April 30, 2025

Center for Consumer Information and Insurance Oversight
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Marketplace Quality Initiatives (MQI)-Draft 2025 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey

To Whom It May Concern:

Covered California appreciates the opportunity to submit the following comments in response to the Centers for Medicare & Medicaid Services (CMS) Draft 2025 Call Letter for the QRS and QHP Enrollee Experience Survey.

As the largest State-Based Marketplace, Covered California has leveraged the Affordable Care Act (ACA) to not only expand access to health care, but also to improve the quality of care provided to Californians. Our efforts are rooted in a strong commitment to accountability and continuous improvement, ensuring that the health plans we offer meet the highest standards of quality and effectively serve the needs of consumers. We make these comments based upon our experience driving meaningful improvements in health outcomes, enhancing the care experience for Californians, and making strides toward the triple aim of better health, better care, and lower costs.

We share the below comments related to the specific topics of: (1) CMS Quality Priorities for the 2025 Ratings Year and Beyond, (2) Proposed Removal of Select Measures, (3) Proposed Addition of Select Measure, (4) Proposed Transition of the Controlling High Blood Pressure (CBP) Measure to the Blood Pressure Control for Patients with Hypertension (BPC-E) Measure**,** (5) Proposed Refinements to Select Measures, (6) Expanding Electronic Clinical Data System (ECDS) Reporting, (7) Proposed Revisions to the QHP Enrollee Survey Sample Frame Variables, and (8) Potential QRS and QHP Enrollee Survey Revisions for Future Years.

CMS Quality Priorities for the 2025 Ratings Year and Beyond

Covered California's vision since inception has been "to improve the health of all Californians by assuring their access to affordable, high-quality care." This ambitious goal of achieving health for all Californians has required Covered California to focus on population health, upstream prevention and wholistic care. We support and agree with centering a comprehensive approach which includes mental, social, and physical health.

Covered California strongly recommends CMS continue to require the collection and submission of race and ethnicity stratification data for select QRS measures and potentially expand to other demographic factors such as disability status and spoken language. Over the last decade we have found it critical to collect and use a broad set of data to ensure that the overall health of our enrollees is improved. Examples of this data include survey results, claims and encounters, out-of-pocket (OOP) costs (deductibles and cost-sharing), quality measures, and, critically, enrollee demographic data. Stratifying operational and quality data by multiple demographic factors helped us identify differences in behavioral health utilization for rural and super rural dwellers. It similarly led to the implementation of outbound calls to support effectuation for Spanish-language dominant enrollees. Race and ethnicity data is another foundational piece of the puzzle, which allows states to monitor the performance of QHP issuers and ensure that all enrollees can achieve the health outcomes that they deserve. This is consistent with and reinforces the important work outlined in the CMS Framework for Healthy Communities. We believe alignment across CMS' programs such as QRS and the Healthy Communities Framework reduces waste, friction, and confusion across the health care ecosystem.

In response to CMS soliciting comments on potential measures, tools, and methodology in the QRS to promote nutrition, physical activity, wellness, and well-being, we applaud CMS' reconsideration of the QRS measure set. We recommend striving to reduce administrative burden for clinicians by aligning the measures across all government quality programs (Medicaid, Exchange, and Medicare) where clinically appropriate. Covered California also supports an overall reduction in the number of measures and redoubling focus on continuous improvement on high impact metrics which reduce morbidity and improve wellness and well-being. Included below are measures that meet agency-wide priorities and Covered California recommends CMS adopt as part of the QRS measure set:

Measure	Measure Steward	Explanation
Continuity of Care Index (CoC)	National Quality Forum (NQF)	Increasing the CoC index is shown to reduce costs, reduce hospitalizations, and lower mortality.[1] A key piece of achieving wellness is having a trusted primary care clinician to ensure appropriate coaching, guidance and receipt of evidence-based screening tests and preventive care.
Primary Care Visits / 1000	N/A	The density of primary care providers in a community has been found to correspond with lower mortality and lower costs. This measure can ensure QHP issuers are linking members to primary care and bring value with their coverage.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	National Committee for Quality Assurance (NCQA)	Assesses the percentage of adults aged 20 and older who receive preventive or ambulatory care visits. These visits are crucial for addressing acute issues, managing chronic conditions, and receiving preventive services like screenings and counseling.
Social Needs Screening	NCQA	Multiple studies have demonstrated that lack of access to food, transportation and housing impede the ability to achieve health and wellness. In fact, there are higher costs to the health care system when these basic needs are not met. While CMS has proposed eliminating this measure, Covered California urges reconsideration. To promote nutrition and wellness, the Marketplaces must have the ability to track the social and environmental challenges impeding or supporting health.

[1] The Center for Professionalism & Value in Health Care. (2025, February). Continuity of Care Annotated Bibliography [PDF file]. Retrieved from https://professionalismandvalue.org/wp-content/uploads/2025/02/Continuity_of_Care_Bibliography.pdf

While challenging to collect at a plan-level, CMS could explore shifting towards patient reported measures such as the Patient Activation Measure (PAM) over a longer term. PAM and other patient reported measures have been validated and capture information such as engagement in managing health and have been linked to health outcome, health behaviors and utilization of care. Covered California recommends CMS leverage the QRS QIS Technical Expert Panel (TEP) for a more extensive conversation on how best to implement patient reported measures.

Proposed Removal of Select Measures

Given measure challenges in the Exchange population and small denominator sizes, Covered California agrees with the removal of International Normalized Ration Monitoring for Individuals on Warfarin (INR) as well as Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO). To replace AMO and continue to address the opioid epidemic, CMS could consider the addition of Pharmacotherapy for Opioid Use Disorder (POD). The focus on evidence-based treatment, including Medication Assisted Treatment helps reduce dependence and overdose death, and improves health outcomes.

In response to CMS' desire to add additional patient safety-related measures that better align with the needs of the Exchange population, Covered California would recommend the addition of the following:

Measure	**Measure Steward**	**Explanation**
Pharmacotherapy for Opioid Use Disorder (POD)	NCQA	Focuses on those who have been diagnosed with an opioid use disorder (OUD) who filled a prescription for, were administered, or dispensed, a Food and Drug Administration (FDA)-approved medication to treat or manage OUD during the measurement year (MY).
Follow-Up After Emergency Department Visit for Individuals with Multiple High-Risk Chronic Conditions (FMC)	NCQA	Plan-attributable, uses digital claims-based data, and identifies a vulnerable, high-utilizer population. This measure aligns with CMS's chronic care management and alternative payment model (APM) goals

Measure	Measure Steward	Explanation
		and fills a critical gap in current QRS safety measures.
Transitions of Care Composite (TRC) (e.g., medication reconciliation, care plan transmission, post-discharge follow-up)	NCQA	Supports care continuity and patient safety during hospital transitions, an area increasingly prioritized in CMS programs. Can leverage electronic data exchange (e.g., Fast Healthcare Interoperability Resources [FHIR]), and aligns with CMS's Digital Quality Strategy and person-centered frameworks.

In addition, social needs screenings are a crucial tool in not only identifying daily barriers that affect one's health but also in providing the help needed to address these needs and reduce barriers. If CMS desires measures that advance whole person care, the proposed removal of Social Need Screening and Intervention (SNS-E) is counterproductive. Removal of SNS-E from the QRS program would be inconsistent with the CMS Framework for Healthy Communities, which acknowledges the daily barriers to care, such as transportation, food security, and housing.[2]

Addressing social needs lowers healthcare costs, especially regarding social determinants of health such as housing, food security, and transportation. By addressing basic needs, healthcare providers can connect individuals with the appropriate and necessary resources, facilitating more equitable and tailored care.[3]

In the Covered California 2024 Member Survey, 44 percent of members reported that they were unable to afford basic needs in the past year. In the same survey, 12 percent of members reported concerns about stable housing and 16 percent reported concerns about food in the past 60 days.[4]

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[2] Centers for Medicare & Medicaid Services. (2022). *CMS Framework for Health Equity*. U.S. Department of Health & Human Services. https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework

[3] Kreuter, M. W., Thompson, T., McQueen, A., & Garg, R. (2021). Addressing social needs in health care settings: Evidence, challenges, and opportunities for public health. *Annual Review of Public Health, 42*, 329–344. https://doi.org/10.1146/annurev-publhealth-090419-102204

[4] NORC at the University of Chicago, Covered California's Policy, Eligibility, and Research Division. (2024, November 21). California Health Coverage Survey: Covered California's 2024 Member Survey Public Report [PDF file]. Retrieved from https://hbex.coveredca.com/data-research/library/Member_Survey_2024_Public_Report.pdf

Proposed Addition of Select Measure

Covered California strongly supports the inclusion of measures which center the enrollee experience, affordability of care, and efficiency. We applaud the creative approach of using existing data from the QHP Enrollee Survey to create a composite score on Enrollee Experience with Cost and the expedited timeline to integrate into scoring. Covered California would caution that survey response rates have been highly variable year over year. As an example, in the most recent QHP Enrollee Survey, for the four questions on cost in the California marketplace, most issuers have less than 200 respondents. We would encourage CMS to work with a measure steward to develop empirical evidence on the acceptability, reliability, and validity of creating a composite that is based on these four survey questions before including in scoring and consumer-facing display. This approach mirrors that which is outlined in the CMS Blueprint Measure Lifecycle.

In addition to this proposed measure addition, we would encourage CMS to consider the following metrics regarding cost and affordability:

Measure	**Measure Steward**	**Explanation**
Affordability of Coverage/ Percent of Income Spent on Coverage	N/A	As plans have the income levels of all their enrollees, issuers could report the percentage of income spent on health care premiums by Federal Poverty Level. This could also be expanded to the share of income spent on total OOP expenses including premiums and cost-sharing for services.
Median OOP Cost by Category	National Association of Insurance Commissioners (NAIC)	A plan-reported measure that captures the median OOP cost incurred by enrollees for a defined set of high-volume, high-impact service categories, such as retail pharmacy, laboratory testing, diagnostic imaging, and outpatient surgical procedures. This measure would require plans to calculate and report member-paid amounts (inclusive of deductibles, copays, and coinsurance) using claims data stratified by service type. Covered California recommends CMS pilot this

Measure	Measure Steward	Explanation
		measure to assess variation in cost-sharing exposure across QHPs and promote transparency in benefit design. Aggregated results would support benchmarking of affordability and equity in access to common medical services within and across markets.
Medication Abandonment/ Delayed Initiation	Pharmacy Quality Alliance (PQA)	Covered California supports CMS exploring a measure that identifies the percentage of prescribed medications that are not filled or are delayed, as a signal of cost-related non-adherence. This measure tracks the rate at which members do not initiate prescribed medications within a defined timeframe, reflecting potential affordability barriers such as high OOP costs or benefit design complexity. This measure would surface pharmacy access issues not visible through traditional adherence metrics and could be derived from claims and pharmacy benefit manager data.

Proposed Transition of the Controlling High Blood Pressure (CBP) Measure to the Blood Pressure Control for Patients with Hypertension (BPC-E) Measure

We applaud your acknowledgment and proposal for the inclusion of BPC-E in Rate Year (RY) RY2026, to be collected in RY2026/MY2025 and scored in RY2027/MY2026. We strongly support and appreciate this addition as well as the overlap period with CBP. We believe this adequately addresses both the health plan and purchaser concerns raised in the past.

The QRS QIS TEP has indicated in the past that national benchmarks will be provided for first-year measures, and will be included in the Public Use Files (PUF) and QRS Proof Sheets (e.g., BPC-E benchmarks will appear in RY2026/MY2025 PUF and Proof Sheets). As this transition to ECDS is an industry-wide challenge, having CMS affirm that national benchmarks will be included for first-year measures as standard practice in

the final QRS Call Letter would be well-received and allow for quality improvement before scoring begins.

Proposed Refinements to Select Measures

We appreciate and support the proposal to move to Breast Cancer Screening (BCS-E) and Adult Immunization Status (AIS-E) with an overlap period to ensure no gaps in measurement. Covered California supports the refined measure specifications for AIS-E to reflect the recommendations of the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices.

We also support the BCS-E age expansion with the thoughtful phased-in approach to scoring the new initial population (42-51 years of age). Once the expanded age range occurs, Covered California recommends continued separate reporting on the Interactive Data Submission System (IDSS) by age band for a period of at least three years. As the United States Preventative Services Task Force recently adjusted the screening guidelines, full adoption has not yet occurred across the delivery system. To fully track where additional quality improvement interventions are needed across the delivery system, we strongly recommend the IDSS layout and technical specifications continue to require reporting of two age stratifications and the total rate. We recommend a similar approach for Colorectal Cancer Screening (COL-E) and any future measures with an age expansion.

Expanding Electronic Clinical Data System (ECDS) Reporting

We thank CMS for the thoughtful approach to rolling out ECDS reporting and appreciate the transition plan to continue to collect both traditional as well as the ECDS version of measures for a period. This dual reporting will prevent a gap in quality oversight for these critical measures. We advise dual mandatory reporting until CMS can score and benchmark the newly introduced ECDS measures to support continuous quality oversight for all QHP issuers.

Dual reporting of both traditional and ECDS methods for a transitional period for the forthcoming measures will allow for industry-wide learning, adjustments and investments by QHP issuers and providers. This phased approach will safeguard against having a period without the ability to assess performance on key quality indicators. Maintaining momentum without any gap in scoring or benchmarking is an essential component of an effective quality program.

To that end, when the measure steward, NCQA, retires cervical cancer screening (CCS), immunizations for adolescents (IMA), and childhood immunization status (CIS), we agree that CCS-E, IMA-E, and CIS-E measures should be submitted mandatorily, but we strongly encourage that either the traditional or ECDS measures are scored in

RY2026/MY2025 to prevent gaps in oversight and performance assessment. If QRS is unable to maintain CCS, IMA, and CIS once NCQA has retired the traditional version of these measures, then we would advise that CCS-E, IMA-E, and CIS-E are immediately scored in RY2026/MY2025. Our understanding is that the performance differences between the traditional and ECDS versions of these measures is not so substantial that a gap year is required before scoring. We also are aware that NCQA has transitioned to the ECDS version of these measures for Medicaid and Commercial, therefore there is minimal administrative burden for plans to also transition their Exchange line of business.

Proposed Revisions to the QHP Enrollee Survey Sample Frame Variables

Covered California supports the addition of variables to the survey collection which may enhance analysis and capture broader enrollee experiences without increasing length of survey or consumer burden of completing.

Potential QRS and QHP Enrollee Survey Revisions for Future Years

Covered California supports CMS' refresh of the QRS Measure Set and QHP Enrollee Survey. We strongly encourage the use of the TEP to assist with this process and not solely using the call letter or rulemaking process. The TEP has been underutilized to date and could serve as a high impact set of stakeholders to help CMS achieve agency goals. We also encourage CMS to consider convening a working group with interested State-Based Marketplaces on revisions to the QRS measure set and QHP enrollee survey questionnaire to help inform future revisions.

For the QHP Enrollee Survey, CA, OR, and WA support the addition of the question on perceived unfair treatment. We believe it is important to include the full suite of options as originally designed: health condition, disability, age, income, type of insurance plan, culture or religion, language or accent, race or ethnicity, sex, sexual orientation, gender or gender identity. When this measure was developed and tested, preliminary results showed that perceived unfair treatment was commonly reported by enrollees with limited income, Black enrollees, and female enrollees.[5] Knowing this is a common experience, QRS would be remiss to exclude these options, however, at a minimum, we would recommend consideration of a new selection choice of "appearance" to allow tracking.

[5] Consumer Assessment of Healthcare Providers and Systems Surveys. (2022, September 22). Consumer Assessment of Healthcare Providers and Systems 2022 Virtual Research Meeting Summary: Assessing Patient Experience for Insights into Enhancing Equity in Healthcare [PDF file]. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/news-and-events/events/webinars/cahps-virtual-research-meeting-summary_2022.pdf

While we believe the proposed Net Promoter Score question is sufficiently similar to the Rating of Health Plan survey question, if CMS does decide to add this and the previous question, we would advise at least one other question is removed to address survey fatigue and length. Our recommendation is to consider removing the following questions:

- In the last six months, how often did written materials or the internet provide the information you needed about how your health plan works?
- When you visited your personal doctor for a scheduled appointment in the last six months, how often did he or she have your medical records or other information about your care?
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last six months, how often were the forms from your health plan easy to fill out?
- In the last six months, how often did the health plan explain the purpose of a form before you filled it out?

For the QRS Measure Set, we would encourage removal of process measures (such as proportion of days covered measures) and a pivot towards outcomes measures (such as diabetes and blood pressure control). We also believe there are too many measures causing overwhelm, frustration, and waste for primary care providers and practices. CMS should review the measures across all its programs and look for ways to reduce redundancy, friction, and inconsistencies. Currently the required measures for Medicare, Medicaid and Marketplaces do not match even when clinically appropriate across populations.

Additionally, the performance for many QHP issuers on metrics within the QRS Measure Set is very poor and has not improved for years. Before considering a replacement measure for Medical Assistance with Smoking and Tobacco Use Cessation or the addition of Lung Cancer Screening or any other new measures, the QRS program should focus on improvement mechanisms for the existing measure set. Increasing the number of measures does not lead to behavior change unless there is health plan accountability through requirements such as public dashboarding or financial incentives. Several Marketplaces, including Covered California, have deployed novel ways to improve health plan quality using the current QRS measure set and have quantitative outcomes which could be shared with CMS and potentially scaled. We encourage a joint learning session between CMS, State-Based Marketplaces and the Federally-Facilitated Marketplace to truly make America healthy.

Thank you for the opportunity to comment.

Sincerely,

S. Monica Soni, MD
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