with that SBE.

6. QRS and QHP Enrollee Survey Requirements

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

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

6.1 Participation Criteria for QHP Issuers

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

QHP issuers are required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data for each unique combination of product type and state.[24] QHP issuers may not combine product types or states. Therefore, the reporting unit for the QRS and QHP Enrollee Survey is defined by the unique state-product type for each QHP issuer. Product types subject to the QRS and QHP Enrollee Survey requirements include EPO, HMO, POS, and PPO. At this time, QRS and QHP Enrollee Survey requirements do not apply to indemnity plans (i.e., fee for service plans), stand-alone dental plans, or child-only plans. The QRS and QHP Enrollee Survey requirements also do not apply to basic health program (BHP) plans.

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

- Offered[25] through an Exchange in the prior year (i.e., 2023 calendar year);

[24] Pursuant to 45 C.F.R. §§ 156.1120(a)(3) and 156.1125(b)(3), QHP issuers participating in the Exchanges must include information in their respective QRS and QHP Enrollee Survey data submissions only for those enrollees at the level specified by HHS.

[25] For purposes of QRS participation, the term "offered" includes all reporting units that are operational through an Exchange (i.e., reporting units that are available for purchase through an Exchange Small Business Health Options Program [SHOP] or individual market, accepting new members or groups, or have active or existing members) during the applicable year.

- Offered through an Exchange in the ratings year (i.e., 2024 calendar year) as the exact same product type; and
- Meets the QRS and QHP Enrollee Survey minimum enrollment requirements:[26, 27]
  - Included more than 500 enrollees as of July 1 in the prior year (i.e., July 1, 2023), and
  - Included more than 500 enrollees as of January 1 of the ratings year (i.e., January 1, 2024).

Note: In other words, QHP issuers are required to collect and submit validated clinical measure data and QHP Enrollee Survey enrollee response data for each *product type* offered through an Exchange for *two consecutive years* (i.e., 2023 and 2024) that had more than 500 enrollees as of July 1, 2024, and more than 500 enrollees as of January 1, 2024.

Reporting units discontinued before June 15 of the ratings year (i.e., June 15, 2024) are exempt from these requirements. For an eligible reporting unit impacted by a QHP issuer change in ownership (e.g., merger, acquisition) effective as of January 1 of the ratings year, the QHP issuer that assumes the reporting unit is responsible for meeting these requirements. For an eligible reporting unit impacted by a transfer (e.g., all enrollees automatically transferred to a new reporting unit of the same product type) effective prior to June 15 of the ratings year, the QHP issuer is responsible for meeting these requirements for that reporting unit.[28]

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

Exhibit 3 represents the process for creating a reporting unit and determining QRS and QHP Enrollee Survey data submission eligibility.

The process includes the following steps: (1) combine the same product types operating in the same state to create a reporting unit (as defined above); (2) determine whether the reporting unit operated on an Exchange in 2023; (3) determine whether the reporting unit will operate on an Exchange in 2024 as the same product type; (4) confirm the reporting unit will not discontinue before June 15, 2024; (5) determine whether the reporting unit met the first enrollment threshold (i.e., had more than 500 enrollees as of July 1, 2023); (6) determine whether the reporting unit met the second enrollment threshold (i.e., had more than 500 enrollees as of January 1, 2024); and (7) if the criteria in steps 1– 6 are met, submit QRS clinical measure data and QHP Enrollee Survey response data.

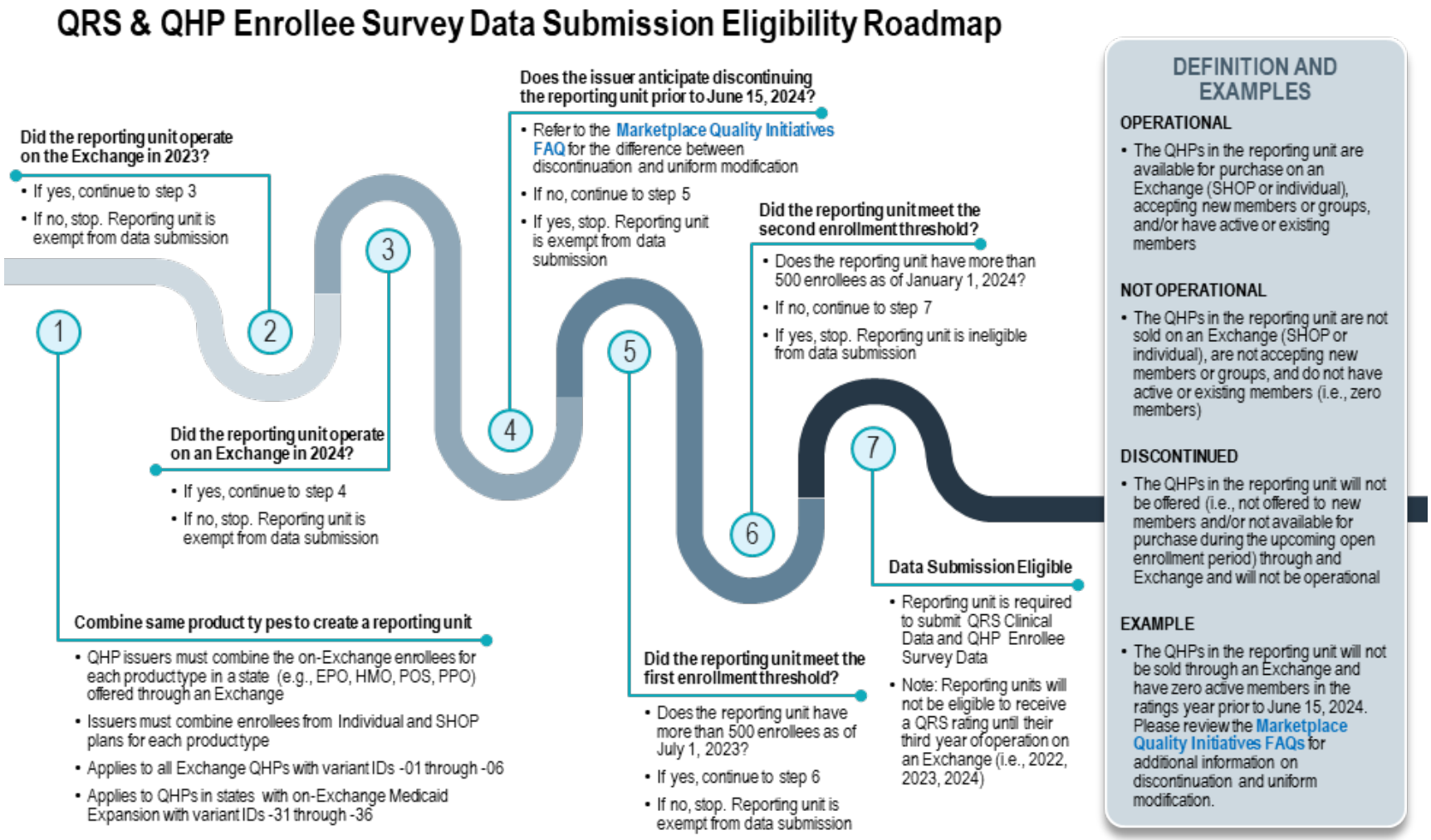
For the purposes of determining eligibility, QHP issuers should review the following definitions:

- **Operational:** The QHPs in the reporting unit are available for purchase on an Exchange (Small Business Health Options Program [SHOP] or individual market), accepting new members or groups, and/or have active or existing members.

[26] 45 C.F.R. §§ 156.1120(a) and 156.1125(b).
[27] The QHP Enrollee Survey minimum enrollment requirement aligns with standards set forth in 45 C.F.R. § 156.1125(b)(1). CMS established the minimum enrollment requirement for QRS to align with the QHP Enrollee Survey minimum enrollment requirement and to support a sufficient size for credible and reliable results.
[28] Please refer to the Marketplace Quality Initiatives FAQs for additional information regarding the difference between discontinuation and uniform modification.

- **Not Operational:** The QHPs in the reporting unit are not sold on an Exchange (SHOP or individual market), are not accepting new members or groups, and do not have active or existing members (i.e., zero members).
- **Discontinued:** The QHPs in the reporting unit will not be offered (i.e., will not be offered to new members and/or not be available for purchase during the 2025 individual market OEP) through an Exchange and will not be operational. For example, the QHPs in the reporting unit will have zero active members in the ratings year prior to June 15, 2024 and will not be sold through an Exchange during the 2025 individual market OEP. Please refer to the Marketplace Quality Initiatives FAQs for additional information regarding the difference between discontinuation and uniform modification.

Exhibit 3. QRS and QHP Enrollee Survey Data Submission Eligibility Roadmap



When determining which enrollees to include in each reporting unit, QHP issuers should follow the checklist provided as Exhibit 4.

Exhibit 4. QRS and QHP Enrollee Survey Enrollee Inclusions and Exclusions

Creating a Reporting Unit Applies to QHP Enrollee Survey and QRS Clinical Measures	✓
Include the Following Enrollees:	
Enrollees in QHPs offered through an Exchange (HIOS variant IDs -01 through -06, and -31 through -36 for states with Medicaid 1115 waivers where the Medicaid expansion population is eligible to enroll in Exchange plans) in the prior year (i.e., 2023 calendar year).	
Enrollees in QHPs that provide family and/or adult medical coverage.	
Enrollees from both the individual market (individual and family plans [IFPs]) and SHOP if the QHP issuer offers the same product type in the individual market as well as the SHOP within a state (i.e., **combine SHOP and IFPs if they are the same product type offered in the same state**). *Example:* • QHP issuer XYZ has 500 SHOP HMO enrollees in a particular state and 200 IFP HMO enrollees in the same state. • QHP issuer XYZ pulls the reporting unit sample frame after January 4, 2024 containing 700 enrollees from SHOP and individual and family HMOs.	
Combine enrollees from multiple products of the same product type in a single state into one reporting unit. *Example:* • QHP issuer XYZ has three HMO plans in a particular state. • QHP issuer XYZ combines enrollees from the three HMO plans for that state into a single reporting unit.	
Combine enrollees from the same product type with multiple plan levels (e.g., Bronze, Expanded Bronze, Silver, Gold, Platinum, Catastrophic) into one reporting unit. *Example:* • QHP issuer XYZ has Silver and Gold HMOs in a particular state. • QHP issuer XYZ combines the Silver and Gold HMOs for that state into a single reporting unit.	
Enrollees in QHPs offered through an Exchange that may be aligned to a different issuer in the prior year in cases where the QHP issuer has documented a change in ownership that is effective as of January 1 of the ratings year (i.e., 2024 calendar year) should be included. In cases of such mergers or acquisitions, the gaining QHP issuer should include enrollees previously aligned to the ceding QHP issuer.	
Exclude the Following Enrollees:	
Enrollees in plans offered outside the Exchange (HIOS variant ID-00) and non-QHPs.	
Enrollees in indemnity (i.e., fee-for-service) plans, child-only health plans, or stand-alone dental plans.	
Enrollees in a BHP plan.	
Confirm Minimum Enrollment Criteria:	
The QHPs in the reporting unit will operate on the Exchange as the exact same product type in both the 2023 and 2024 calendar years.	
There were more than 500 enrollees in the reporting unit as of July 1 in the prior year (i.e., July 2023).	
There were more than 500 enrollees in the reporting unit as of January 1 of the ratings year (i.e., January 2024).	

Example:

A fictional QHP issuer is certified to offer family medical coverage in two states: West Virginia (WV) and Maryland (MD). Exhibit 5 shows the characteristics of the issuer's reporting units. In accordance with the participation criteria defined above, this QHP issuer must collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data to CMS for only the following reporting units: 12345-WV-PPO, 12345-MD-EPO. The other reporting units either

did not have a sufficient number of enrollees as of July 1, 2023; did not have a sufficient number of enrollees as of January 1, 2024; or will be discontinued before June 15, 2024.

Exhibit 5. Example Reporting Units for a QHP Issuer Assessed Against 2024 QRS and QHP Enrollee Survey Participation Criteria

Reporting Unit	Enrollment as of July 1, 2023 (total and per individual market vs. SHOP)	Enrollment as of January 1, 2024 (total and per individual market vs. SHOP)	Discontinued prior to June 15, 2024	Meet participation criteria? (i.e., required to submit QRS and QHP Enrollee Survey measure data)?
12345-WV-PPO	505 (505 individual, 0 SHOP)	505 (505 individual, 0 SHOP)	No	Yes
12345-WV-HMO	601 (501 individual, 100 SHOP)	N/A	Yes – Discontinued as of December 31, 2023	No – Not operating in ratings year
12345-MD-PPO	100 (55 individual, 45 SHOP)	100 (55 individual, 45 SHOP)	No	No – Insufficient enrollment size in both years
12345-MD-HMO	700 (700 individual, 0 SHOP)	300 (300 individual, 0 SHOP)	No	No – Insufficient enrollment size as of January 1, 2024
12345-MD-EPO	505 (300 individual, 205 SHOP)	501 (300 individual, 201 SHOP)	No	Yes
12345-WV-EPO	500 (300 individual, 200 SHOP)	500 (300 individual, 200 SHOP)	No	No – Insufficient enrollment size in both years

QHP issuers with specific questions related to the application of the QRS and QHP Enrollee Survey participation criteria and/or determining reporting unit eligibility should seek guidance from CMS via the Marketplace Service Desk (MSD). Details on addressing membership changes in measure data collection are provided in the "General Guidelines for Data Collection" section of the *2024 Quality Rating System Measure Technical Specifications* under "Membership Changes."

6.2 QHP Enrollee Survey Sample Frame

This section provides detailed instructions for QHP issuers eligible to field the QHP Enrollee Survey on how to determine which enrollees to include in each reporting unit's sample frame. It also provides instructions for vendors on how to draw the QHP Enrollee Survey sample from each sample frame.

6.2.1 Create the Sample Frame (QHP Issuers)

QHP issuers must populate a complete, accurate, and valid sample frame of all survey-eligible enrollees for each reporting unit required to field the survey. The sample frame includes one record or line for each survey eligible enrollee (i.e., one enrollee record per line). ***All sample frames must include current enrollees as of 11:59 pm ET on January 4, 2024 (the anchor***

date). Sample frames may not be pulled before this date. All sample frames must be pulled on or after January 5, 2024, and must include all enrollees as of the anchor date – not the date the sample frame was pulled. QHP issuers must generate all sample frames in a time frame that supports validation by a HEDIS® Compliance Auditor (auditor) and submission to the vendor completed no later than January 31, 2024.

Note: Survey eligible enrollees must meet the criteria in Exhibit 6. However, eligibility determinations for reporting units to submit QRS clinical data and QHP Enrollee Survey response data are based on total enrollment (i.e., all enrollees in the reporting unit) and not the count of survey-eligible enrollees.

6.2.1.1 Inclusion and Exclusion Criteria

Exhibit 6 provides an overview for QHP issuers to determine which enrollees to include in each reporting unit's sample frame. Enrollees are considered continuously enrolled if they are enrolled in the eligible QHP from July 1 through December 31, 2023 with no more than one 45-day break in enrollment. An allowable gap can occur anytime during the continuous enrollment period (July 1 through December 31, 2023). Enrollees who switch among different coverage (i.e., Exchange, non-Exchange, Medicaid, Medicare) and products (i.e., HMO, POS, PPO, EPO) during the continuous enrollment period are considered continuously enrolled if they experience no more than one 45-day break in enrollment and were enrolled in an eligible QHP at the end of the continuous enrollment period (i.e., December 31, 2023). Enrollees are considered currently enrolled if they are enrolled in the eligible QHP at the end of the continuous enrollment period (i.e., December 31, 2023) and on January 4, 2024.

To ensure all enrollees meet the continuous and current enrollment criteria, QHP issuers may ***not*** generate sample frames until January 5, 2024. CMS will ***not*** accept submissions for reporting units that do not follow the specified guidelines for determining which enrollees should be included in the sample frame. QHP issuers must use a consistent approach when determining the eligible population and reporting for the QHP Enrollee Survey, the QRS clinical measures, and for each product offering.

Note: QHP issuers must provide a list of common plan name aliases to vendors prior to survey fielding to enable vendors to make accurate eligibility determinations for enrollee response data.

Exhibit 6. Enrollee Eligibility Requirements for the 2023 QHP Enrollee Survey (Survey Eligible Enrollees)

Eligibility Criteria	✓
Enrollee Eligibility Status: **Eligible if all the listed criteria are met. Include enrollee in sample frame if:**	
Enrollee is in a QHP offered through the Exchange (HIOS variant IDs -01 through -06 or -31 through -36 for states with Medicaid 1115 waivers allowing access to Exchange plans).	
Enrollee is in a QHP offered through the Exchange that provides family and/or adult medical coverage.	
Enrollee is 18 years of age or older as of December 31, 2023.	
Enrollee meets continuous enrollment criteria.	
Enrollee is still enrolled on January 4, 2024 (i.e., meets current enrollment criteria).	
Enrollee has requested to not be contacted (i.e., a "Do Not Survey" list). **Note:** Vendors will exclude enrollees from fielding based on their internal "Do Not Survey" list; however, enrollees on a QHP issuer's "Do Not Survey" list remain eligible for sampling.	

Eligibility Criteria	✓
Enrollee Eligibility Status: Ineligible if any of the listed criteria apply. Exclude enrollee from the sample frame if:	
Enrollee is in a QHP offered outside the Exchange (HIOS variant ID-00) or a non-QHP.	
Enrollee is in a QHP offered through the Exchange that is an indemnity (i.e., fee-for-service) plan, a child-only health plan or a stand-alone dental plan.	
Enrollee is in a basic health program (BHP) plan	
Enrollee is younger than 18 years of age as of December 31, 2023.	
Enrollee does not meet continuous enrollment criteria.	
Enrollee discontinued enrollment for the 2024 Plan Year prior to 11:59 pm on January 4, 2024. **Note:** QHP issuers are not permitted to generate a separate list of disenrollees. All exclusions of disenrollees must occur prior to submitting the sample frame for the HEDIS® Compliance Audit.	
Enrollee is deceased as of January 4, 2024.	

6.2.1.2 Sample Frame Data Format

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

6.2.2 Validate Sample Frame

CMS requires that QHP issuers use a HEDIS® Compliance Auditor (auditor) to validate the QHP Enrollee Survey sample frame and the QRS clinical measure data. Each QHP issuer is responsible for selecting a HEDIS® Compliance Organization, determining fees, and entering into a data validation contract (if necessary). This process is designed to give QHP issuers the maximum opportunity to have valid and publicly reportable results. QHP issuers should refer to the following website to access the list of NCQA-certified HEDIS® Compliance Auditors: https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/.

Exhibit 7 provides an overview of the sample frame validation process.

Exhibit 7. Sample Frame Validation Process

Step	Description	✓
Step 1	The QHP issuer generates the sample frame data file(s) per specifications.	
Step 2	The QHP issuer delivers the sample frame data file(s) to the HEDIS® Compliance Auditor (auditor).	

Step	Description	✓
Step 3	The auditor validates the sample frame data file(s) and notifies the QHP issuer of the results. If the auditor determines the quality or completeness of the sample frame poses a threat to the desired survey response rate, the QHP issuer makes corrections to the sample frame until the desired audit result is achieved.	
Step 4	The QHP issuer forwards the auditor-locked sample frame data file(s) and documentation of the validation results to the QHP Enrollee Survey vendor.	
Step 5	The vendor draws the survey sample and administers the QHP Enrollee Survey per specifications.	

6.2.3 Provide Sample Frame to Vendor

Once a QHP issuer has received a validated sample frame from the auditor, the issuer must provide it directly to the contracted vendor in a secure manner. Vendors review the sample frame and assess the completeness of the contact information (e.g., mailing address, telephone number, and email addresses) included in the sample frame for each eligible enrollee. Vendors also conduct quality assurance (QA) checks of the sample frame to verify the accuracy of the information provided by the QHP issuer. Vendors must notify CMS (QHP_Survey@air.org) of any QHP issuer clients that have not provided a validated sample frame by the deadline established by CMS (see Exhibit 1).

6.3 Reporting Ineligible Reporting Units

QHP issuers with ineligible reporting units must submit the reporting unit information and ineligibility reason to CMS by January 31, 2024. QHP issuers must include complete information for each reporting unit that does not meet eligibility criteria by selecting from a menu of ineligibility reasons. *The 2024 QRS and QHP Enrollee Experience Survey: Operational Instructions* are scheduled for posting on the CMS MQI website in the fall of 2023. These instructions will include detailed steps on the process for submitting ineligibility information via the QHP Enrollee Survey Website.

6.4 QRS Measure Set

QHP issuers that meet the participation criteria as defined in Section 6.1 are required to collect and submit validated data for all measures as listed in Exhibit 8. The QRS measure set consists of measures that address the areas of: Clinical Quality Management; Enrollee Experience; and Plan Efficiency, Affordability, & Management. The QRS measures align with the quality priority areas that are focal to the Meaningful Measures Initiative including person-centered care, safety, chronic conditions, and equity.

Some measures have multiple indicators (or rates), including additional sub-levels (e.g., age bands). QHP issuers are required to submit validated data for all elements within a measure.

The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which draws heavily from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[29] surveys. Note that the QRS survey measures (except for the clinical

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

measure captured in the QHP Enrollee Survey) and the QRS clinical measure *Plan All-Cause Readmissions (PCR)* are case-mix adjusted. See Section 6.5 for details on the QHP Enrollee Survey.

Exhibit 8. QRS Measure Set

Measure Title ¥ indicates **measure** not endorsed by **Consensus Based Entity (CBE)** € indicates measure with ECDS-only reporting	CBE ID[30]	QRS Measure Type
Access to Care	0006[31]	Survey
Access to Information ¥	0007	Survey
Adult Immunization Status €	3620	Clinical
Annual Monitoring for Persons on Long-term Opioid Therapy	3541	Clinical
Antidepressant Medication Management	0105	Clinical
Appropriate Treatment for Upper Respiratory Infection	0069	Clinical
Asthma Medication Ratio	1800	Clinical
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	0058	Clinical
Breast Cancer Screening €	2372	Clinical
Care Coordination	0006	Survey
Cervical Cancer Screening	0032	Clinical
Child and Adolescent Well-Care Visits ¥	N/A	Clinical
Childhood Immunization Status (Combination 10)	0038	Clinical
Chlamydia Screening in Women	0033	Clinical
Colorectal Cancer Screening	0034	Clinical
Eye Exam for Patients with Diabetes	0055	Clinical
Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%)	0059	Clinical
Controlling High Blood Pressure	0018	Clinical
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)	0576	Clinical
Immunizations for Adolescents (Combination 2)	1407	Clinical
Initiation and Engagement of Substance Use Disorder Treatment	0004	Clinical
International Normalized Ratio Monitoring for Individuals on Warfarin	0555	Clinical
Kidney Health Evaluation for Patients with Diabetes ¥	N/A	Clinical
Medical Assistance with Smoking and Tobacco Use Cessation ¥	0027	Survey
Oral Evaluation, Dental Services	2517	Clinical

[30] The Consensus-Based Entity (CBE), as required by section 1890 of the Social Security Act, performs various duties related to health care performance measurement including endorsement and maintenance of quality measures. For additional information about endorsement and maintenance and other CBE work funded by CMS, see the Partnership for Quality Measurement website available at: https://p4qm.org/.

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

Measure Title ¥ indicates **measure** not endorsed by **Consensus Based Entity (CBE)** € indicates measure with ECDS-only reporting	CBE ID[30]	QRS Measure Type
Plan Administration	0006	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
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 30 Months of Life	1392	Clinical

Appendix B includes summaries of each QRS measure. For detailed measure specifications, QHP issuers should refer to each measure's technical specifications (in the *2024 Quality Rating System Measure Technical Specifications*), which specify criteria for determining the eligible population.[32]

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

6.5 QHP Enrollee Survey

The QHP Enrollee Survey is the survey used to measure the experience of the enrollee population in the Exchanges. While the survey utilizes questions from the CAHPS® Health Plan Surveys, which are used widely to assess Medicare, Medicaid, and other commercial health plan performance, modifications and new questions were designed specifically for use with the Exchange enrollee population.

Consistent with CAHPS® instruments, the QHP Enrollee Survey uses a six-month reference period. The survey assesses enrollee experience with a QHP offered through an Exchange on the topics presented in Exhibit 9. 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.

[32] The *2024 QRS Measure Technical Specifications* released in March 2023 include the specifications for any measures and/or measure rates proposed for addition and removal in the Draft 2023 Call Letter proposed to be applicable in the 2024 ratings year. CMS released an updated version of the *2024 QRS Measure Technical Specifications* in fall 2023 that reflects the final decisions applicable to the 2024 ratings year communicated via the Final 2023 Call Letter.

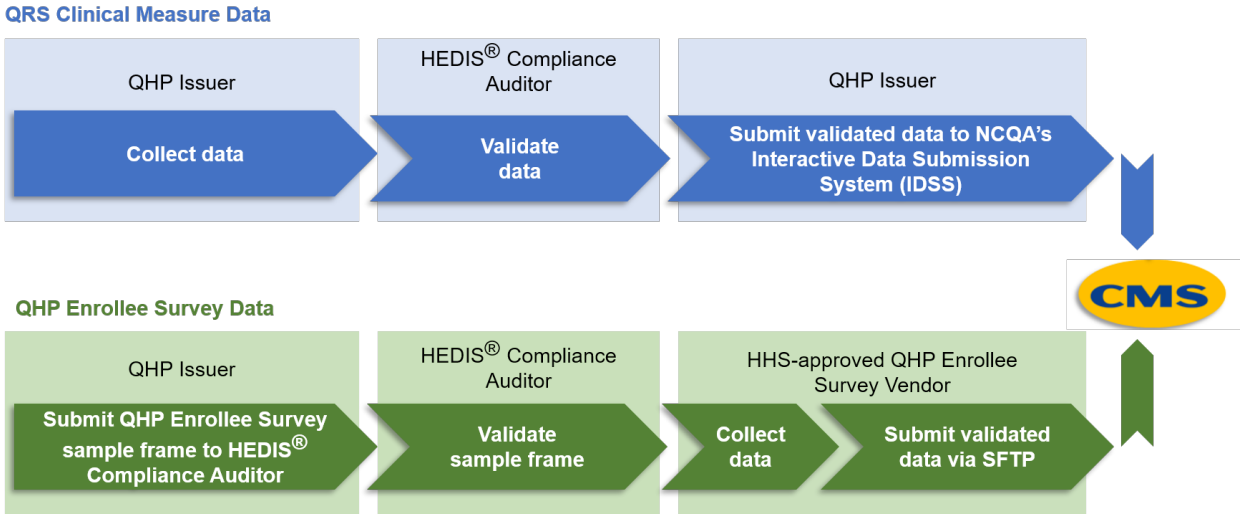
Exhibit 9. QHP Enrollee Survey Topics

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

6.6 Data Collection, Validation, and Submission

The following sections address the protocols for data collection, data validation, and data submission of the QRS clinical measure and QHP Enrollee Survey response data. Exhibit 10 illustrates the process and interested parties with primary responsibility for the associated steps. The steps are detailed in subsequent sections.

Exhibit 10. QRS Clinical Measure and QHP Enrollee Survey Response Data Process Flow[33]



6.6.1 Data Collection

The next sections summarize details related to the data collection protocols for QRS clinical measure data and QHP Enrollee Survey response data. For additional data collection instructions for the QRS clinical measures, including the required data elements, refer to the *2024 Quality Rating System Measure Technical Specifications*. For additional data collection procedures

[33] QHP issuers may access the Secure File Transfer Protocol (SFTP) link via the QHP Enrollee Survey website that will be available in spring 2024.

related to the QHP Enrollee Survey, refer to the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications for 2024.*

6.6.1.1 QRS Clinical Measure Data Collection

QHP issuers will collect data for QRS clinical measures using administrative sources, a hybrid of administrative and medical record sources, and/or ECDS data. 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.
- **Electronic Clinical Data Systems (ECDS):** Uses data sources that include, but are not limited to, electronic member eligibility files, electronic health records (EHRs), personal health records (PHRs), clinical registries, health information exchanges (HIEs), administrative claims systems, electronic laboratory reports (ELRs), electronic pharmacy systems, immunization information systems (IISs), and disease/case management registries to identify the eligible population (denominator) and numerator compliance.[34,35]

QHP issuers must refer to the *2024 Quality Rating System Measure Technical Specifications*[36] to determine which data collection method is appropriate for each clinical measure. If more than one method is allowed (i.e., administrative and hybrid), the QHP issuer may choose its preferred method.

For the 2024 ratings year, CMS will offer optional ECDS reporting for four measures: *Colorectal Cancer Screening*, *Cervical Cancer Screening*, *Immunization for Adolescents (Combination 2)*, and *Childhood Immunization Status (Combination 10).* QHP issuers that submit optional ECDS reporting are required to do so alongside data reported via either the administrative method or hybrid method. For example, QHP issuers that voluntary report the *Colorectal Cancer Screening* measure using ECDS reporting method for 2024 must also report *Colorectal Cancer Screening* measure data using the administrative or hybrid method.

For the 2024 ratings year, QHP issuers are required to collect and report race and ethnicity stratifications as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity for 10 measures in the QRS measure set: *Asthma Medication Ratio*, *Breast Cancer Screening, Child and Adolescent*

[34] More information on ECDS reporting is available at: https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/.
[35] For more information on QRS measures reported using ECDS reporting, see the *2024 QRS Measure Technical Specifications*: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.
[36] *Id*.

Well-Care Visits, Colorectal Cancer Screening, *Controlling High Blood Pressure, Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c poor control (>9.0%)*, *Immunizations for Adolescents, Initiation and Engagement of Substance Use Disorder Treatment, Prenatal and Postpartum Care*, and *Well-Child Visits in the First 30 Months of Life*.[37] For the 2024 ratings year, QHP issuers may report stratified data using their own directly collected member data for race and ethnicity as outlined in the *2024 Quality Rating System Measure Technical Specifications*[38] or supplement directly collected data with indirect race and ethnicity data (i.e., assigned or imputed from secondary data sources such as assignment by geographic location, surname analysis, and geocoding).[39] QHP issuers will not be required to use a standardized method for reporting stratified race and ethnicity data when using indirect data sources to impute race or ethnicity data.

QHP issuers must request access to NCQA's HOQ to submit QRS clinical measure data.

6.6.1.2 QHP Enrollee Survey Data Collection

Prior to survey administration, each QHP issuer will develop a sample frame of enrollees for each of its eligible reporting units (per criteria detailed in Section 6.1). QHP issuers are required to authorize a survey vendor for eligible reporting units beginning in January 2024. QHP issuers with reporting units required to participate in the QHP Enrollee Survey must attest to reporting unit information and contract with an HHS-approved QHP Enrollee Survey vendor to administer the QHP Enrollee Survey.[40] Vendors will sample eligible enrollees using a standardized data collection protocol specified by CMS.[41] These vendors will collect enrollee responses to the survey questions on behalf of the QHP issuer.[42]

A list of HHS-approved survey vendors is available on the MQI website; vendors are conditionally approved until the completion of training in the fall of each year. QHP issuers are not required to contract with the same vendor from the previous survey administration year, but may do so if the contracted vendor is on the list of approved vendors for the current survey administration year.

By January 31, 2024, each QHP issuer must formally attest reporting eligibility for their reporting units and authorize a vendor to collect and submit QHP Enrollee Survey response data to CMS on its behalf.[43] The *2024 QRS and QHP Enrollee Experience Survey: Operational Instructions* is scheduled for posting on the MQI website in the fall of 2023. These instructions will include detailed steps on how to complete the attestation and survey vendor authorization, as

[37] For more information on the OMB race and ethnicity reporting categories, see the *2024 QRS Measure Technical Specifications*, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page and the Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, available at: https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf.
[38] See supra note 28.
[39] See the "General Guidelines for Data Collection" in the *2024 QRS Measure Technical Specifications* for more information regarding race and ethnicity stratifications, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.
[40] 45 C.F.R. § 156.1125(a).
[41] 45 C.F.R. § 156.1105(b)(5).
[42] 45 C.F.R. §§ 156.1105 and 156.1125.
[43] 45 C.F.R. § 156.1125(a).

well as how to submit eligibility (or ineligibility) information, via the QHP Enrollee Survey Website.

6.6.2 Data Validation

Each QHP issuer must have its clinical measure data and the QHP Enrollee Survey sample frame validated by a data validator in accordance with the measure stewards' protocols prior to data submission.[44] For 2024, CMS requires that QHP issuers use a HEDIS® Compliance Auditor to validate all QRS measures, including the QHP Enrollee Survey sample frame.[45] The sections below contain details related to these data validation requirements.

6.6.2.1 Data Validators

QHP issuers must use a HEDIS® Compliance Auditor (validator) to validate all clinical measures and the survey sample frame. Each QHP issuer is responsible for selecting the HEDIS® Compliance Licensed Organization, determining fees, and entering into a data validation contract (if necessary).

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

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

6.6.2.2 Data Validation Standards

The data validation standards for QRS clinical measures 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 *2024 Quality Rating System Measure Technical Specifications*.

QHP issuers should refer to the *HEDIS Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures*, which is available for purchase on the following website: https://store.ncqa.org/hedis-quality-measurement.html.

6.6.2.3 Data Validation Results

All QRS measures must have a final, validated result that indicates data are complete, accurate, and comparable. The HEDIS® Compliance Auditor will determine if the QHP issuer's clinical

[44] 45 C.F.R. §§ 156.1120(a)(2) and 156.1125(b)(2).
[45] The Pharmacy Quality Alliance (PQA) does not have a defined measure validation strategy for the *Proportion of Days Covered, Annual Monitoring for Persons on Long-term Opioid Therapy,* and *International Normalized Ratio Monitoring for Individuals on Warfarin* measures. CMS requires these measures to be validated using the HEDIS® Compliance Audit standards, policies, and procedures.

measure rates are reportable using the HEDIS® Compliance Audit standards described above and determine if the QHP Enrollee Survey sample 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. The following reason codes may be assigned:

- **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 rate or the measure rate was otherwise invalid in the QRS Proof Sheets, a rate would be designated as "NR" if the reporting unit had no data to report for the measure.
- **Not Applicable (NA):** The QHP issuer followed the specifications, but the denominator was too small (i.e., less than 30 [or 150 for the PCR measure]) to report a valid rate. The QHP issuer did not have sufficient data to fulfill the continuous enrollment criteria for the measure. For example, a QHP issuer that has operated for only one year may be unable to meet the continuous enrollment criteria for the *Breast Cancer Screening* measure, which requires multi-year continuous enrollment as outlined in the *2024 Quality Rating System Measure Set Technical Specifications*.

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

6.6.2.3.1 Compliance Reviews

CMS may conduct targeted compliance reviews under 45 C.F.R. § 156.715 to examine compliance with the federal data submission and reporting requirements for the QRS and QHP Enrollee Survey (subsequent to data validation of QRS clinical measure and QHP Enrollee Survey response data) by QHP issuers participating in an FFE. These reviews could occur in cases where CMS suspects that a QHP issuer's mishandling of data, inappropriate processing, or implementation of incorrect practices has resulted in erroneous data, scores, or ratings. Examples include, but are not limited to: a QHP issuer's failure to adhere to QRS and QHP Enrollee Survey reporting requirements, and a QHP issuer's failure to pass data validation directly related to data reported for specific measures. Based on the findings of this compliance review or other evidence received by CMS, CMS may take enforcement action, such as the imposition of civil money penalties and/or decertification of the affected QHPs.[46]

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

[46] See, e.g., 45 C.F.R. § 156.800.

6.6.3 Data Submission

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

6.6.3.1 QRS Clinical Measure Data Submission

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

NCQA will open the annual HOQ completion process in December 2023 and close access in February 2024. When opened by NCQA, the HOQ can be accessed at: https://applications.ncqa.org/. For more information regarding the HOQ, visit: https://www.ncqa.org/hedis/data-submission/. QHP issuers should submit questions about the HOQ to the NCQA portal.

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

QHP issuers must work with their HEDIS® Compliance Auditors to submit the validated QRS clinical measure data and signed attestations (i.e., confirm data are accurate and reflect plan performance) by 9:00 pm ET, June 14, 2024. QHP issuers should submit questions regarding the IDSS to the NCQA portal.

6.6.3.2 QHP Enrollee Survey Data Submission

On behalf of the QHP issuer, the HHS-approved QHP Enrollee Survey vendor will securely submit deidentified enrollee response data to CMS via the QHP Enrollee Survey Website: https://qhpsurvey.cms.gov/. CMS will provide detailed instructions to vendors during the mandatory Data Submission Training held at the end of February 2024.

QHP Enrollee Survey vendors must submit the QHP Enrollee Survey response data by 11:59 pm ET, May 17, 2024.

7. QRS Rating Methodology

This section describes how CMS will calculate 2024 QRS quality ratings based on the QRS clinical measure data and QHP Enrollee Survey response data submitted in 2024.

CMS continuously refines the QRS program and QHP Enrollee Survey based on a variety of factors, including interested party feedback, clinical guideline changes, Agency priorities, and advances in quality measurement and survey administration that impact each year's ratings. Refinements should be considered when reviewing year over year comparisons.

Appendix D provides the 2024 QRS rating methodology.

7.1 Measures and Scoring

For the 2024 QRS data submission, QHP issuers are required to collect and submit validated data for 36 measures in the QRS measure set; however, CMS will only include 32 measures in the calculation of 2024 QRS scores and ratings. For the 2024 ratings year and beyond, CMS incorporated the *Oral Evaluation, Dental Services*, *Adult Immunization Status (AIS-E),* and *Breast Cancer Screening (BCS-E)* measures into the QRS measure set. CMS will begin data collection in 2024 for these measures, but will not include them in scoring until the 2025 ratings year, at the earliest.

Additionally, CMS transitioned the *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c control (<8.0%)* measure to the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* beginning with the 2024 ratings year. CMS will collect measure data for the *HbA1c Control for Patient with Diabetes: HbA1c poor control (>9.0%)* measure data in 2024, but will not include it in scoring until the 2025 ratings year, at the earliest.

For the 2024 ratings year, CMS will include the *Kidney Health Evaluation for Patients with Diabetes* measure in scoring, reintroduce the *Initiation and Engagement of Substance Use Disorder Treatment* measure in scoring, and introduce the refined *Colorectal Cancer Screening* measure that includes the revised age range (45 – 75) in scoring.

For the 2024 ratings year and beyond, CMS removed the *Annual Dental Visit*, *Flu Vaccinations for Adults Ages 18-64*, and the *Appropriate Testing for Pharyngitis* measures from the QRS measure set. Exhibit 11 offers a comparative summary of the QRS measures and scoring approach for the 2023 and 2024 ratings years.

Exhibit 11. QRS Measures and Scoring[47]

QRS Measures	2023	2024 (current year)
Number of measures required for QRS data submission	37	36*
Number of measures to be used for QRS scoring	35	32[48]

* 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; therefore, a new QHP issuer or reporting unit may be unable to report a numeric rate for this measure).

[47] In communicating total measure counts, the totals presented here represent the perspective of the measure steward, rather than the perspective of the QRS scoring methodology. If counting based on the perspective of the scoring methodology, there are 39 measures in total (rather than 36 measures). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care (CBE ID #1517) is split into two distinct measures for the QRS hierarchy: *Timeliness of Prenatal Care* and *Postpartum Care*. Similarly, Proportion of Days Covered (CBE ID #0541) is split into three distinct measures: *Renin Angiotensin System Antagonists (PDC-RASA), Diabetes All Class (PDC-DR),* and *Statins (PDC-STA)*.

[48] Four additional or transitioned measures are included in the QRS measure set beginning with the 2024 ratings year: *Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%)*, *Breast Cancer Screening (BCS-E)*, *Adult Immunization Status (AIS-E)*, and *Oral Evaluation, Dental Services*. QHP issuers are required to submit data for these measures as part of the 2024 QRS data submission. However, these measures will not be included in scoring until the 2025 ratings year, at the earliest.

While QHP issuers are required to submit QRS measure data for eligible reporting units beginning with the reporting unit's second year of operation, eligible reporting units will not receive QRS scores and ratings until their *third* consecutive year of operation in the Exchange. Therefore, a reporting unit that is eligible to be scored must meet the criteria for data submission (as defined by Section 6.1) *and have been in operation for at least three consecutive years.* For example, as shown in Exhibit 12, to receive QRS scores and ratings in 2024, a reporting unit must be in operation in 2022, 2023, and 2024.

Exhibit 12. Reporting Unit Data Submission and Scoring Example

Criteria	Required to submit data?	Eligible to be scored?
Reporting unit operates in ratings year only (2024)	No, does not meet the QRS participation criteria	No
Reporting unit operates in ratings year and prior year (2024 and 2023) and meets the QRS participation criteria (as defined in Section 6.1)	Yes	No
Reporting unit operates for at least three consecutive years, (i.e., 2024, 2023, 2022) and meets the QRS participation criteria (as defined in Section 6.1)	Yes	Yes

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

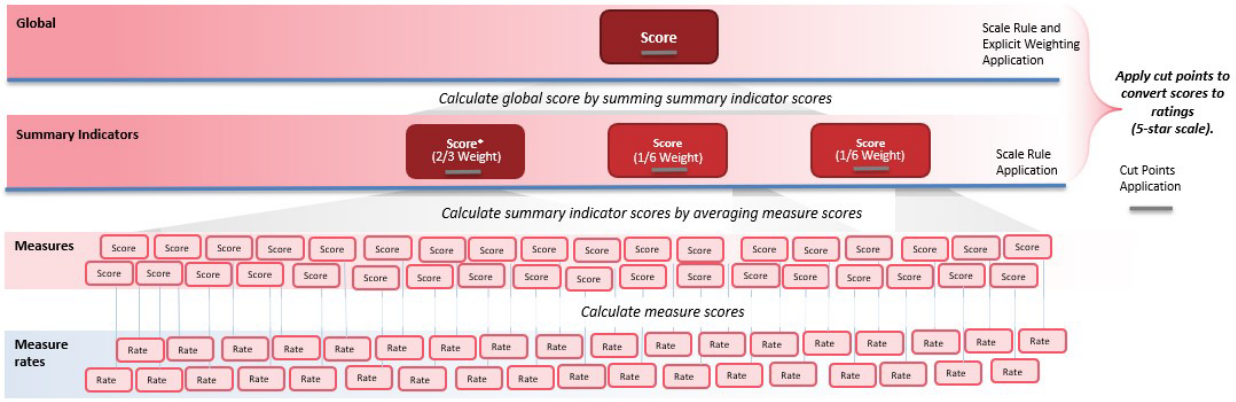
7.2 QRS Hierarchy

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

7.3 Overview of Process for Calculating QRS Scores and Ratings

Exhibit 13 is a visual overview of the QRS rating methodology, which shows how CMS calculates QRS scores and ratings from submitted QRS measure data.

Exhibit 13. Overview of QRS Rating Methodology



*The Clinical Quality Management summary indicator and at least one of the other summary indicators must have a valid score to calculate the global rating for a given reporting unit.

This overview shows how CMS converts submitted measure data into higher-level QRS hierarchy component scores and ratings. The global score is the sum of weighted summary indicator scores (e.g., a weight of two-thirds [66.67%] to the Clinical Quality Management summary indicator, and a weight of one sixth [16.67%] to the Enrollee Experience and the Plan Efficiency, Affordability, & Management summary indicators).

The summary indicator scores are calculated by averaging scores of the underlying measures.

Exhibit 14 further describes the process for calculating 2024 QRS scores and ratings. CMS conducts QA activities throughout the data scoring process, beginning upon receipt of QRS clinical measure data and QHP Enrollee Survey response data. These QA activities include verification of submitted data file attributes and data content quality checks to validate the accuracy, completeness, consistency, and validity of output files and reports.

Exhibit 14. Steps for Calculating QRS Scores and Ratings

Step	Sub-steps
Step 1. Calculate measure rates	▪ *Calculate QRS clinical measure rates.* For QRS clinical measures with multiple measure indicators, calculate measure rates per the method defined by the measure's technical specifications. ▪ *Calculate QRS survey measure rates.* For QRS survey measures, calculate measure rates from QHP Enrollee Survey data.
Step 2. Determine scoring status and application of denominator criteria	▪ *Apply the scoring eligibility criteria*. Only reporting units that have operated for three consecutive years on the Exchange and meet the QRS enrollment criteria are ratings eligible. Reporting units that do not meet the ratings eligibility criteria are removed from the analytical data, and do not go through steps 3–7 below. ▪ *Apply the denominator criteria.* The minimum denominator size is 30 observations for QRS clinical measures (including clinical measures captured in the QHP Enrollee Survey), 150 for the PCR measure, and 100 for QRS survey measures. Measure data that do not meet the minimum denominator size requirement for scoring are excluded from QRS scoring.

Step	Sub-steps
Step 3. Apply the Benchmark Ratio approach to calculate benchmarks and measure scores	▪ *Calculate measure benchmarks.* Use the calculation for each measure type (i.e., PCR, QRS clinical measure, CAHPS®-based QHP Enrollee Survey) to calculate a data-driven benchmark that defines a performance threshold based on the top performance of reporting units on that measure. ▪ *Calculate measure scores.* Transform all raw measure rates independently using the Benchmark Ratio approach. Compare the measure rate value of each reporting unit to the respective measure benchmark. Apply the upper cap to measure scores that exceed the score of 110 and lower cap to measure scores that fall below 0.
Step 4. Calculate summary indicator scores	▪ *Determine if the score can be calculated.* Apply the half-scale rule, meaning the summary indicator score can be calculated only if at least half (≥50%) of the associated measures have a score for the reporting unit. ▪ *Calculate the score.* If the half-scale rule is met, average measure scores to calculate the specific summary indicator for the reporting unit. Otherwise, no summary indicator score is calculated.
Step 5. Calculate global score	▪ *Determine if the score can be calculated.* The global score can be calculated only if the Clinical Quality Management summary indicator received a score and at least one of the other two summary indicators received a score. Otherwise, no global score is calculated. ▪ *Calculate the score.* If the above scoring rule is met, sum the summary indicator scores with explicit weights applied (e.g., a weight of 2/3 (66.67%) applied to the Clinical Quality Management summary indicator score, a weight of 1/6 (16.67%) applied to the Enrollee Experience summary indicator score, and a weight of 1/6 (16.67%) applied to the Plan Efficiency, Affordability, & Management summary indicator score).[49]
Step 6. Convert scores to ratings	▪ *Convert scores to ratings.* Apply the static cut point values of 60, 70, 80, and 90 to delineate the 5-star rating categories and convert global and summary indicator scores into a rating.
Step 7. Produce QRS results for preview and finalization	▪ *Prepare Ratings Output File (ROF) (for internal CMS use).* ▪ *Prepare QRS Preview Reports and QRS Proof Sheets for preview.*

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

QHP issuers and State Exchange administrators will receive QHP quality rating information and QHP Enrollee Survey results, and will be able to preview these results via the CMS Health Insurance Oversight System-Marketplace Quality Module (HIOS-MQM)[50] website during the annual preview period (anticipated August–September 2024). QHP issuers and State Exchange administrators will receive an email notification via the HIOS-MQM website prior to the start of preview.

[49] In scenarios where a reporting unit has only two valid summary indicator scores (one of which is the Clinical Quality Management summary indicator score), CMS calculates the summary indicator weights by redistributing the weight assigned to the missing summary indicator, proportionally, based on the predefined explicit weights. The resulting summary indicator weights are (approximately) 80 percent for the Clinical Quality Management summary indicator score and 20 percent for the other summary indicator score.

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

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

During the QRS and QHP Enrollee Survey preview period, QHP issuers in all Exchanges will be able to preview their respective QRS and QHP Enrollee Survey results via CMS' HIOS-MQM website and submit any related inquiries to CMS. Exhibit 15 provides descriptions of the documents that will be available for preview on the HIOS-MQM website. The QRS Preview Reports, QRS Proof Sheets, QHP Enrollee Survey Quality Improvement (QI) Reports, QHP Enrollee Survey QI Reports Methodology Guide, and National Quality Improvement Benchmark Report for the applicable ratings year will be available for preview on CMS' HIOS-MQM website concurrently.

Exhibit 15. QRS and QHP Enrollee Survey Documents Available for Preview on the HIOS-MQM Website

Document Title	Description
QRS Preview Report	The QRS Preview Report provides the QRS ratings for each QHP issuer's eligible reporting unit(s). The ratings are provided on a 5-star scale for both QRS hierarchy components (i.e., summary indicators, and the global result). The QRS Preview Report will be available online and for download as a PDF file on CMS' HIOS-MQM website.
QRS Proof Sheet	The QRS Proof Sheet provides additional detail behind the ratings shown in the QRS Preview Report. The QRS Proof Sheet will be available for download on CMS' HIOS-MQM website as a PDF file and comma separated values (CSV) file. The PDF file displays outputs for each step of the QRS rating methodology, from the submitted raw measure values through the global score and rating. Specifically, the PDF file includes the following: ▪ Scores and ratings for all QRS hierarchy components. ▪ Results for all QRS measures, including measures not included in scoring. For all measures, the file will include the raw rate and total denominator size. ▪ Cut points used to convert numeric scores to star ratings for each QRS hierarchy component. The CSV file provides additional information, specifically: ▪ Measure indicator and below values. ▪ Percentile values for raw measure rates, allowing a QHP issuer to compare its reporting unit's results to all other reporting units nationally. CMS includes the 5th, 10th, 25th, 50th, 75th, 90th, 95th percentile of the numerical rates (raw values) across all eligible reporting units. To create these values, CMS uses only raw measure rates that have met the minimum denominator size criteria for scoring. ▪ Measure benchmarks calculated using the Benchmark Ratio approach. ▪ Eligible population of the measure.
QRS Proof Sheet User Guide	A PDF file that describes the contents of the QRS Proof Sheet and provides detail regarding the QRS rating methodology used to produce the QRS scores and ratings shown in the QRS Proof Sheet.
QHP Enrollee Survey Quality Improvement Reports (QI Reports)	These reports communicate the results of the full QHP Enrollee Survey, including questions not included as part of the QRS measure set. The raw frequencies for all QHP Enrollee Survey questions are included in the QHP Enrollee Survey QI Reports.
QHP Enrollee Survey QI Reports Methodology Guide	A PDF file that describes the contents of the QHP Enrollee Survey QI Reports. It includes details regarding the survey process and timeline, the data analysis methods used for scoring the data (including reliability calculations, response rate calculations, weight calculations, case-mix adjustment, and score transformation), as well as survey item-to-composite crosswalk and a copy of the 2024 survey instrument.

Document Title	Description
National Quality Improvement Benchmark Report	The National Quality Improvement Benchmark Report provides national-level statistics for the QHP Enrollee Survey scoring questions, screener questions, about-the-enrollee questions, and survey disposition. QHP issuers can use this report to compare the performance of their respective eligible reporting units to the performance of all reporting units that participated in the QHP Enrollee Survey for the given year.

8.1.1 Instructions for Accessing QRS and QHP Enrollee Survey Results

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

1) Log in to the HIOS-MQM website.
   - Users new to HIOS need to request access to HIOS and the MQM through the CMS Enterprise Portal. Existing HIOS users who are new to the MQM need to request a new role: Ratings/Reports Viewer. The Ratings/Reports Viewer role authorizes the user to perform predetermined functions and access certain data sets. Detailed instructions for registering for access to HIOS and the MQM can be found in the *MQM HIOS Quick Reference Guide for Production User*, located on the CMS MQI website.
2) Navigate to the Preview Ratings and Survey Results webpage and reports will populate for the user's corresponding QHPs. To access the QRS Preview Report, QRS Proof Sheet, and QI Report, click the appropriate **Download** link at the bottom of the page.

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

1) Log in to the HIOS-MQM website.
   - Users new to HIOS need to contact the appropriate authorizing official: CMS (via the Marketplace Service Desk [MSD]) or the cognizant State Access Administrator (SAA) to initiate a role request.
2) Navigate to the Preview Ratings and Survey Results webpage and reports will populate for the user's corresponding QHPs. To access the QRS Preview Report, QRS Proof Sheet, and QI Report, click the appropriate **Download** link at the bottom of the page.
3) Navigate to the Download State Ratings and Survey Results webpage and download the State-level compiled QHP Enrollee Survey QI Report by selecting the **Download** link in the State Level QI Report column.
   - In September of the ratings year, download the machine readable, state-level compiled QRS quality ratings data file by selecting the **Download** link in the State Rating File column. Download the State Ratings Report by selecting the **Download** link in the State Rating Report column. (The State Ratings Report communicates the same information as the State Rating File in a user-friendly format.)

8.2 Additional Ratings Preview by SBEs

An SBE may choose to conduct an additional rating preview period for QHP issuers operating in that Exchange. CMS encourages the SBEs to do so, particularly in states that require QHP

issuers to report additional quality measures beyond the federal QRS and QHP Enrollee Survey requirements.

8.3 Preview Period Inquiries

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

9. Display Guidelines for QHP Quality Rating Information

CMS is committed to increasing transparency and providing quality information to help empower consumers in making informed health care decisions. Public display of the 2024 QHP quality rating information by all Exchanges, including the FFEs, SBE-FPs, and SBEs, is required during the individual market Open Enrollment Period (OEP) and throughout the 2025 Plan Year.[51]

In accordance with Section 1311(c)(3) and (c)(4) of the Patient Protection and Affordable Care Act and 45 C.F.R. §§ 155.1400 and 155.1405, all Exchanges are required to publicly report 2024 quality rating information on their websites to help consumers compare and shop for QHPs.

CMS intends to release subsequent guidance regarding display of 2024 quality rating information beginning with the 2025 individual market OEP to coincide with the release of the 2025 Final Letter to Issuers in the Federally-facilitated Exchanges (anticipated in the spring of 2024). Subsequent guidance will specify the form and manner for display of the 2024 ratings, additional guidelines for Direct Enrollment (DE) entities and Exchanges, and what to display in cases where a QHP did not receive a rating. CMS will publish this guidance prior to the 2025 individual market OEP.

9.1 Display on HealthCare.gov

CMS intends to release subsequent guidance specifying the form and manner in which CMS will display 2024 QHP quality rating information on HealthCare.gov. For example, on HealthCare.gov, CMS anticipates referring to the QRS global rating as the "Overall Quality Rating;" the Clinical Quality Management summary indicator as "Medical Care;" the "Enrollee Experience" summary indicator as "Member Experience;" and the "Plan Efficiency, Affordability, & Management" summary indicator as "Plan Administration."

9.2 Display Guidance for SBEs

CMS intends to release subsequent guidance regarding display of 2024 QHP quality rating information for SBEs. SBEs that display the federally calculated QHP quality ratings information, whether directly on the SBE website or a static website, must prominently display the following disclaimer language:

[51] See supra note 20.

> *Plan quality ratings and enrollee survey results are calculated by CMS using data provided by health plans in 2024. The ratings will be displayed for health plans for the 2025 plan year. Learn more about these ratings. [Link to appropriate explanatory/Help text on HealthCare.gov.]* [52]

SBEs will continue to have some flexibility to customize the display of the QHP quality rating information on their respective websites.[53]

9.3 Display Guidance for Direct Enrollment Entities

CMS intends to release subsequent display guidance for QHP issuer and web-broker DE entities that facilitate enrollment through Exchanges. QHP issuer and web-broker DE entities that display 2024 QHP quality rating information on their websites beginning during the 2025 individual market OEP should prominently display the following disclaimer language:

> *Plan quality ratings and enrollee survey results are calculated by CMS using data provided by health plans in 2024. The ratings will be displayed for health plans for the 2025 plan year. Learn more about these ratings. [Link to appropriate explanatory/Help text on HealthCare.gov.]*

10. Marketing Guidelines for QHP Quality Rating Information

QHP issuers may reference the 2024 QRS quality ratings and QHP Enrollee Survey results for their QHPs in marketing materials in a manner specified by CMS.[54] Any QHP issuer that elects to include its 2024 QHP quality rating information — specifically, its QRS scores and ratings and QHP Enrollee Survey results — in its marketing materials (whether paper, electronic, or other media) must do so in accordance with the CMS instructions below.[55]

The 2024 marketing guidelines are generally based on CMS guidance related to marketing QHPs as communicated in the annual *Letter to Issuers in the Federally-facilitated Exchanges*.[56] 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 detail the manner in which QRS and QHP Enrollee Survey information must be communicated in marketing materials:

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[52] SBEs that customize the display of their QHP quality rating information should not display this disclaimer on their SBE website or static website that displays QHP quality information.
[53] See the HHS Notice of Benefit and Payment Parameters for 2021; Final Rule, 85 FR 29164 at 29214 – 29216 (May 14, 2020).
[54] 45 C.F.R. §§ 156.1120(c) and 156.1125(c).
[55] The scope of the definition for "marketing" extends beyond the public's general concept of advertising materials. CMS interprets the definition of marketing materials, as referenced here, as equivalent to the definitions for the Medicare Advantage program in 42 C.F.R. § 422.2260.
[56] See Chapter 5 in the *Final 2024 Letter to Issuers in the Federally-facilitated Exchanges*, available at https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf; and Chapter 5, Section 5, "Oversight of Marketing Activities," in the Addendum to the *Final 2018 Letter to Issuers in the Federally-facilitated Marketplaces*, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf. See also 45 C.F.R. §§ 156. 225 (Marketing and Benefit Design of QHPs), 155.260 (Privacy and Security), and 156.200(e) (Non-discrimination).

- **Disclaimers:** QHP issuers must include the following disclaimers on marketing materials referencing QRS or QHP Enrollee Survey information. All disclaimers must be clear and conspicuous. Disclaimers are not required on call scripts, banners and banner-like ads, envelopes, outdoor advertising (e.g., billboards), text messages, and social media.
  - If marketing materials reference only QRS information, QHP issuers must include the following disclaimer on all materials:
    - *CMS scores qualified health plans (QHPs) offered through the Exchanges using the Quality Rating System (QRS) based on third-party validated clinical measure data and QHP Enrollee Survey responses. CMS calculates ratings yearly on a 5-star scale. Ratings may change from year to year.*
  - If marketing materials reference only QHP Enrollee Survey information, QHP issuers must include the following disclaimer on all materials:
    - *CMS evaluates qualified health plans (QHPs) offered through the Exchanges using QHP Enrollee Survey responses. QHP issuers work with HHS-approved survey vendors that independently conduct the survey each year. QHP Enrollee Survey results may change from year to year.*
  - If marketing materials reference QRS and QHP Enrollee Survey information, QHP issuers must include the following disclaimer on all materials:
    - *CMS scores qualified health plans (QHPs) offered through the Exchanges using the Quality Rating System (QRS) based on third-party validated clinical measure data and QHP Enrollee Survey responses. CMS calculates QRS ratings yearly on a 5-star scale. QHP issuers work with HHS-approved survey vendors that independently conduct the survey each year. QRS ratings and QHP Enrollee Survey results may change from year to year.*
- **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 applicable to the plan year. QHP issuers must use the quality ratings applicable to the plan year, and QHP issuers must discontinue marketing based on the previous year's information. CMS anticipates issuing the final QRS ratings to QHP issuers and Exchange administrators annually, prior to the start of the individual market OEP. QHP issuers may use the final quality ratings that are published via the Quality Public Use File (PUF) and Nationwide QRS PUF, applicable to the plan year, which will become available on the Marketplace Quality Initiatives (MQI) website in October 2024.[57, 58]
- **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

[57] Available at https://www.cms.gov/medicare/quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo.

[58] QHP issuers participating in the FFE and SBE-FPs that are also DE entities will also have access to quality rating information through the Marketplace Application Program Interface (API).

Survey results are calculated for each product type (i.e., EPO, HMO, POS, and 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 the QRS summary indicator component.
    - If QHP issuers choose to advertise the QRS global rating, it must be labeled "Overall Rating" consistent with HealthCare.gov consumer-facing language. If QHP issuers choose to advertise ratings for the three summary indicators, they must be labeled "Member Experience," "Medical Care," and "Plan Administration," consistent with HealthCare.gov consumer-facing language.
    - QHP issuers required to adhere to requirements for providing information in languages other than English must use translated content consistent with HealthCare.gov. If QHP issuers choose to advertise ratings for any QRS summary indicator component, the QHP issuer may use only the component titles assigned by CMS without variation (e.g., "Member Experience"). Additionally, if the QHP issuer references a QRS summary indicator rating, they must also include the QRS global 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 a QRS summary indicator component to imply a higher global rating than was actually received. For example, a QHP issuer may not promote a QHP that received a global rating of three stars and a summary indicator rating of five stars as a "5-star plan."
- QHP issuers may not use superlatives (e.g., "highest ranked," "one of the best") without additional context. For example, a QHP that received a 5-star rating for a specific QRS component, but received a 3-star global rating, may not be promoted as the highest ranked QHP in the state when other QHPs have a higher global rating.
- QHP issuers may not claim that any of their product types or QHPs are recommended or endorsed by the federal government, HHS, CMS, CCIIO, or the Exchanges. This includes, but is not limited to, use of the Department's name or logo; any HHS Agency's name and marks; or the Exchanges' names, logos, and marks in a manner that would convey the false impression that any product type is recommended or endorsed by the federal government, HHS or its Agencies, or the Exchanges.

- **Compliance with state law and regulations:** QHP issuers must comply with all applicable state laws and regulations on health plan marketing, and must not employ marketing practices that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.[59]

Pursuant to 45 C.F.R. § 156.340(a)(1), a QHP issuer participating in an FFE or an SBE-FP maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, including affiliated agents and brokers, with the QRS and QHP Enrollee Survey marketing standards.[60]

States generally regulate health plan marketing practices and materials and related documents under state law. CMS does not intend to review QHP marketing materials for compliance with state standards as described at 45 C.F.R. § 156.225(a).[61] In the FFE, CMS may review QHP marketing materials for compliance with applicable federal regulations.[62] CMS will work with states to determine where additional monitoring and review of marketing activities may be needed.

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

[59] See 45 C.F.R. § 156.225.
[60] This includes, but is not limited to, compliance by delegated and downstream entities with the marketing standards at 45 C.F.R. §§ 156.225, 156.1120(c), and 156.1125(c).
[61] See supra note 50.
[62] See, for example, 45 C.F.R. §§ 156.200(e), 156.225(b), 156.1120(c), and 156.1125(c).

Appendix A. Relevant Statutory and Regulatory Citations

Exhibit 16 through Exhibit 20 include excerpts from the Patient Protection and Affordable Care Act and supporting regulations that are relevant to QRS and the QHP Enrollee Survey (referred to in the statute as the enrollee satisfaction survey system). The exhibits in this appendix are intended for reference only, and do not comprise an exhaustive list of QHP issuer and/or Exchange requirements.

Exhibit 16. Patient Protection and Affordable Care Act, 42 U.S.C. Sec. 18031 (March 23, 2010)

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

Exhibit 17. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, 77 Fed. Reg. 18310-18475 (March 27, 2012)

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

Exhibit 18. 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 apply for each year that approval is sought. (b) *Standards.* To be approved by HHS, an enrollee satisfaction survey vendor must meet each of the following standards: (1) Sign and submit an application form for approval in accordance with paragraph (a) of this section; (2) Ensure, on an annual basis, that appropriate staff participate in enrollee satisfaction survey vendor training and successfully complete a post-training certification exercise as established by HHS; (3) Ensure the accuracy of their data collection, calculation and submission processes and attest to HHS the veracity of the data and these processes; (4) Sign and execute a standard HHS data use agreement, in a form and manner to be determined by HHS, that establishes protocols related to the disclosure, use and reuse of HHS data; (5) Adhere to the enrollee satisfaction survey protocols and technical specifications in a manner and form required by HHS; (6) Develop and submit to HHS a quality assurance plan and any supporting documentation as determined to be relevant by HHS. The plan must describe in adequate detail the implementation of and compliance with all required protocols and technical specifications described in paragraph (b)(5) of this section;	45 C.F.R. § 156.1105(a)-(c) Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges

Topic	Provisions	Citation
	(7) Adhere to privacy and security standards established and implemented under § 155.260 of this subchapter by the Exchange with which they are associated; (8) Comply with all applicable state and federal laws; (9) Become a registered user of the enrollee satisfaction survey data warehouse to submit files to HHS on behalf of its authorized QHP contracts; (10) Participate in and cooperate with HHS oversight for quality-related activities, including, but not limited to: review of the enrollee satisfaction survey vendor's quality assurance plan and other supporting documentation; analysis of the vendor's submitted data and sampling procedures; and site visits and conference calls; and, (11) Comply with minimum business criteria as established by HHS. (c) *Approved list.* A list of approved enrollee satisfaction survey vendors will be published on an HHS Web site.	

Exhibit 19. Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final Rule, 79 Fed. Reg. 30240-30353 (May 27, 2014)

Topic	Provisions	Citation
Exchange standards for public display of QRS ratings[63]	The Exchange must prominently display the quality rating information assigned to each QHP on its Web site, in accordance with § 155.205(b)(1)(v), as calculated by HHS and in a form and manner specified by HHS.	45 C.F.R. § 155.1400 Quality rating system
Exchange standards for public display of QHP Enrollee Survey information[64]	The Exchange must prominently display results from the Enrollee Satisfaction Survey for each QHP on its Web site, in accordance with § 155.205(b)(1)(iv), as calculated by HHS and in a form and manner specified by HHS.	45 C.F.R. § 155.1405 Enrollee satisfaction survey system
QHP certification standards: public reporting of QHP quality rating information[65]	(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. (b) *QHP issuer requirement.* A QHP issuer must— (5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Patient Protection and Affordable Care Act consistent with the standards of section 1311(g) of the Patient Protection and Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Patient Protection and Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Patient Protection and Affordable Care Act; (h) As a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements described in subparts D, E, H, K, L, and M of this part.	45 C.F.R. § 156.200(a),(b)(5),(h) QHP issuer participation standards

[63] See Exhibit 20 for details on amendments to this regulation to capture flexibility for certain States Exchanges to customize the display of quality rating information on their websites within certain parameters.
[64] Ibid.
[65] The QHP participation standards at 45 C.F.R. § 156.200 were first codified as part of the "Establishment of Exchange and QHP Standards; Exchange Standards for Employers" Final Rule (March 27, 2012). This citation is included here because of the technical amendments that were made as part of the "Exchange and Insurance Market Standards for the 2015 and Beyond" Final Rule (May 27, 2014) to cross-reference the QRS statutory provisions and correctly align it with the other quality standards originally listed in the regulation as part of the QHP certification standards.

Topic	Provisions	Citation
Monitoring of QHP Enrollee Survey vendors and vendor appeals	(d) *Monitoring.* HHS will periodically monitor HHS-approved enrollee satisfaction survey vendors to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS determines that an HHS-approved enrollee satisfaction survey vendor is non-compliant with the standards required in paragraph (b) of this section, the survey vendor may be removed from the approved list described in paragraph (c) of this section and/or the submitted survey results may be ineligible to be included for ESS results. (e) *Appeals.* An enrollee satisfaction survey vendor that is not approved by HHS after submitting the application described in paragraph (a) of this section may appeal HHS's decision by notifying HHS in writing within 15 days from receipt of the notification of not being approved and submitting additional documentation demonstrating how the vendor meets the standards in paragraph (b) of this section. HHS will review the submitted documentation and make a final approval determination within 30 days from receipt of the additional documentation.	45 C.F.R. § 156.1105(d),(e) Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges
Standards for QRS data submission, data validation, implementation timeline, and marketing of QRS ratings; Multi-State Plan requirements	(a) *Data submission requirement.* (1) A QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP that has been offered in an Exchange for at least one year. (2) In order to ensure the integrity of the data required to calculate the QRS, a QHP issuer must submit data that has been validated in a form and manner specified by HHS. (3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS. (b) *Timeline.* A QHP issuer must annually submit data necessary to calculate the QHP's quality ratings to HHS and Exchanges, on a timeline and in a standardized form and manner specified by HHS. (c) *Marketing requirement.* A QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS. (d) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (a) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.	45 C.F.R. § 156.1120 (a)–(d) Quality rating system
Standards for administering the QHP Enrollee Survey and marketing survey results; Multi-State Plan requirements	(a) *General requirement.* A QHP issuer must contract with an HHS-approved enrollee satisfaction survey (ESS) vendor, as identified by § 156.1105, in order to administer the Enrollee Satisfaction Survey of the QHP's enrollees. A QHP issuer must authorize its contracted ESS vendor to report survey results to HHS and the Exchange on the issuer's behalf. (b) *Data requirement.* (1) A QHP issuer must collect data for each QHP, with more than 500 enrollees in the previous year that has been offered in an Exchange for at least one year and following a survey sampling methodology provided by HHS. (2) In order to ensure the integrity of the data required to conduct the survey, a QHP issuer must submit data that has been validated in a form and manner specified by HHS, and submit this data to its contracted ESS vendor.	45 C.F.R. § 156.1125 (a)–(e) Enrollee satisfaction survey system

Topic	Provisions	Citation
	(3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS. (c) *Marketing requirement.* A QHP issuer may reference the survey results for its QHPs in its marketing materials, in a manner specified by HHS. (d) *Timeline.* A QHP issuer must annually submit data necessary to conduct the survey to its contracted ESS vendor on a timeline and in a standardized form and manner specified by HHS. (e) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (b) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.	

Exhibit 20. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans (May 14, 2020)[66]

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

[66] This rulemaking amended §§ 155.1400 and 155.1405 to codify the flexibility for State Exchanges that operate their own eligibility and enrollment platforms to customize the display of quality rating information on their websites to display the quality rating information as calculated by HHS or to display quality rating information based upon certain state-specific customizations of the quality rating information provided by HHS.

Appendix B. QRS Measure Summaries

Exhibit 21 includes measure summaries for the final 2024 QRS measure set, organized alphabetically. Measures denoted with an asterisk (*) use a look-back period (i.e., contain multiple years of data).

For detailed QRS clinical measure specifications, refer to the *2024 Quality Rating System Measure Technical Specifications* at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), please see Appendix C.

Exhibit 21. QRS Measure Summaries

Measure Name:	**Access to Care**
Measure Steward:	Agency for Healthcare Research and Quality (AHRQ)
CBE Endorsement ID:	0006[67]
Description:	Enrollee experience related to the following: • Got care as soon as needed • Got non-urgent appointment as soon as needed • How often it was easy to get necessary care, tests, or treatment • Got appointment with specialists as soon as needed
Reporting Method(s):	QHP Enrollee Survey

Measure Name:	**Access to Information**
Measure Steward:	AHRQ
CBE Endorsement ID:	0007 (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
Reporting Method(s):	QHP Enrollee Survey

[67] The QRS *Access to Care* measure includes two separate CBE-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:	Adult Immunization Status
Measure Steward:	NCQA
CBE Endorsement ID:	3620
Description:	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Reporting Method(s):	ECDS

Measure Name:	Annual Monitoring for Persons on Long-term Opioid Therapy
Measure Steward:	PQA
CBE Endorsement ID:	3541
Description:	The percentage of individuals 18 years and older who are prescribed long-term opioid therapy and have not received a drug test at least once during the measurement year.
Reporting Method(s):	Administrative

Measure Name:	Antidepressant Medication Management*
Measure Steward:	NCQA
CBE Endorsement ID:	0105
Description:	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 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).
Reporting Method(s):	Administrative

Measure Name:	Appropriate Treatment for Upper Respiratory Infection*
Measure Steward:	NCQA
CBE Endorsement ID:	0069
Description:	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.
Reporting Method(s):	Administrative

Measure Name:	Asthma Medication Ratio
Measure Steward:	NCQA
CBE Endorsement ID:	1800
Description:	The percentage of members 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Reporting Method(s):	Administrative

Measure Name:	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*
Measure Steward:	NCQA
CBE Endorsement ID:	0058
Description:	The percentage of episodes for members 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.
Reporting Method(s):	Administrative

Measure Name:	Breast Cancer Screening*
Measure Steward:	NCQA
CBE Endorsement ID:	2372
Description:	The percentage of women 50 – 74 years of age who had a mammogram to screen for breast cancer.
Reporting Method(s):	ECDS

Measure Name:	Care Coordination
Measure Steward:	AHRQ
CBE Endorsement ID:	0006
Description:	Enrollee experience related to the following: • Doctor had medical records • Doctor followed up about blood test, x-ray results • Got blood test, x-ray results as soon as needed • Doctor talked about prescription drugs • Got help you needed from doctor's office to manage care among different providers • Doctor seemed informed and up to date about care from other health providers
Reporting Method(s):	QHP Enrollee Survey

Measure Name:	Cervical Cancer Screening*
Measure Steward:	NCQA
CBE Endorsement ID:	0032
Description:	The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
Reporting Method(s):	Administrative and Hybrid *Optional:* ECDS

Measure Name:	Child and Adolescent Well-Care Visits
Measure Steward:	NCQA
CBE Endorsement ID:	N/A (Not Endorsed)
Description:	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a Primary Care Physician (PCP) or an Obstetrician/Gynecologist (OB/GYN) practitioner during the measurement year.
Reporting Method(s):	Administrative

Measure Name:	Childhood Immunization Status (Combination 10)*
Measure Steward:	NCQA
CBE 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 haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and one separate combination rate.
Reporting Method(s):	Administrative and Hybrid *Optional:* ECDS

Measure Name:	Chlamydia Screening in Women
Measure Steward:	NCQA
CBE 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.
Reporting Method(s):	Administrative

Measure Name:	**Colorectal Cancer Screening***
Measure Steward:	NCQA
CBE Endorsement ID:	0034
Description:	The percentage of patients 45–75 years of age who had appropriate screening for colorectal cancer.
Reporting Method(s):	Administrative and Hybrid *Optional:* ECDS

Measure Name:	**Controlling High Blood Pressure***
Measure Steward:	NCQA
CBE Endorsement ID:	0018
Description:	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Reporting Method(s):	Administrative and Hybrid

Measure Name:	**Eye Exam for Patients with Diabetes***
Measure Steward:	NCQA
CBE Endorsement ID:	0055
Description:	The percentage of members 18-75 years of age with diabetes (types 1 and 2) during the measurement year or the year prior to the measurement year who had a retinal eye exam.
Reporting Method(s):	Administrative and Hybrid

Measure Name:	**Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-Up)**
Measure Steward:	NCQA
CBE 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 or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge. • The percentage of discharges for which the member received follow-up within 7 days after discharge.
Reporting Method(s):	Administrative

Measure Name:	**Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%)***
Measure Steward:	NCQA
CBE Endorsement ID:	0059
Description:	The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) level was at the HbA1c Poor Control (>9.0%) level during the measurement year or the year prior to the measurement year.
Reporting Method(s):	Administrative and Hybrid

Measure Name:	**Immunizations for Adolescents (Combination 2)***
Measure Steward:	NCQA
CBE Endorsement ID:	1407
Description:	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.
Reporting Method(s):	Administrative and Hybrid *Optional:* ECDS

Measure Name:	**Initiation and Engagement of Substance Use Disorder Treatment ***
Measure Steward:	NCQA
CBE Endorsement ID:	0004
Description:	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • *Initiation of SUD Treatment*. The percentage of SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days. • *Engagement of SUD Treatment*. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation visit.
Reporting Method(s):	Administrative

Measure Name:	**International Normalized Ratio Monitoring for Individuals on Warfarin (INR)**
Measure Steward:	PQA
CBE Endorsement ID:	0555
Description:	The percentage of members 18 years of age and older who had at least one 56-day interval of warfarin therapy and who received at least one international normalized ratio (INR) monitoring test during each 56-day interval with active warfarin therapy.
Reporting Method(s):	Administrative

Measure Name:	Kidney Health Evaluation for Patients With Diabetes*
Measure Steward:	NCQA
CBE Endorsement ID:	N/A (Not Endorsed)
Description:	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Reporting Method(s):	Administrative

Measure Name:	Medical Assistance With Smoking and Tobacco Use Cessation*
Measure Steward:	NCQA
CBE Endorsement ID:	0027 (Not Endorsed)
Description:	The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: • *Advising Smokers and Tobacco Users to Quit*: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. • *Discussing Cessation Medications*: A rolling average represents the percentage of members 18 years of age and older who were 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 were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.
Reporting Method(s):	QHP Enrollee Survey

Measure Name:	Oral Evaluation, Dental Services
Measure Steward:	NCQA
CBE Endorsement ID:	2517
Description:	The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.
Reporting Method(s):	Administrative

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)
CBE Endorsement ID:	0006
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
Reporting Method(s):	QHP Enrollee Survey

Measure Name:	**Plan All-Cause Readmissions**
Measure Steward:	NCQA
CBE Endorsement ID:	1768 (Not Endorsed)
Description:	For members 18-64 years of age, the number of acute inpatient and observation 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.
Reporting Method(s):	Administrative

Measure Name:	**Prenatal and Postpartum Care***
Measure Steward:	NCQA
CBE Endorsement ID:	1517 (Not Endorsed)
Description:	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, 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 in the first trimester, on or before the enrollment start date or within 42 days of enrollment within the organization. • *Postpartum Care*. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Reporting Method(s):	Administrative and Hybrid

Measure Name:	Proportion of Days Covered
Measure Steward:	PQA
CBE Endorsement ID:	0541
Description:	The percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year. Report a rate for each of the following: • Renin Angiotensin System Antagonists (PDC-RASA) Diabetes All Class (PDC-DR) Statins (PDC-STA)
Reporting Method(s):	Administrative

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

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

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

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

Measure Name:	Use of Imaging Studies for Low Back Pain*
Measure Steward:	NCQA
CBE Endorsement ID:	0052 (Not Endorsed)
Description:	The percentage of members 18-75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
Reporting Method(s):	Administrative

Measure Name:	Weight Assessment and Counseling for Nutrition and Physical Activity Children and Adolescents
Measure Steward:	NCQA
CBE Endorsement ID:	0024
Description:	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN and who had evidence of the following during the measurement year. • BMI Percentile documentation. • Counseling for Nutrition. • Counseling for Physical Activity.
Reporting Method(s):	Administrative and Hybrid

Measure Name:	Well-Child Visits in the First 30 Months of Life*
Measure Steward:	NCQA
CBE Endorsement ID:	1392
Description:	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • *Well-Child Visits in the First 15 Months.* Children who turned 15 months old during the measurement year: Six or more well-child visits. • *Well-Child Visits for Age 15 Months–30 Months.* Children who turned 30 months old during the measurement year: Two or more well-child visits.
Reporting Method	Administrative

Appendix C. Crosswalk of 2024 QHP Enrollee Survey Questions Included in the QRS

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

Exhibit 22. Crosswalk of 2024 QHP Enrollee Survey Questions Included in the QRS

2023 QRS Survey Measure	2023 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Access to Care	Getting Care Quickly	21	In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed? *Include in-person, telephone, or video appointments.*	CAHPS® Health Plan Survey 5.0
		22	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? Include in-person, telephone or video appointments. *Include in-person, telephone, or video appointments.*	CAHPS® Health Plan Survey 5.0
	Getting Needed Care	24	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? Include in-person, telephone or video appointments. *Include in-person, telephone, or video appointments.*	CAHPS® Health Plan Survey 5.0
		40	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? Include in-person, telephone or video appointments. *Include in-person, telephone, or video appointments.*	CAHPS® Health Plan Survey 5.0
Access to Information	Access to Information[68]	3	In the last 6 months, how often did the written materials or the internet provide the information you needed about how your health plan works?	CAHPS® Health Plan Survey 4.0 —Supplemental Items (HEDIS®)
		4	In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?	CAHPS® Health Plan Survey 4.0 —Supplemental Items (HEDIS®)
		5	In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?	CAHPS® Health Plan Survey 4.0 —Supplemental Items (HEDIS®)
Care Coordination	Care Coordination	32	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? Include in-person, telephone or video appointments.	CAHPS® Health Plan Survey 5.0 —Supplemental Items
		33	In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?	CAHPS® Health Plan Survey 5.0 —Supplemental Items

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

2023 QRS Survey Measure	2023 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Care Coordination (continued)	Care Coordination (continued)	34	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 Survey 5.0 —Supplemental Items
		35	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 Survey 5.0 —Supplemental Items
		38	In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?	CAHPS® Health Plan Survey 5.0 —Supplemental Items
		42	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 Survey 5.0 —Supplemental Items
Plan Administration	Plan Administration	6	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	CAHPS® Health Plan Survey 5.0
		7	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	CAHPS® Health Plan Survey 5.0
	Single Item Measure (Plan Administration)	8	In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected?	Question developed for QHP Enrollee Survey
		9	In the last 6 months, how often were the forms from your health plan easy to fill out?	CAHPS® Health Plan Survey 5.0
		10	In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?	CAHPS® Health Plan Survey 5.0 —Supplemental Items
Rating of all Health Care	Single Item Measure	26	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? Include in-person, telephone or video appointments.	CAHPS® Health Plan Survey 5.0
Rating of Health Plan	Single Item Measure	19	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months?	CAHPS® Health Plan Survey 5.0
Rating of Personal Doctor	Single Item Measure	39	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 Survey 5.0
Rating of Specialist	Single Item Measure	43	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 Survey 5.0

2023 QRS Survey Measure	2023 QHP Enrollee Survey Composite	Question Number	Question Wording	Question Source
Medical Assistance with Smoking and Tobacco Use Cessation	Single Item Measure (Prevention)	47	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	HEDIS® CAHPS® Health Plan Survey 5.1
	Single Item Measure (Prevention)	48	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	HEDIS® CAHPS® Health Plan Survey 5.1
	Single Item Measure (Prevention)	49	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	HEDIS® CAHPS® Health Plan Survey 5.1

Appendix D. 2024 QRS Rating Methodology

STEP 1: CALCULATE MEASURE RATES

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

If a QHP issuer **did not submit a valid** measure rate for the reporting unit, then an invalid code will appear in the Raw Value field for the measure in the QRS Proof Sheet (and a null value [a dash, "-" or zero, "0"] will appear in the Measure Denominator field). A measure rate is considered invalid if the reporting unit received one of the audit designations or if the reporting unit had a measure rate with a denominator of zero. The audit designations are provided in Exhibit 23.

Exhibit 23. Audit Designations

Audit Designation	Meaning
Benefit Not Offered (NB)	The QHP issuer did not offer the health benefit required by the measure.
Biased Rate (BR)	The QHP issuer's calculated rate was materially biased.
Not Reported (NR)	The QHP issuer chose not to report the measure, or the measure rate was otherwise invalid (i.e., there is no valid rate because the denominator is zero).

In the QRS Proof Sheets, a rate would be designated as "NR" if the reporting unit had no data to report for the measure. Invalid measure data are not used in scoring, meaning not used in Step 3 (Calculate Standardized Measure Scores) or beyond. Invalid measure data or for instances where the denominator criteria was not met are assigned an invalid code of **NC (Not Calculated)** in the Standardized score field.

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

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

QRS Clinical Measures

For QRS clinical measures composed of multiple indicators, the following table summarizes various aggregation methods to calculate a measure rate per the measure's technical specifications. See Exhibit 24 for a summary of each method; further detail can be found in the *2024 Quality Rating System Measure Technical Specifications*.

Exhibit 24. Aggregation Methods for QRS Clinical Measures with Multiple Indicators

Measure (M)	Measure Indicator (MI) ¥ indicates below sub-measure indicator[69]	Method for Calculating Measure Rate	Method for Calculating Total Measure Denominator Size	Method for Calculating Total Measure Eligible Population
Antidepressant Medication Management	• Antidepressant Medication Management: Acute • Antidepressant Medication Management: Continuation	Average of MI rates	Average of MI denominators	Average of MI eligible populations
Chlamydia Screening in Women	• Chlamydia Screening (16-20 Years) • Chlamydia Screening (21-24 Years)	$\frac{\sum Numerator}{\sum Denominator}$	Sum of MI denominators	Sum of MI eligible populations
Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-Up)	• Follow-up After Hospitalization for Mental Illness (30-Day Follow-Up) • Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up)	Average of MI rates	Average of MI denominators	Average of MI eligible populations
Initiation and Engagement of Substance Use Disorder (SUD) Treatment	• Initiation of Alcohol and Other Drug Dependence Treatment (Total) – Initiation (13-17) ¥[70]Alcohol Abuse or Dependence Opioid Abuse or Dependence Other Drug Abuse or Dependence – Initiation (18+) ¥Alcohol Abuse or Dependence Opioid Abuse or Dependence Other Drug Abuse or Dependence • Engagement of Alcohol and Other Drug Dependence Treatment (Total) – Engagement (13-17) ¥Alcohol Abuse or Dependence Opioid Abuse or Dependence Other Drug Abuse or Dependence – Engagement (18+) ¥Alcohol Abuse or Dependence Opioid Abuse or Dependence Other Drug Abuse or Dependence	Three Steps: 1. Sub-MI = Count of unique enrollees per age band across treatments (b-sub-MIs) 2. $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 3. Average of MI rates	Three Steps: 1. Sub-MI = Count of unique enrollees per age band across treatments (b-sub-MIs) 2. $\sum Denominator_{sub}$ 3. Average of MI denominators	Three Steps: 1. Sub-MI = Count of unique enrollees per age band across treatments (b-sub-MIs) 2. $\sum Elig_{sub-MI}$ 3. Average of MI eligible populations

[69] Below sub-measure indicators (b-sub-MI) are rates for a single age-band across several assessment areas; they are aggregated together to calculate the sub-MI rate estimate for a single assessment area.
[70] Sub-measure indicators (sub-MIs) are combined via an average (sum of numerators divided by sum of denominators) to create the rate for a measure indicator (MI).

Measure (M)	Measure Indicator (MI) ¥ indicates below sub-measure indicator[69]	Method for Calculating Measure Rate	Method for Calculating Total Measure Denominator Size	Method for Calculating Total Measure Eligible Population
Kidney Health Evaluation for Patients With Diabetes (KED)	• Kidney Health Evaluation for Patients with Diabetes: 18-64 years • Kidney Health Evaluation for Patients with Diabetes: 65-74 years • Kidney Health Evaluation for Patients with Diabetes: 75-85 years	$\frac{\sum Numerator}{\sum Denominator}$	Sum of MI denominators	Sum of MI eligible populations
Medical Assistance with Smoking and Tobacco Use Cessation[71]	• How Often Advised to Quit Smoking or Using Tobacco – How Often Advised to Quit Smoking or Using Tobacco (Current Year) ¥ – How Often Advised to Quit Smoking or Using Tobacco (Previous Year) ¥ • How Often Medication Recommended or Discussed – How Often Medication Recommended or Discussed (Current Year) ¥ – How Often Medication Recommended or Discussed (Previous Year) ¥ • How Often Provided Strategies to Quit – How Often Provided Strategies to Quit (Current Year) ¥ • How Often Provided Strategies to Quit (Previous Year) ¥	Two Steps: 1. $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 2. Average of MI rates	Two Steps: 1. $\sum Denominator_{sub-MI}$ 2. Average of MI denominators	Two Steps: 1. $\sum Elig_{sub-MI}$ 2. Average of MI eligible populations

[71] Per the measure technical specifications, the *Medical Assistance with Smoking and Tobacco Use Cessation* (Tobacco) measure is calculated as a rolling average based on sub-MI data. CMS uses the data reported in the prior ratings year and the current ratings year to calculate a two-year rolling average. CMS merges information for a given reporting unit from the two ratings years to calculate the measure rate for the current ratings year (e.g., CY 2023 and CY 2024 data will be used to generate CY 2024 rates). The Tobacco sub-MIs are reported in the QRS Proof Sheets as M25a1-M25c1 and M25a2-M25c2, respectively. For reporting units that were ineligible to receive a QRS rating in the prior year (i.e., not scoring eligible), CMS still uses the reported rates from the prior year calculate the Tobacco measure rate. For example, if a reporting unit is newly eligible to receive a QRS rating in 2024, CMS will use the reporting unit's reported data for 2023 and 2024 to calculate the Tobacco measure rate.

Measure (M)	Measure Indicator (MI) ¥ indicates below sub-measure indicator[69]	Method for Calculating Measure Rate	Method for Calculating Total Measure Denominator Size	Method for Calculating Total Measure Eligible Population
Oral Evaluation, Dental Services (OED)	• Oral Evaluation, Dental Services: 0-2 years • Oral Evaluation, Dental Services: 3-5 years • Oral Evaluation, Dental Services: 6-14 years • Oral Evaluation, Dental Services: 15-20 years	$\frac{\sum Numerator}{\sum Denominator}$	Sum of MI denominators	Sum of MI eligible populations
Plan All-Cause Readmissions	• Observed Readmission (Numerator/Denominator) Total • Average Adjusted Probability Total	Observed Readmission divided by Average Adjusted Probability	Sum of MI denominators	N/A: PCR does not have an eligible population
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	• Body Mass Index (BMI) Percentile Documentation – BMI Percentile – 3-11 Years ¥ – BMI Percentile – 12-17 Years ¥ • Counseling for Nutrition – Counseling for nutrition – 3-11 Years ¥ – Counseling for nutrition – 12-17 Years ¥ • Counseling for Physical Activity – Counseling for Physical Activity – 3-11 Years ¥ • Counseling for Physical Activity – 12-17 Years ¥	Two Steps: 1. $\frac{\sum Numerator_{sub-MI}}{\sum Denominator_{sub-MI}}$ 2. Average of MI rates	Two Steps: 1. $\sum Denominator_{sub-MI}$ 2. Average of MI denominators	Two Steps: 1. $\sum Elig_{sub-MI}$ 2. Average of MI eligible populations
Well-Child Visits in the First 30 Months of Life	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months – 30 Months	$\frac{\sum Numerator}{\sum Denominator}$	Sum of MI denominators	Sum of MI eligible populations

QRS Survey Measures

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

QRS survey measures are grouped into two categories:

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

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

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

CAHPS®-based QRS Survey Measures

CMS calculates CAHPS®-based QRS survey measures with an approach similar to the one CMS uses in the Medicare Advantage-Prescription Drug Program (MA-PDP) quality measurement initiative for data collected through the MA-PDP CAHPS® survey.[72]

CMS calculates QRS survey measures rates from the QHP Enrollee Survey using the CAHPS® Analysis Program Version 5.0 ("CAHPS® macro"), which was developed by the CAHPS® Consortium under the auspices of the Agency for Healthcare Research and Quality (AHRQ) and is commonly used for scoring CAHPS-related applications. A comprehensive description of the calculations performed by the CAHPS® Macro can be found in the *Instructions for Analyzing Data from CAHPS Surveys (Document No. 20-M019)* which is included in the CAHPS Survey and Reporting Kit. These materials are available at: https://www.ahrq.gov/cahps/surveys-guidance/helpful-resources/analysis/index.html.

To adjust for any systematic biases with the enrollee response data, CMS applies a case-mix adjustment to the QHP Enrollee Survey response data and uses the adjusted data when calculating the QRS survey measures. It is common in survey-based applications to case-mix adjust for such factors as overall health status, age, and education to account for biases due to survey response tendencies. The QHP Enrollee Survey variables used in the case-mix adjustment include the following: general health rating, mental health rating, chronic conditions/ medications, age, education, survey language, help with the survey, and survey mode. The final variables to be included in the case-mix adjustment will be determined based on additional analysis of the 2024 QHP Enrollee Survey data.

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

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

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

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

Rating of Health Plan

Question 19 in the 2024 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

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

use to rate your health plan in the last 6 months?" Use the following steps to calculate the QRS measure rate for Rating of Health Plan:

1. Calculate the weighted, case-mix adjusted mean for question 19.
2. Transform to a 0 – 100 scale as follows: score = [(x – a)/(b – a)]*100, where x = the weighted, case-mix adjusted mean from step 1; a = minimum possible value of x; and b = maximum possible value of x. This is the QRS measure rate for Rating of Health Plan.
   - **Note:** This rescaling allows the presentation of different measures on a common metric; the transformation to a 0 – 100 scale applies to all QRS survey measures that are CAHPS®-based.

Rating of All Health Care

Question 26 in the 2024 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? Include in-person, telephone, or video appointments." To calculate the QRS measure rate for *Rating of All Health Care* measure, use the same steps that were used to calculate the rate for Rating of Health Plan.

Rating of Personal Doctor

Question 39 in the 2024 QHP Enrollee Survey asks, "Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?" To calculate the QRS measure rate for *Rating of Personal Doctor*, use the same steps that were used to calculate the rate for Rating of Health Plan.

Rating of Specialist

Question 43 in the 2024 QHP Enrollee Survey asks, "We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?" To calculate the QRS measure rate for *Rating of Specialist*, use the same steps that were used to calculate the score for Rating of Health Plan.

Access to Care

The QRS *Access to Care* measure is made up of four questions, all of which are coded on a 1 – 4 scale in the 2024 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS measure rate for Access to Care:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Access to Care measure:
   - Question 21: In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed? Include in-person, telephone, or video appointments.
   - Question 22: 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? Include in-person, telephone, or video appointments.

- Question 24: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? Include in-person, telephone, or video appointments.
- Question 40: In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? Include in-person, telephone, or video appointments.

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

Care Coordination

The QRS *Care Coordination* measure is made up of six questions, all of which are coded on a 1 – 4 scale in the 2024 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS measure rate for the *Care Coordination* measure:

1. Questions 33 and 34 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 21 and 22 using equal weighting of the two questions. Use this average in Step 3.
2. Calculate the weighted, case-mix adjusted mean separately for each question included in the *Care Coordination* measure:
   - Question 32: 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? Include in-person, telephone, or video appointments.
   - Question 33: In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
   - Question 34: 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 35: In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
   - Question 38: In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?
   - Question 42: In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
3. Calculate the average of the weighted, case-mix adjusted means across the five survey questions (i.e., Questions 32, 35, 38, and 42, and the average of Questions 33 and 34 from Step 2); use equal weighting of the questions.
4. Transform the average from Step 3 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the QRS measure rate for *Care Coordination*.

Access to Information

The QRS *Access to Information* measure is made up of three questions, all of which are coded on a 1 – 4 scale in the 2024 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS measure rate for Access to Information:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the *Access to Information* measure:
   - Question 3: In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?
   - Question 4: In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?
   - Question 5: In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?
2. Calculate the average of the weighted, case-mix adjusted means across the three survey questions; use equal weighing of the questions.
3. Transform the average from Step 2 to a 0 – 100 scale (use the same formula as described in Step 2 for Rating of Health Plan). This is the QRS measure rate for *Access to Information*.

Plan Administration

The QRS Plan Administration measure is made up of five questions, all of which are coded on a 1 – 4 scale in the 2024 QHP Enrollee Survey (i.e., 1 = Never, 2 = Sometimes, 3 = Usually, and 4 = Always). Use the following steps to calculate the QRS score for the Plan Administration measure:

1. Calculate the weighted, case-mix adjusted mean separately for each item included in the Plan Administration measure:
   - Question 6: In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
   - Question 7: In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
   - Question 8: In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected?
     - **Note:** To make the direction of coding of Question 8 consistent with the other questions, Question 8 needs to be recoded so higher values represent a more positive response, as follows:

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

- Question 9: In the last 6 months, how often were the forms from your health plan easy to fill out?
- Question 10: In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?

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

QRS Clinical Measures Captured in QHP Enrollee Survey

The following QRS survey measure is clinical in nature:

- Medical Assistance with Smoking and Tobacco Use Cessation

Scoring specifications for the clinical measure collected through the 2024 QHP Enrollee Survey follow the HEDIS® specifications as defined by NCQA. CMS applies the QRS clinical measure denominator criterion of 30 to the clinical measure captured in the QHP Enrollee survey. The scoring procedures are described below. The specifications are also presented in the *2024 Quality Rating System Measure Technical Specifications*.

Medical Assistance with Smoking and Tobacco Use Cessation

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

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

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

   Advising Smokers and Tobacco Users to Quit (advised_quit_tob):

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

   Discussing Cessation Medications (recommend_tob_med):

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

   Discussing Cessation Strategies (discuss_tob_non_meds):

   - Include:
     - Current smokers or tobacco user (i.e., respondents coded as 1 or 2 on use_tobacco).

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

2. Calculate the unadjusted proportion of respondents who indicated on each item included in the measure that they received some level of advice/discussion (i.e., proportion on each item with codes of sometimes, usually, or always).

   Note: The proportion is not weighted and not case-mix adjusted. These are the indicators used in the calculation of the QRS survey measure rate for Medical Assistance with Smoking and Tobacco Use Cessation:

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

STEP 2: DETERMINE SCORING STATUS AND APPLICATION OF DENOMINATOR CRITERIA

For each reporting unit, CMS assesses whether measure data can be included in QRS scoring based on the reporting unit's ratings eligibility status, and each measure's denominator size. A reporting unit is considered ratings-eligible if it has operated in an Exchange for three consecutive years and meets the minimum enrollment criteria (i.e., more than 500 enrollees as of July 1 of the prior year [i.e., 2023] and the ratings year [i.e., 2024]).

Reporting units that do not meet the ratings eligibility criteria are removed from scoring and will receive an invalid code. Similarly, while QHP issuers submit measure data to CMS regardless of denominator size, measures that do not meet the minimum denominator criteria for scoring (see Exhibit 25) are excluded from QRS scoring.

Exhibit 25. Minimum Denominator Size Required for Inclusion in QRS Scoring

Measure	Minimum Denominator Criteria for Inclusion in QRS Scoring
QRS Clinical Measure	30
PCR Measure	150
QRS Clinical Measures Captured in QHP Enrollee Survey	30
QRS CAHPS®-based Survey Measure	100

The minimum denominator size of 100 applies to all QRS CAHPS®-based survey measures, regardless of the number of survey questions associated with the measure. The minimum denominator size of 30 applies to all QRS clinical measures (including the clinical measure captured in the 2024 QHP Enrollee Survey), with the exception of the PCR measure.

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

QRS Clinical Measures

For QRS clinical measures, CMS determines if the minimum denominator size is met based on the measure's total denominator size. Different measures have different aggregation methods, as shown in Exhibit 26.

As shown in the illustrative example in Exhibit 26, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure has three indicators. For this example reporting unit, the measure's denominator size of 995 (average of the three measure indication denominators) meets the minimum denominator size criteria of 30. Therefore, CMS will use this measure data in QRS scoring (i.e., proceed to use this measure data in the standardization procedures described in Step 3).

Exhibit 26. Example Denominator Size for QRS Clinical Measure Indicators

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

CAHPS®-based QRS Survey Measures

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

Exhibit 27 shows an example (using mock data) of denominator size calculation for the CAHPS®-based QRS survey measure *Access to Care*. *Access to Care* is composed of four questions. As shown, there can be valid denominator observations for each of the four questions that are *lower* than 100 and yet the measure denominator size can still be *greater* than 100. Enrollees are not required to respond to all survey questions to be included in a given measure's denominator or rate. The total measure denominator size (161), meaning that 161 unique respondents answered across the four questions needed to calculate *Access to Care*, is greater than the minimum denominator size needed for QRS scoring (100). Therefore, CMS calculates the average of the case-mix adjusted mean across the four survey questions to obtain the Access to Care measure score.

Exhibit 27. Example of Total Denominator Size Calculation for CAHPS®-Based QRS Survey Measure

QRS Component	Name	Question Details	Denominator Size
Indicator	CAHPS® Getting Care Quickly: Non-Urgent Care	Question 22: 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? Include in-person, telephone or video appointments.	136
Indicator	CAHPS® Getting Care Quickly: Urgent Care	Question 21: In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed? Include in-person, telephone, or video appointments.	77
Indicator	CAHPS® Getting Needed Care: Easy Care, Tests, or Treatment	Question 24: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? Include in-person, telephone or video appointments.	146

QRS Component	Name	Question Details	Denominator Size
Indicator	CAHPS® Getting Needed Care: Easy to See Specialist	Question 40: In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? Include in-person, telephone or video appointments.	90
Measure	***Access to Care***		**161**

STEP 3: APPLY THE BENCHMARK RATIO APPROACH TO CALCULATE BENCHMARKS AND MEASURE SCORES

CMS calculates measure scores using the Benchmark Ratio approach. The Benchmark Ratio approach consists of two distinct parts: 1) the calculation of the measure-specific performance targets (i.e., measure benchmarks) and 2) the calculation of the measure scores using the measure benchmark.

CMS calculates measure benchmarks annually using measure data collected in a single ratings year. A benchmark is calculated for each measure using the data for all reporting units eligible to receive a score for the given measure (i.e., reporting units are excluded from the benchmark calculation if they are not ratings eligible or do not meet the minimum denominator criteria).

Given differences in the structure of measures, CMS uses different benchmark calculations for certain measure types. The steps for calculating each measure-specific benchmark (i.e., QRS clinical measures, PCR measure, and QRS CAHPS-based survey measures) are below.

Clinical Measures (Excluding PCR) Benchmark Calculation

The process to create a clinical measure-specific benchmark is as follows:

A. Rank all reporting units from highest to lowest performance based on the reported measure rate.

B. Sum the eligible population across reporting units to calculate the total number of eligible enrollees; calculate 10% of the total number of enrollees.[73]

C. Select the subset of the highest performing scoring eligible reporting units until ≥10% of total number of enrollees is captured in the subset.[74]

D. Sum the number of enrollees associated with the reporting units selected in Step C by combining the numerators for the measures (i.e., calculate the numerator).

   1. For measure data captured using the hybrid method, the reported rate is extrapolated to the eligible population, creating an estimated numerator relative to the eligible population, instead of the selected sample of cases.

[73] The eligible population for the *Medical Assistance with Smoking and Tobacco Use Cessation* measure is defined as current smokers or tobacco users (i.e., respondents coded as 1 or 2 on the *use_tobacco* field) aggregated from prior year and current submission eligible data.

[74] In the case of tied reporting units based on reported, valid, and top performing measure rates, all tied reporting unit data will be included in the benchmark.

E. Sum the eligible populations associated with the reporting units selected in Step C (i.e., calculate the denominator).

F. Divide the numerator from Step D by the denominator in Step E to generate the measure benchmark.

$$Benchmark_{Measure\ X} = \frac{\sum_{i=1}^{n}(Rate_{X,RU\ i} * Elig_{X,RU\ i})}{\sum_{i=1}^{n} Elig_{X,RU\ i}}$$

$$Where\ n\ =\ the\ highest\ performing,\ scoring-eligible\ reporting\ units\ post-denominator\ criteria\ until\ \geq 10\%\ of\ the\ total\ eligible\ population\ is\ represented$$

PCR Measure Benchmark Calculation

The process to create the PCR measure benchmark is as follows:

A. Rank all reporting units from highest-performing to lowest-performing (i.e., lowest values to highest values) based on the reported PCR measure rate.

B. Calculate the count of Observed Readmissions by multiplying the measure denominator (count of index hospital stays) by the measure indicator for Observed Readmissions rate.

C. Calculate the count of Expected Readmissions by multiplying the measure denominator by the measure indicator for Expected Readmissions rate.

D. Sum the count of index hospital stays (IHS) to identify the total number of IHS across all scoring-eligible RUs satisfying denominator criteria.

E. Calculate 10% of the total number of IHS identified in Step D.

F. Select reporting units starting from highest performing (i.e., lowest reported PCR rate) until ≥10% of total IHS is represented.

G. Sum the count of Observed Readmissions from subset of reporting units selected in Step F.

H. Sum the count of Expected Readmissions from subset of reporting units selected in Step F.

I. Divide count of observed readmissions from Step G (i.e., numerator) by the count of expected readmissions from Step H (i.e., denominator) to determine the benchmark for PCR.

$$Benchmark_{PCR} = \frac{\sum_{i=1}^{n}(Observed\ Readmissions\ Rate_{PCR,RU\ i} * Den_{PCR\ ,RU\ i})}{\sum_{i=1}^{n}(Expected\ Readmissions\ Rate_{PCR,RU\ i} * Den_{PCR\ ,RU\ i})}$$

$$Where\ n\ =\ the\ highest\ performing\ (based\ on\ reported\ PCR),\ scoring-eligible\ reporting\ units\ post-denominator\ criteria\ until\ \geq 10\%\ of\ the\ total\ denominator\ (Count\ of\ Index\ Hospital\ Stays)\ is\ represented$$

Survey Measure Benchmark Calculation

The process to create the CAHPS-based survey measure-specific benchmark is as follows:

A. Rank all reporting units from highest to lowest based on the reported measure rate.

B. Calculate the eligible population across scoring-eligible reporting units meeting the denominator criteria per measure using the sampled enrollees selected to receive the survey as a proxy for eligible population.
   1. Eligible population for survey measures is approximated as the sample of enrollees minus those deemed ineligible via codes X20 and X40.

C. Select the subset of the highest performing scoring eligible reporting units until ≥10 percent of the total sampled enrollee population (defined in Step B) is captured.

D. Calculate the weighted mean of the reported measure rate for the top-performing subset of reporting units selected in Step C, weighted using the eligible population, to generate the measure benchmark.

$$Benchmark_{Measure\ X} = \frac{\sum_{i=1}^{n}(Rate_{X,RU\ i} * Elig_{X,RU\ i})}{\sum_{i=1}^{n} Elig_{X,RU\ i}}$$

$$Where\ n\ =\ the\ highest\ performing,\ scoring-eligible\ reporting\ units\ post-denominator\ criteria\ until\ \geq 10\%\ of\ the\ total\ eligible\ population\ is\ represented$$

After calculation of the benchmarks for each measure, CMS calculates measure scores by independently transforming the raw measure rate using the measure benchmarks. The scores reflect how well a reporting unit did compared to the measure-specific performance target.

To calculate scores for measures other than the PCR and AMO measures, CMS independently divides each reporting unit's reported measure rate by the measure benchmark and multiplies by 100. An example using mock data is shown in Exhibit 28.

Exhibit 28. Example Clinical non-PCR and CAHPS®-Adjusted Survey Measure Score After Benchmark Ratio Approach

Measure Name	Raw Value	Measure Benchmark	Score
Cervical Cancer Screening	0.6213781	0.773	80.385

$$Reporting\ Unit\ Measure\ Score = \frac{Reporting\ unit\ reported\ rate}{Measure\ benchmark} * 100$$

Reporting Unit CCS Measure Score: 0.6213781/0.773 * 100 = 80.385

To calculate the measure score for measures where lower rates indicate better performance (i.e., PCR and AMO), CMS uses a slightly modified calculation than with other clinical and survey measures. The score for the PCR measure is calculated as shown in Exhibit 29.

Exhibit 29. Example PCR Score after Benchmark Ratio Approach

Measure Name	Raw Value	Measure Benchmark	Score
Plan All-Cause Readmissions	0. 7710132	0.545	58.530

$$Reporting\ Unit\ Measure\ Score = 100 + \left(1 - \left(\frac{Reporting\ unit\ reported\ rate}{Measure\ benchmark}\right)\right) * 100$$

Reporting Unit PCR Measure Score: 100 + ((1-0.7710132/0.545) * 100) = 58.530

The score for the AMO measure is calculated as shown in Exhibit 30.

$$Reporting\ Unit\ Measure\ Score = \left(\frac{1 - Reporting\ unit\ reported\ rate}{1 - Measure\ benchmark}\right) * 100$$

Exhibit 30. Example AMO Measure Score after Benchmark Ratio Approach

Measure Name	Raw Value	Measure Benchmark	Score
Annual Monitoring for Persons on Long-term Opioid Therapy	0.4429901	0.391	91.463

Reporting Unit AMO Measure Score: (1-0.4429901)/(1-0.391)*100 = 91.463

Under the Benchmark Ratio approach, a reporting unit receives a measure score of 100 when the reporting unit meets the target benchmark. Therefore, the Benchmark Ratio approach allows for the possibility of measure scores and, by extension, component level scores (e.g., global scores) to surpass 100. To limit the impact of exceedingly high measure score(s) on the aggregated scores, measure rates will be capped at 110. CMS will continue to truncate measure score values under zero by applying a lower cap of zero on measure scores.

STEP 4: CALCULATE SUMMARY INDICATOR SCORES

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

1. **Determine if the summary indicator score can be calculated.** To calculate the summary indicator score, CMS uses the *half-scale rule* to determine if at least half (≥50%) of the associated measures have a valid score. If the summary indicator score cannot be calculated, it will not receive a score (i.e., receives an invalid result of CSR-I).
2. **Calculate the summary indicator score.** If the summary indicator score can be calculated, CMS averages the available measure scores. All valid measure scores within a summary indicator are given equal weight when calculating the summary indicator score. An example using mock data is shown in Exhibit 31.

Exhibit 31. Example Summary Indicator Score Calculation

Name	QRS Component	Score
Access to Care	Measure	59.227
Care Coordination	Measure	34.302
Rating of All Health Care	Measure	Not Calculated (NC)
Rating of Personal Doctor	Measure	Not Calculated (NC)
Rating of Specialist	Measure	44.062
Enrollee Experience	**Summary Indicator**	**45.864 (Average of available measure scores)**

STEP 5: CALCULATE GLOBAL SCORE

CMS first applies explicit weights at the summary indicator level when calculating QRS scores and ratings. CMS assigns a weight of 2/3 (66.67%) to the Clinical Quality Management summary indicator, and a weight of 1/6 (16.67%) to each of the Enrollee Experience and the Plan Efficiency, Affordability, & Management summary indicators.[75] This weighting structure reflects the approximate percentage of measures in each summary indicator. Exhibit 32 includes an example of the application of the explicit weights to the summary indicator scores using mock data.

Exhibit 32. Application of the Explicit Weights to the Summary Indicator Score

Name	Type of QRS Component	Unweighted Score	Weight	Weighted Summary Indicator Score
Clinical Quality Management	Summary Indicator	58.119	* 0.6667	38.747
Enrollee Experience	Summary Indicator	46.765	* 0.16665	7.793
Plan Efficiency, Affordability, & Management	Summary Indicator	57.803	* 0.16665	9.632

1. After the weight values are calculated, the global score itself is calculated using the following steps: **Determine if the global score can be calculated.** CMS calculates the global score for the reporting unit only if the Clinical Quality Management summary indicator has a score and *at least one of the other two summary indicators* has a score. If the global score cannot be calculated due to inability to pass this scoring rule, then the reporting unit receives the following invalid code:
   - **No Global (NG):** Insufficient data to calculate a global rating.
2. **Calculate the global score.** If the global score can be calculated according to the scoring rule described above, CMS sums the available weighted summary indicator scores. An example using mock data is shown in Exhibit 33.

Exhibit 33. Example Global Score Calculation

Name	QRS Component	Example Weighted Summary Indicator Score
Clinical Quality Management	Summary Indicator	38.747
Enrollee Experience	Summary Indicator	7.793
Plan Efficiency, Affordability, & Management	Summary Indicator	9.632
Global	**Global**	**56.172 (Sum of available weighted summary indicator scores)**

CMS then sums the weighted scores to calculate the global score.[76]

[75] Explicit weights are applied on the unrounded summary indicator scores calculated in Step 4 to determine the global score. After calculation of global score, all summary indicator and global component scores are rounded to three decimal places before star ratings are determined in Step 7.

[76] In scenarios where a reporting unit has only two valid summary indicator scores, CMS calculates the summary indicator weights by redistributing the weight assigned to the missing summary indicator, proportionally, based on the predefined explicit weights. The resulting summary indicator weights are approximately 80 percent for the S1 score and approximately 20 percent for the other summary indicator score.

STEP 6: CONVERT SCORES TO RATINGS

Beginning with the 2023 ratings year, CMS converts scores to ratings using the static cut point approach, using 60, 70, 80, and 90 threshold values. This approach maintains more clear and consistent performance goals across years as the cut point threshold values are now fixed. Combined with the Benchmark Ratio approach, the static cut point approach also allows for ratings to better reflect underlying health plan performance.

CMS converts each component score (for summary indicators and global level) into a rating using the pre-determined static cut points that delineate the rating categories of 1, 2, 3, 4, and 5 stars. Scores fall into one of the five categories created by the static cut point values of 60, 70, 80, and 90.

Ratings are assigned on a 5-star scale and only whole stars (1, 2, 3, 4 or 5) are assigned.

Exhibit 34 shows how a global score is converted to a global rating using the static cut points of 60, 70, 80, and 90. A reporting unit that received a global score of 87.522 would receive a 4-star rating as the score lies within the limits of the fourth category (80 ≤ Score < 90).

Exhibit 34. Example Global Rating Calculation with Static Cut Points

Example Cut Points	Rating
0 < Score < 60	1 star (★)
60 ≤ Score < 70	2 stars (★★)
70 ≤ Score < 80	3 stars (★★★)
80 ≤ Score < 90	4 stars (★★★★) **For example, a global score of 87.522 would be assigned a 4-star global rating**
90 ≤ Score	5 stars (★★★★★)

STEP 7: PRODUCE QRS RESULTS FOR PREVIEW AND FINALIZATION

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

Please note that CMS does not publish the ROF. Within the HIOS-MQM, states are only granted access to ratings information for QHP issuers operating within their state, and QHP issuers may only access ratings information for their respective reporting units.

Following preview period and finalization of ratings, CMS will publish the Quality Public Use Files (PUFs) and Nationwide QRS PUFs, applicable to the plan year, on the MQI website in October 2024. PUFs are provided in CSV format.

Appendix E. QRS Hierarchy

The QRS measures are organized into a hierarchical structure that serves as a foundation of the QRS rating methodology (the QRS hierarchy). The measures are grouped into summary indicators to form a single global rating.[77]

Exhibit 35 illustrates the 2024 QRS hierarchy, which is the organization of measures into summary indicators and, ultimately, a single global rating. The survey measures in the QRS measure set are noted with an asterisk (*). The measures collected using the ECDS reporting method are noted with a euro sign (€). Measures not currently endorsed by the CBE are noted as ¥. Measures highlighted in grey are not included in the calculation of 2024 QRS scores and ratings.

Exhibit 35. QRS Hierarchy

QRS Summary Indicator	Measure Title (* indicates survey measure)	Consensus Based Entity (CBE) ID (¥ indicates not currently endorsed)
Clinical Quality Management	Asthma Medication Ratio	1800
	Antidepressant Medication Management	0105
	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30- Day Follow-Up)	0576
	Initiation and Engagement of Substance Use Disorder Treatment	0004
	Controlling High Blood Pressure	0018
	Proportion of Days Covered (RAS Antagonists)	0541
	Proportion of Days Covered (Statins)	0541
	Eye Exam for Patients with Diabetes	0055
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c poor control (>9.0%)	0059
	Kidney Health Evaluation for Patients with Diabetes	N/A¥
	Proportion of Days Covered (Diabetes All Class)	0541
	International Normalized Ratio Monitoring for Individuals on Warfarin	0555
	Annual Monitoring for Persons on Long-term Opioid Therapy	3541
	Plan All-Cause Readmissions	1768¥

[77] In communicating total measure counts, the totals presented here represent the perspective of the scoring methodology, rather than the perspective of the measure steward. If counting based the perspective of the scoring methodology, there are 39 measures that are collected and used in scoring (rather than 36). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care (CBE ID #1517) is split into two distinct measures for the QRS hierarchy: *Timeliness of Prenatal Care* and *Postpartum Care*. Similarly, Proportion of Days Covered (CBE ID #0541) is split into three distinct measures*: Renin Angiotensin System Antagonists (PDC-RASA), Diabetes All Class (PDC-DR),* and *Statins (PDC-STA).*

QRS Summary Indicator	Measure Title (* indicates survey measure)	Consensus Based Entity (CBE) ID (¥ indicates not currently endorsed)
Clinical Quality Management (continued)	Breast Cancer Screening€	2372
	Cervical Cancer Screening	0032
	Colorectal Cancer Screening	0034
	Prenatal and Postpartum Care (Postpartum Care)	1517¥
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517¥
	Chlamydia Screening in Women	0033
	Medical Assistance with Smoking and Tobacco Use Cessation*	0027¥
	Adult Immunization Status€	3620
	Oral Evaluation, Dental Services	2517
	Childhood Immunization Status (Combination 10)	0038
	Immunizations for Adolescents (Combination 2)	1407
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024
	Well-Child Visits in the First 30 Months of Life	1392
	Child and Adolescent Well-Care Visits	N/A
Enrollee Experience	Access to Care*	0006
	Care Coordination*	0006
	Rating of All Health Care*	0006
	Rating of Personal Doctor*	0006
	Rating of Specialist*	0006
Plan Efficiency, Affordability, & Management	Appropriate Treatment for Upper Respiratory Infection	0069
	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	0058
	Use of Imaging Studies for Low Back Pain	0052¥
	Access to Information*	0007¥
	Plan Administration*	0006
	Rating of Health Plan*	0006

Appendix F. Overview of QHP Enrollee Survey Results

Exhibit 36 provides an overview of different resources through which QHP Enrollee Survey results are communicated to QHP issuers.

Exhibit 36. QHP Issuer Resources for Reviewing QHP Enrollee Survey Results

Resource	Description
QHP Enrollee Survey Quality Improvement (QI) Reports	These reports communicate the full results of the QHP Enrollee Survey, including questions not included as part of the QRS measure set. The raw frequencies for all QHP Enrollee Survey questions are included in the QHP Enrollee Survey QI Reports. CMS intends to release the QHP Enrollee Survey QI Reports during the QRS preview period. The results shown in QHP Enrollee Survey QI Reports are produced after data cleaning and scoring procedures. First, the data used for these reports are cleaned according to standard CAHPS® rules. Second, the scores are weighted and case-mix adjusted. Lastly, the scores are calculated using the CAHPS® Analysis Program (CAHPS® Macro) and the full national QHP Enrollee Survey database. This program, along with instructions for using it, are available at no cost at https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/helpful-resources/analysis/2020-instructions-for-analyzing-data.pdf The QI Reports, available via the MQM, contain additional information about the methodology behind the QHP Enrollee Survey QI Reports.
QRS survey measures (e.g., via QRS preview)	CMS-calculated results for the QRS include survey measures derived from a subset of questions in the QHP Enrollee Survey. The results in the QHP Enrollee Survey QI Reports differ from those reported for QRS survey measures as additional scoring specifications are used to calculate QRS survey measure results. QRS survey measure results are calculated via additional post-survey processing including case-mix adjustment, removal of invalid responses, and including appropriate respondents in the denominator totals.
QHP Enrollee Survey QI Reports Methodology Guide	A PDF file that describes the contents of the QHP Enrollee Survey QI Reports and includes details regarding the survey process and timeline and the methods for analyzing the survey data.
National QI Benchmark Report	The National Quality Improvement Benchmark Report provides national-level statistics for the QHP Enrollee Survey scoring questions, screener questions, about-the-enrollee questions, and survey disposition. QHP issuers can use this report to compare the performance of their respective reporting units to the performance of all reporting units that participated in the QHP Enrollee Survey for the given year.
Raw results provided by the QHP Enrollee Survey vendors upon data submission	The estimates provided by survey vendors are preliminary and are intended to provide QHP issuers with an early estimate of their survey scores. Survey vendors may not perform the same type of data cleaning performed by CMS. Additionally, survey vendors are unable to implement the identical case-mix adjustment that is performed by CMS because they do not have access to the full national dataset. A survey vendor may analyze the survey data in order to provide QHP issuers with aggregated results and may conduct additional analyses. These survey vendor analyses are not official survey results and should only be used for quality improvement purposes.

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

QHP Enrollee Survey Composite versus QRS Survey Measure Construction: Historically, the CAHPS® program has used the term "composite" to refer to a construct that is derived from more than one survey question. The QHP Enrollee Survey QI Reports use the term composite in the same context as other CAHPS® surveys (e.g., Getting Needed Care and Getting Care Quickly). However, for the QRS, the term composite refers to a grouping of measures; it is the first level of summary results in the QRS hierarchy. For example, the Enrollee Experience with

Health Plan composite in the QRS includes the scores for three QRS measures: *Access to Information*, *Plan Administration*, and *Rating of Health Plan*.

The questions included in QRS survey *measures* may be different than the questions included in "*composites*" shown in the QHP Enrollee Survey QI Reports. For example, the *Access to Care* measure is composed of four questions, while in the QHP Enrollee Survey QI Reports these four questions make up two separate composites: Getting Care Quickly and Getting Needed Care.

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

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

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

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

Due to these different approaches, there are instances when an eligible reporting unit could score average or above average on QHP Enrollee Survey items in the QI Reports and receive 1-star or 2-star ratings for certain QRS components.

Appendix G. Glossary and List of Acronyms

Exhibit 37 includes definitions for key terms used in this document.

Exhibit 37. 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.
Benchmark Ratio approach	The Benchmark Ratio approach provides measure-specific performance targets and measure scores using those measure benchmarks. The Benchmark Ratio approach consists of two distinct parts: 1) the calculation of the measure-specific performance targets (i.e., measure benchmarks) and 2) the calculation of the measure scores using the measure benchmark. CMS will calculate annual benchmarks using the measure data collected in a single ratings year.
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.
Consensus-Based Entity (CBE)	The consensus-based entity (CBE) is responsible for managing the process through which quality measures become endorsed, and maintaining measure endorsement(s) over time. The CBE also manages the Pre-Rulemaking Measure Review (PRMR) (formerly known as the Measure Applications Partnership [MAP])[78].Battelle is the Centers for Medicare & Medicaid Services (CMS) certified CBE currently tasked with managing these processes.
Component	The QRS hierarchy includes two components: summary indicators and global. These components represent levels of scores and ratings. Summary indicator scores are averages of associated measure scores, while the global score is the sum of weighted summary indicator scores.
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. The QRS cut points are static and remain as 60, 70, 80, and 90 threshold values year over year.
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 2024, CMS requires QHP issuers to contract with a HEDIS® Compliance Licensed 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 using the HEDIS® Compliance Audit standards, policies, and procedures and will determine the accuracy of the sample frame for the QHP Enrollee Survey.
Data validator	An independent third party that validates the QRS clinical measure data and the sample frame for the QHP Enrollee Survey prior to data submission. QHP issuers must contract with a HEDIS® Compliance Auditor, who will serve as the data validator.
Direct Enrollment Entity	An entity that an Exchange permits to assist consumers with direct enrollment in qualified health plans offered through the Exchange.
Discontinued	The QHPs in the reporting unit will not be offered (i.e., not offering to new members and/or not available for purchase during the upcoming open enrollment period) through an Exchange and will not be operational.

[78] See supra note 30.

Term	Definition
Draft and Final Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey	CMS releases an annual Draft Call Letter that serves to communicate proposed refinements to the QRS and QHP Enrollee Survey for the current and future years. These refinements are then finalized in the annual Final Call Letter for the QRS and QHP Enrollee Survey programs.
Electronic Clinical Data Systems (ECDS) Reporting	A network of data containing a plan member's personal health information and records of their experiences within the healthcare system. ECDS is a HEDIS® reporting standard for health plans collecting and submitting quality measures to NCQA. This reporting standard defines the data sources and types of structured data acceptable for use for a measure. For more information about ECDS reporting, please see ECDS Frequently Asked Questions, available at: https://www.ncqa.org/hedis/the-future-of-hedis/ecds-frequently-asked-questions/.
Exclusive Provider Organization (EPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO enrollees will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.
Federally-facilitated Exchange (FFE)	The Exchange model operated by HHS for individual and small group market coverage. For QHP issuers operating in the FFEs, CMS will display QHP quality rating information on HealthCare.gov alongside other QHP information to inform consumers.
FFEs where the State performs plan management functions	A type of FFE in which a State operates plan management functions, while the remaining Exchange functions are operated by HHS. For QHP issuers operating in States performing plan management functions in the FFEs, CMS will display QHP quality rating information on HealthCare.gov.
Global	A component of the QRS hierarchy. A score or rating for this component is created by summing the summary indicator scores (e.g., a weight of 2/3 (66.67%) to the Clinical Quality Management summary indicator, and a weight of 1/6 (16.67%) to the Enrollee Experience and the Plan Efficiency, Affordability, & Management summary indicators.
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. This rule is intended for component scores to be comparable across reporting units.
Health Insurance Exchange (Exchange)	A service in each State where qualified individuals, families, and small businesses can learn about their health insurance options; compare QHPs based on quality, costs, benefits, and other important features; choose a QHP; and enroll in coverage. In some States, the Exchange is operated by the State. In others, it is operated by the federal government.
Health Maintenance Organization (HMO)	A type of health insurance product that usually limits coverage to care from providers who work for or contract with the HMO and generally will not cover out-of-network care except in an emergency. In this type of organization, enrollees must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.
Healthcare 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 Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures,* which is available for purchase and can be accessed at the following link: https://store.ncqa.org/hedis-quality-measurement.html.

Term	Definition
HealthCare.gov	The consumer-facing website developed and operated by CMS that provides eligibility information, enrollment instructions, and QHP information for consumers looking to enroll in a health insurance plan through the FFEs. QRS ratings for QHP issuers operating in the FFEs, including States performing plan management functions, and SBE-FPs will be displayed on HealthCare.gov to support consumers as they search for and enroll in a QHP.
HEDIS® Compliance Auditor	An individual certified by the National Committee for Quality Assurance (NCQA) to validate QRS clinical measure data and the QHP Enrollee Survey sample frame.
Hybrid data collection method	Uses data obtained from both administrative and medical record/ electronic medical record sources to identify the eligible population and numerator compliance. The denominator consists of a systematic sample of enrollees drawn from the measure's eligible population. QHP issuers then: a) review administrative data to determine numerator compliance, and b) review medical record data for enrollees who do not meet numerator criteria based on administrative data, in order to identify additional numerator compliance for the measure. Details on the collection method are included in a measure's technical specifications (see the *Quality Rating System Measure Technical Specifications).*
Indicator	A rate that forms a measure. Some QRS measures have multiple indicators or additional sub-levels (i.e., below sub-measure indicators and sub-measure 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.
Meaningful Measures Initiative	A CMS framework which identifies the highest priorities for quality measurement and improvement. The framework involves only assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes. The Meaningful Measure Areas serve as the connectors between CMS strategic goals and individual measures/initiatives that demonstrate how high-quality outcomes are being achieved. Meaningful Measures Areas are concrete quality topics, which reflect core issues that are most vital to high quality care and better patient outcomes.
Measure	Rate variables that serve as the fundamental building blocks of the QRS hierarchy. Each measure is assigned to a summary indicator and contributes to the scoring for the global level of the hierarchy.
Measurement Year	The measurement year refers to the year reflected in the data. All measure data are retrospective. The exact period of time represented by the measure is dependent on the technical specifications of that measure.
National Committee for Quality Assurance (NCQA)	NCQA developed and maintains the system through which QHP issuers will submit validated QRS clinical measure data to CMS, the Interactive Data Submission System (IDSS). NCQA is the measure steward for HEDIS® measures. NCQA also manages the HEDIS® Compliance Audit program.
Not Applicable (NA)	Data validation result assigned for a measure if the QHP issuer followed the specifications but the denominator was too small (e.g., less than 30) to report a valid rate. The QHP issuer did not have sufficient data to fulfill the continuous enrollment criteria for the measure.
Not Calculated (NC)	Invalid code assigned to measures with an insufficient denominator size.
No Global (NG)	Invalid code assigned to reporting units with insufficient data to calculate a global rating.
Not Reported (NR)	Data validation result assigned for a measure if the QHP issuer chose not to report the measure rate or the measure rate was otherwise invalid.
Not Operational	The QHPs in the reporting unit are not sold on an Exchange (SHOP or individual), are not accepting new members or groups, and do not have active or existing members (i.e., zero members).

Term	Definition
Operational	The QHPs in the reporting unit are available for purchase on an Exchange (SHOP or individual), accepting new members or groups, and/or have active or existing members.
Pharmacy Quality Alliance (PQA)	The measure steward for the *Proportion of Days Covered* (PDC) measure, the Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) measure, and the International Normalized Ratio (INR) Monitoring for Individuals on Warfarin 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.
Qualified Health Plan Enrollee Experience Survey: Technical Specifications	A document published on the MQI website that includes detailed specifications and protocols for HHS-approved survey vendors to conduct the QHP Enrollee Survey.
QHP Enrollee Survey score	The average value for a measure from the QHP Enrollee Survey calculated for survey respondents in a given reporting unit. A survey score can be for a single assessment question or a combination of several questions on a similar topic that are combined to form a single measure.
QHP Enrollee Survey vendor	An 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. CMS finalized the removal of the composite and domain levels of the hierarchy beginning with the 2022 ratings year in the HHS Notice of Benefit and Payment Parameter for 2022 Final Rule.
QRS rating methodology	The rules for combining measures and converting scores into quality ratings for the QRS.
QRS survey measures	QRS measures calculated using enrollee responses to a subset of specified questions in the QHP Enrollee Survey. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to Appendix C of this Guidance.
Qualified Health Plan (QHP)	A health insurance plan that has in effect a certification that it meets the standards established by the Patient Protection and Affordable Care Act and supporting regulations, issued or recognized by each Exchange through which such plan is offered.
Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)	A survey tool developed, as directed by the Patient Protection and Affordable Care Act section 1311 (c)(4), that includes a comprehensive set of questions related to enrollee experience with their QHP offered through the Exchange. CMS will use enrollee response data for a specified subset of the questions to calculate the QRS survey measures.

Term	Definition
Qualified Health Plan (QHP) issuer	A health insurance issuer that offers a QHP in accordance with a certification from an Exchange, as defined by 45 C.F.R. § 155.20. Each QHP issuer participating in an Exchange is defined by a separate federal Health Insurance Oversight (HIOS) Issuer ID. Each QHP issuer is defined by a State geographic unit.
Quality Rating System Measure Technical Specifications	A document published on the CMS Health Insurance Marketplace® Quality Initiatives website (https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/aca-mqi/aca-mqi-landing-page) that includes detailed measure specifications and general guidelines for QRS measure data collection.
QHP Enrollee Survey sample frame	A text file containing data elements for all survey-eligible enrollees for each reporting unit required to field the survey from which vendors draw the QHP Enrollee Survey sample. QHP issuers must populate a complete, accurate, and valid sample frame of all survey-eligible enrollees for each reporting unit required to field the survey.
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 Patient Protection and Affordable Care Act section 1311 (c)(3), the QRS is a system of rating QHPs offered through the Exchange based on quality and price. The QHP quality rating information will be provided to individuals and employers to inform their selection of a QHP and will provide a system for monitoring of QHP quality by regulators.
QRS rating	Also referred to as "categorical rating" or "star rating." A discrete value based on a score for QRS components (summary indicators and global), which facilitates consumer understanding of QHP performance.
QRS score	A numerical value that indicates the level of QHP performance for QRS measures and hierarchy components (summary indicators and global). For component scores, summary indicator scores are averages of standardized measures scores for a QHP; and the global score is the sum of the weighted summary indicator scores for a QHP.
Ratings year	The ratings year refers to the year the data are collected (including fielding of the QHP Enrollee Survey), validated, submitted, and ratings are calculated.
Reference group	A population of reporting units that is defined based on specification of a geographical region and/or time period. A reporting unit's level of performance is relative to the average performance of the national all-product reference 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 measure score	A value ranging from 0 to 110 that results from dividing the reporting unit's measure rate by the benchmark for that measure and multiplying by 100. Under the Benchmark Ratio approach, a reporting unit would receive a measure score of 100 when the reporting unit meets the target benchmark. Therefore, the Benchmark Ratio approach allows for the possibility of measure scores to surpass 100. The limit instances in which a reporting unit overperforms on one measure, CMS has established an upper cap of 110 on measure scores to more accurately measure both high and low performers.
State-based Exchange (SBE)	An Exchange model in which a State operates its own Health Insurance Exchange, for both the individual and small group markets. An SBE is responsible for certifying QHP issuers, overseeing QHP issuer compliance with federal Exchange quality standards as a condition of certification, and displaying QHP quality rating information to help consumers compare QHPs.

Term	Definition
State-based Exchange on the Federal Platform (SBE-FP)	An Exchange model in which a State operates its own Health Insurance Exchange, for both the individual and small group markets but relies on the federal platform to perform certain eligibility and enrollment functions. An SBE-FP is responsible for certifying issuers, overseeing issuer compliance with federal Exchange quality standards as a condition of certification. For QHP issuers operating in SBE-FPs, CMS/CCIIO will display QHP quality rating information on HealthCare.gov.
Summary indicator	A component of the QRS hierarchy. A score for this component is created by averaging scores from associated measures.
Summary-level measure data	The level of QRS clinical measure data that QHP issuers will submit to CMS for each eligible reporting unit. Summary-level data elements are specified for each QRS clinical measure in the *Quality Rating System Measure Technical Specifications*, and include elements like eligible population (denominator), numerator, and the rate.
Survey sample 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 sample frame, and the HHS-approved QHP Enrollee Survey vendor will generate an enrollee sample based on the validated sample frame.
Weighted average	An average that is calculated in which some data points (values) contribute more than others to the final average.

Exhibit 38 provides definitions for acronyms that appear in this 2024 Guidance.

Exhibit 38. List of Acronyms

Acronym	Definition
AHRQ	Agency for Healthcare Research and Quality
AMO	Annual Monitoring for Persons on Long-Term Opioid Therapy
API	Application Program Interface
BHP	Basic Health Program
BMI	Body Mass Index
BR	Biased Rate
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CBE	Consensus-Based Entity
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Center for Medicare & Medicaid Services
CSR-I	Insufficient data to calculate a score according to the QRS rating methodology.
DE	Direct Enrollment
ECDS	Electronic Clinical Data Systems
EPO	Exclusive Provider Organization
FFE	Federally-facilitated Exchange
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	Department of Health & Human Services
HIOS-MQM	Health Insurance Oversight System-Marketplace Quality Module
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HOQ	Healthcare Organization Questionnaire
HPV	Human Papillomavirus
HTN	Diagnosis of Hypertension

Acronym	Definition
IDSS	Interactive Data Submission System
IFP	Individual and Family Plan
IHS	Index Hospital Stays
INR	International Normalized Ratio Monitoring for Individuals on Warfarin
MMR	Measles, Mumps and Rubella
M-NS	Measure – Not Scored
MQI	Marketplace Quality Initiatives
MSD	Marketplace Service Desk
NA	Not Applicable
NB	Benefit Not Offered
NC	Not Calculated
NCQA	National Committee for Quality Assurance
NG	No Global
NR	Not Reported
OB/GYN	Obstetrician/Gynecologist
OEP	Open Enrollment Period
PCD-RASA	Renin Angiotensin System Antagonists
PCD-STA	Statins
PCP	Primary Care Physician
PCR	Plan All-Cause Readmissions
PDC	Proportion of Days Covered
PDC-DR	Diabetes All Class
POS	Point of Service
PPO	Preferred Provider Organization
PQA	Pharmacy Quality Alliance
PUF	Public Use File
QHP	Qualified Health Plan
QI	Quality Improvement
QIS	Quality Improvement Strategy
QRS	Quality Rating System
REGTAP	Registration for Technical Assistance Portal
ROF	Ratings Output File
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
SERVIS	State Exchange Resource Virtual Information System
SHOP	Small Business Health Options Program
SUD	Substance Use Disorder

Appendix H. Sample Frame Layout for 2024 QHP Enrollee Survey

An individual sample frame must be generated for each reporting unit required to administer the 2024 QHP Enrollee Survey (i.e., multiple reporting units cannot be combined into a single file) and must include a single record for each enrollee that meets the eligibility requirements outlined in the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications for 2024*. The sample frame must be specific to a given reporting unit (unique state-product type for each QHP issuer) and must not be combined with other product lines or products. The required data elements described in Exhibit 40 must be included for each enrollee included in the sample frame.

QHP issuers must attempt to fully populate all sample frame variables.[79] CMS has included completeness thresholds (i.e., not missing) for variables in the sample frame. Field population for all variables is required, not optional, and QHP issuers should meet these minimum completeness thresholds.

Select variables must be populated for every record in the file (0% bias variables). These variables must meet logic agreements for each record in the sample frame. For example, the product type variable must be the same for all records in the sample frame file. Discrepancies in these variables can be indicative of a potential sampling error. The 0% bias variables for 2024 survey administration, in addition to suggested logic checks for each variable are listed in Exhibit 39.

Exhibit 39. Recommended Logic Agreement Checks for 0% Bias Variables

Variable	Logic Agreement Checks	Example
Product Type	• Must match the reported 3-character Product Type in the **Reporting Unit ID** variable. • Must not be missing. • Must be identical for all records in the sample frame.	Reporting Unit ID=12345-TX-**PPO**; then Product Type=**PPO** for all records.
Issuer ID	• Must match the reported 5-digit Issuer ID in the **Reporting Unit ID** variable. • Must not be missing. • Must be identical for all records in the sample frame.	Reporting Unit ID=**12345**-TX-PPO; then Issuer ID=**12345** for all records.
QHP State	• Must match the reported 2-character QHP State postal code in the **Reporting Unit ID** variable. • Must not be missing. • Must be identical for all records in the sample frame.	Reporting Unit ID=12345-**TX**-PPO; then QHP State=**TX** for all records.
Reporting Unit ID	• Must match the reported values for the **Issuer ID**, **QHP State**, and **Product Type** variables. • Must not be missing. • Must be identical for all records in the sample frame. • Must be listed as it appears in "Reporting Units Required to Submit 2024 QRS Clinical Measure Data and QHP Enrollee Survey Response Data" in the *2024 QHP Enrollee Survey: Operational Instructions*, which will be available fall 2023.	Reporting Unit ID=**12345-TX-PPO**; then for all records: • 5-digit Issuer ID=Issuer ID variable=**12345**; • 2-character QHP state postal code=QHP State variable=**TX**; • 3-character product type=Product Type variable=**PPO**.

[79] CMS may conduct targeted compliance reviews under 45 C.F.R. § 156.715 to examine QHP issuer compliance with the federal data submission and reporting requirements for the QRS and QHP Enrollee Survey subsequent to the data validation of QRS clinical measures.

Variable	Logic Agreement Checks	Example
Variant ID	• Must not be missing (or must be coded with valid value 09 = Missing). • Must not include records with a Variant ID of 00.	All records must have a Variant ID with a valid value.
Reporting Status	• Must not be missing. • Must be identical for all records in the sample frame.	• Reporting Status=**1** for all records when reporting unit began operating in 2020 or before. • Reporting Status=**2** for all records when reporting unit began operating in 2021.
Total Enrollment	• Must be total number of enrollees within the reporting unit, not the number of survey-eligible enrollees. • Must be greater than 500 and greater than eligible population (sample frame). • Must not be missing. • Must be identical for all records in the sample frame. • Please refer to the Evaluate Reporting Unit Eligibility Criteria section of the *2024 QHP Enrollee Survey Technical Specifications*.	If a sample frame has 700 records, then Total Enrollment must be greater than 700.

Specific information about each variable is included in Exhibit 40.

Select variables in the sample frame may be used for case mix adjustment for sampled enrollees when scoring survey results. Incomplete data for a given reporting unit could decrease the amount of data available for case mix adjustment, which may impact scoring precision for both the QHP Enrollee Survey QI Report scores and the scored survey measures included in the Quality Rating System. QHP issuers are expected to provide data based upon completeness thresholds provided in the sample frame layout below. A QHP issuer's submission of the locked and audited sample frame file to their vendor constitutes the QHP issuer's attestation to the accuracy, completeness, and quality of data in the sample frame.[80] Sample frame files not meeting completeness thresholds may be subject to resubmission by the QHP issuer until the completeness thresholds are met. Recommended quality control checks for the sample frame are available in the Create Sample Frame and Draw Sample (Sampling) section of the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications for 2024*.

In the rare instances in which required enrollee data are missing, QHP issuers must denote these data elements with the valid value for *Missing*. QHP issuers may not append any additional data fields to the sample frame that are not specified in the sample frame file layout. All entries must be left justified. The sample frame includes personally identifiable information; therefore, all vendors and QHP issuers must safeguard sample frame data in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the security requirements outlined in the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications for 2024*.

[80] Accuracy, completeness, and data quality are required by CMS. Inaccurate data may affect scoring for both the QHP QI Reports and the QHP Enrollee Survey measures included in the QRS.

Exhibit 40. 2024 QHP Enrollee Survey Sample Frame Data Elements

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
QHP Issuer Legal Name	Char	60	1	60	Legal name of the issuer of the QHP in which the individual is enrolled, specific to the state in which the QHP is operating.	**Note:** This variable MUST be identical for all enrollees included in the sample frame and MUST NOT be blank. **Note:** Do NOT use acronyms or abbreviations. Do NOT include extra spaces or parentheses. Do NOT include superscript characters or trademark symbols. **Note:** This variable is used in the QI Reports. Please confirm QHP Issuer Legal Name is spelled correctly.	100%
Product Line	Num	1	61	61		3 = Exchange **Note:** A valid value is required for every enrollee in the record. Only "3" is valid for the QHP Enrollee Survey.	100%
Product Type	Num	1	62	62	Name of the product type under which the enrollee's QHP falls.	1 = Health Maintenance Organization (HMO) 2 = Point of Service (POS) 3 = Preferred Provider Organization (PPO) 4 = Exclusive Provider Organization (EPO) **Note:** A valid value is required for every enrollee in the record. QHP issuers may NOT combine product types. This variable MUST be identical for all enrollees included in the sample frame. **Note:** This variable MUST match the reported 3-character product type in the Reporting Unit ID variable. For example: Reporting Unit ID = 12345-TX-**PPO**; then **all** Product Type = **PPO**. **Note:** This variable MUST NOT be missing (0% bias variable).	100%

[81] Completeness thresholds are the recommended percentage of records with populated data (i.e., not missing) within a sample frame. QHP issuers are expected to meet the specified completeness threshold requirements or be able to justify any missing information, if requested.

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
Subscriber ID	Char	25	63	87	Subscriber or family ID number, which is the common ID for the subscriber and all dependents. Each issuer can decide the format used for this ID.		100%
Enrollee Unique ID	Char	25	88	112	Unique enrollee ID. This ID differentiates between individuals when family members share the Subscriber ID. Each issuer can decide the format used for this ID, given it uniquely identifies the enrollee and can be linked back to the issuer's records.		100%
Enrollee First Name	Char	25	113	137	Enrollee first name		100%
Enrollee Middle Initial	Char	1	138	138	Enrollee middle initial		
Enrollee Last Name	Char	25	139	163	Enrollee last name		100%
Enrollee Gender	Num	1	164	164		1 = Male 2 = Female 9 = Missing/Not Available **Note:** A valid value is required for every enrollee in the record.	90% 10% = 9
Enrollee Date of Birth	Num	8	165	172		MMDDYYYY	100%
Enrollee Mailing Address 1	Char	50	173	222	Street address or post office box		100%
Enrollee Mailing Address 2	Char	50	223	272	Mailing address, 2nd line (if needed)		
Enrollee City	Char	30	273	302			100%
Enrollee State	Char	2	303	304	2-character Postal Service state abbreviation		100%
Enrollee ZIP Code	Num	9	305	313	9-digit number no separators or delimiters; leave last 4 digits blank if not available		100%

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
Enrollee Phone 1	Num	11	314	324	1 plus 3-digit area code plus 7-digit phone number; no separators or delimiters		100%
Enrollee Age	Num	2	325	326	Enrollee age as of December 31, 2023.	Numeric, 2-digit variable. For enrollees age 80 years and older, code as 80. For example, an enrollee who is 89 years of age as of December 31, 2023, will be coded 80. **Note:** A valid value is required for every enrollee in the record.	100%
Enrollee Education	Num	1	327	327	The highest grade or level of school that the enrollee has completed.	1 = 8th grade or less 2 = Some high school, but did not graduate 3 = High school graduate or GED 4 = Some college or 2-year degree 5 = 4-year college graduate 6 = More than 4-year college degree 9 = Missing **Note:** A valid value is required for every enrollee in the record.	
Enrollee Employment	Num	1	328	328	Best description of enrollee's employment status.	1 = Employed full-time 2 = Employed part-time 3 = Homemaker 4 = Full-time student 5 = Retired 6 = Unable to work for health reasons 7 = Unemployed 8 = Other 9 = Missing **Note:** A valid value is required for every enrollee in the record.	
Issuer ID	Num	5	329	333	Unique HIOS issuer ID number.	**Note:** A valid value is required for every enrollee in the record. This variable MUST be identical for all enrollees included in the sample frame. **Note:** This variable MUST match the reported 5-digit **Issuer ID** in the **Reporting Unit ID** variable. For example: Reporting Unit ID	100%

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
						= **12345**-TX-PPO; then **all** Issuer ID = **12345**. **Note:** This variable MUST NOT be missing (0% bias variable).	
QHP State	Char	2	334	335	State associated with the QHP issuer. This variable is different than Enrollee State.	2-character Postal Service state abbreviation. **Note:** A valid value is required for every enrollee in the record. This variable MUST be identical for all enrollees included in the sample frame. **Note:** This variable MUST match the reported 2-character **QHP state** postal code in the **Reporting Unit ID** variable. For example: Reporting Unit ID = 12345-**TX**-PPO; then **all** QHP State = **TX**. **Note:** This variable MUST NOT be missing (0% bias variable).	100%
Reporting Unit ID	Char	12	336	347	Reporting Unit ID. It is made up of the following parts (with a hyphen separating each part): 5-digit Issuer ID, 2-character QHP State postal code, and 3-character Product Type.	5-digit Issuer ID = Issuer ID variable. 2-character QHP state postal code = QHP State variable. 3-character product type = Product Type (HMO, POS, PPO, EPO) variable. **Note:** A valid value is required for every enrollee in the record. This variable MUST be identical for all enrollees included in the sample frame and the components of this variable MUST match the reported values for the **Issuer ID**, **QHP State**, and **Product Type** variables. For example: Reporting Unit ID = 12345-TX-PPO; then **all** 5-digit Issuer ID = Issuer ID variable = **12345**; **all** 2-character QHP state postal code = QHP State variable = **TX**; **all** 3-character product type = Product Type variable = **PPO**.	100%

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
						Note: This Reporting Unit ID MUST be listed as it appears in the "Reporting Units Required to Submit 2024 QRS Clinical Measure Data and QHP Enrollee Survey Response Data" in the 2024 QHP Enrollee Survey: Operational Instructions, which will be made available in the fall of 2023. **Note:** This variable MUST NOT be missing (0% bias variable).	
Metal Level	Num	1	348	348	Metal level associated with enrollee's QHP.	1 = Platinum 2 = Gold 3 = Silver 4 = Bronze 5 = Catastrophic 6 = Bronze Expanded 9 = Missing **Note:** A valid value is required for every enrollee in the record.	100%
Variant ID	Char	2	349	350	Variant ID associated with enrollee's QHP. Variant IDs 02 and 03 are for federally recognized tribes and eligible Alaska Natives with incomes above 300% of the federal poverty line. The Variant IDs associated with Medicaid Expansion Enrollees (31-36) are determined based on the actuarial value; issuers should have the Variant IDs assigned to their enrollees and plans. **Note:** Variant IDs relate to the plan's cost-sharing structure.	01 = Exchange variant (No CSR) 02 = Zero Cost Sharing Plan Variation 03 = Limited Cost Sharing Plan Variation 04 = 73% Actuarial Value (AV) Level Silver Plan CSR 05 = 87% AV Level Silver Plan CSR 06 = 94% AV Level Silver Plan CSR 31 = Medicaid Expansion 32 = Medicaid Expansion 33 = Medicaid Expansion 34 = Medicaid Expansion 35 = Medicaid Expansion 36 = Medicaid Expansion 09 = Missing	100%

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
						Note: A valid value is required for every enrollee in the record. Only the Variant IDs listed above can be included in the sample frame. Do NOT include enrollees in QHPs offered outside the Exchange (off-Exchange health plans) or in non-QHPs, designated by HIOS Variant ID 00. **Note:** Variant IDs of 09 = Missing remain in the sample frame. The enrollee is assumed to be eligible (in an on-Exchange health plan) unless there is evidence to suggest otherwise.	
Spoken Language Preference	Num	1	351	351	Enrollee's preferred spoken language.	1 = English 2 = Spanish 3 = Chinese 4 = Other 9 = Missing **Note:** A valid value is required for every enrollee in the record.	50% 50% = 9
Written Language Preference	Num	1	352	352	Enrollee's preferred written language.	1 = English 2 = Spanish 3 = Chinese 4 = Other 9 = Missing **Note:** A valid value is required for every enrollee in the record.	50% 50% = 9
APTC Eligibility Flag	Num	1	353	353	Indicates whether enrollee qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction.	1 = Yes 2 = No 9 = Missing **Note:** If an enrollee is eligible for APTCs at any point during the continuous enrollment period (July 1 through December 31, 2023), the variable should be coded as 1 = Yes. **Note:** A valid value is required for every enrollee in the record.	70% 30% = 9

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
Plan Marketing Name	Char	250	354	603	The common name of the QHP in which the individual is enrolled (e.g., the name a consumer would see on an Exchange website when enrolling or on a bill).	If Missing, use "Unavailable."	50% 50% = "Unavailable"
Medicaid Expansion QHP Enrollee	Num	1	604	604	QHPs operating in a state with a Section 1115 waiver as part of the Medicaid Expansion MUST include all QHP enrollees and indicate whether they are enrolled via an 1115 waiver. It is the responsibility of the QHP to know whether their reporting units contain such persons.	1 = Yes 2 = No 3 = Missing 9 = Not Applicable (State Does Not Have a Medicaid 1115 Waiver) **Note:** A valid value is required for every enrollee in the record. **Note:** Organizations with Medicaid Expansion QHP enrollees (1 = Yes) should have Variant ID values between -31 and -36. **Note:** QHPs operating in states without Section 1115 waivers use 9 = Not Applicable. **Note:** QHPs operating in states with Section 1115 waivers that are NOT Medicaid Expansion states also use 9 = Not Applicable. **Note:** If an expansion enrollee is enrolled in a QHP via an 1115 waiver at any point during the continuous enrollment period (July 1 through December 31, 2023), the variable should be coded as 1 = Yes.	100%

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
Reporting Status	Num	1	605	605	This variable is an identifier to determine whether a particular reporting unit is eligible for scoring as part of the Quality Rating System. Only plans that began offering coverage within a state's Exchange in Plan Year 2022 or before are eligible for scoring. This variable is based on the plan year the QHP issuer began offering the reporting unit within the state's Exchange. Please refer to the Create Sample Frame and Draw Sample (Sampling) section of the *2024 QHP Enrollee Survey Technical Specifications* for more information.	1 = Issuer began offering this product type within state's Exchange in Plan Year 2022 or before (i.e., operational in 2022, 2023, and 2024) 2 = Issuer began offering this product type within state's Exchange in Plan Year 2023 9 = Missing **Note:** A valid value is required for every enrollee in the record. **Note:** This variable MUST NOT be missing (0% bias variable). **Note:** Only plans that began coverage within a state's Exchange in Plan Year 2022 or before are eligible for scoring. **Note:** A reporting unit that began operating in 2023 is required to both field the survey and submit QRS clinical data but is not eligible for scoring. Review the *2024 QHP Enrollee Survey: Operational Instructions* (available in the fall of 2023) to confirm whether the reporting unit is required to field the survey and submit QRS clinical data. Review the QRS Scoring Eligibility Criteria section of the *2024 QHP Enrollee Survey Technical Specifications* to confirm scoring eligibility. **Note:** The value included for the Reporting Status variable in the sample frame must align with the following criteria: Has this reporting unit been operational for three years for the exact sample product type (2022, 2023, and 2024)? If Yes, then Reporting Status = 1. If No, then Reporting Status = 2.	100%

Variable	Type	Field Position Length	Field Position Start	Field Position End	Description	Valid Values	Completeness Threshold[81]
Enrollee Email Address	Char	320	606	925	Email address.	Maximum of 64 characters for the user name, 1 character for the @, and 255 characters for the domain name. **Note:** A valid value is required for every enrollee in the record. If not available, leave blank. Enrollee email addresses are necessary for internet survey administration.	80% 20% = blank
Enrollee Phone 2	Num	11	926	936	1 plus 3-digit area code plus 7-digit phone number; no separators or delimiters.	**Note:** A valid value is required for every enrollee in the record. If not available, leave blank.	
Total Enrollment	Num	9	937	945	The total number of members enrolled in the reporting unit. This must be total number of enrollees within the reporting unit, not the number of survey-eligible enrollees. Please refer to the Evaluate Reporting Unit Eligibility Criteria of the *2024 QHP Enrollee Survey Technical Specifications*. **Note:** Total Enrollment should be calculated as of 11:59 pm ET on January 1, 2024. **Note:** If total enrollment is 500 or less, consult the *2024 QHP Enrollee Survey: Operational Instructions* (available in the fall of 2023) for guidance.	0 – 999999999 -1 = Unknown/Missing **Note:** A valid value is required for every enrollee in the record. If unavailable, use -1 = Unknown/Missing. Do NOT leave field blank. **Note:** This variable MUST be identical for all enrollees included in the sample frame. **Note:** This variable MUST NOT be missing (0% bias variable).	100%