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:

This letter comes to you on behalf of Covered California, the Oregon Health Insurance Marketplace, and the Washington Health Benefit Exchange. We appreciate the opportunity to submit the following comments in response to the Centers for Medicare & Medicaid Services (CMS) Draft 2025 Call Letter for QRS and QHP Enrollee Experience Survey. As long-standing, active State-Based Marketplaces, our three states have leveraged the Affordable Care Act (ACA) to not only expand access to health coverage, but also to improve the quality of care provided to our citizens. 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 enrollees, and making strides toward the triple aim of better health, better care, and lower costs.

We applaud this administration's focus on overall wellness and chronic conditions. In addition to the measure-specific comments below, we urge CMS to consider how policies like automatic re-enrollment and more generous plan designs allow insurance issuers to better assist enrollees in improving and maintaining health.

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, (8) Potential QRS and QHP Enrollee Survey Revisions for Future Years.

CMS Quality Priorities for the 2025 Ratings Year and Beyond

California

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 holistic care. We support and agree with centering a comprehensive approach which includes mental, social, and physical health.

To that end, 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 costs (deductibles and cost-sharing), quality measures and, critically, enrollee demographic data. The ability to stratify 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. 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. 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 Community framework reduces waste, friction, and confusion across the health care ecosystem.

Oregon

The Oregon Health Insurance Marketplace has long been involved in the CMS Marketplace Quality Initiatives work. We asked to be part of the QRS pilot when it was first introduced, have developed our own Quality Improvement Strategy form, and have participated in the QRS QIS Technical Expert Panel (TEP) since 2019. As a State-Based Marketplace using the Federal Platform for eligibility and enrollment, (SBM-FP), Oregon does not have access to much of our enrollee data. The QRS is an important tool we use to monitor the effects of our state-level policies and our progress toward our parent agency's goal of eliminating health inequities by 2030.

Washington

The Washington Health Benefit Exchange (WAHBE) is a State-Based Marketplace established as a public-private partnership in 2011 by state legislation. WAHBE is governed by a bi-partisan board and has participated in the QRS/QIS TEP since its

inception. In pursuit of our mission to redefine people's experience with health care, WAHBE has developed a robust quality program, which includes requirements beyond the federal QRS requirements that support state priorities and state-specific QIS form.

WAHBE has required carriers to stratify clinical quality measures by key demographic information, including race/ethnicity and urban/rural designation since 2023 in their QIS reporting. The intent of the stratification is to identify the populations of customers who carriers and providers should devote more resources to ensure these enrollees receive the care they need to improve and to maintain health. As CMS outlines in Healthy People 2030, these factors outside the provider's office, such as where an enrollee resides, can impact their health significantly. It is critical that CMS continues to collect this enrollee demographic data to ensure that the significant federal investment in coverage is resulting in all enrollees receiving appropriate and timely care. A recent actuarial study estimated that socioeconomic disparities in chronic diseases rates such as diabetes and asthma resulted in an additional $320 billion in annual health care spending in the United States.[1]

Our three states 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. We also support 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. We have therefore included below measures which meet the agency-wide priorities:

Measure	**Measure Steward**	**Explanation**
Continuity of Care Index (CoC)	NQF	Increasing the CoC index has been shown to reduce costs, reduce hospitalizations, and lower mortality. 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)	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, CA, OR, and WA urge reconsideration. For promotion of nutrition and happiness to occur, the Exchanges must have the ability to track the social and environmental challenges impeding or supporting health.

While challenging to collect at a plan-level, the Agency could explore shifting towards patient reported measures such as the Patient Activation Measure (PAM) over a longer horizon. 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. We recommend CMS leverage of the QRS QIS TEP for a more extensive conversation on how best to implement patient reported measures.

Proposed Removal of Select Measures

We agree 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) given measure challenges in the Exchange population and small denominator sizes.

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 enrollees, we recommend 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.
Follow-Up After Emergency Department Visit for Individuals with Multiple High-Risk Chronic Conditions	NCQA	Plan-attributable, uses digital claims-based data, and identifies a vulnerable, high-utilizer population. It aligns with CMS's chronic care management and APM goals and fills a critical gap in current QRS safety measures.
Transitions of Care Composite (e.g., medication reconciliation,	NCQA	Supports care continuity and patient safety during hospital transitions, an area increasingly prioritized in CMS programs. Can

care plan transmission, post-discharge follow-up)		leverage electronic data exchange (e.g., FHIR), and align with CMS's Digital Quality Strategy and person-centered frameworks.

However, we argue that if the agency desires measures that advance whole person care, removal of Social Need Screening and Intervention (SNS-E) is flawed. Given nutrition is a priority of the agency, it is critical that carriers and providers report on screening efforts for food security to find those members in the QHP population who need extra support in this area. Moreover, 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]

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. 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] Additionally, current QHP enrollees will eventually age into Medicare. If today's QHP enrollees have their social needs addressed upstream when they are younger, they will be in better health and have fewer chronic conditions as older adults in Medicare.

In a Covered California 2024 Member Survey, 44% of members reported that they were unable to afford basic needs in the past year. In the same survey, 12% of members reported concerns about stable housing and 16% reported concerns about food in the past 60 days.[4] Oregonians have similar experiences, with over 50% of low-income Oregonians facing unaffordable housing costs and 12.8% of all Oregonians experiencing food insecurity.[5] [6]

Proposed Addition of Select Measure

Our three states strongly support the inclusion of measures which center the enrollee experience, affordability of care, and efficiency. We applaud the creative approach to use 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. We caution that survey response rates have been highly variable year after year. As an example, for these 4 questions on cost, in all 3 of our marketplaces, most issuers have less than 200 respondents. We encourage CMS to work with a measure steward to develop empirical evidence on the acceptability, reliability, and validity of creating a composite 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 encourage CMS to consider these additional 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 FPL. This could also be expanded to the share of income spent on total out-of-pocket expenses including premiums and cost-sharing for services.
Median Out-of-Pocket Cost by Category	National Association of Insurance Commissioners (NAIC)	A plan-reported measure that captures the median out-of-pocket (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. We recommend CMS pilot this 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	We support 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. Tracks the rate at which members do not initiate prescribed medications within a defined timeframe, reflecting potential affordability barriers such as high out-of-pocket 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

Thank you for acknowledging and proposing the inclusion of BPC-E in 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.

QRS QIS TEP has indicated in the past that national benchmarks will be provided for first-year measures, and these benchmarks 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 BCS-E and AIS-E and to do so with an overlap period to ensure no gaps in measurement. We support the refined measure specifications for AIS-E to reflect the recommendations of the CDC and ACIP.

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, we recommend continuing separate reporting on IDSS by age band for a period of at least 3 years. As USPSTF 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 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. Critically 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 CCS, IMA, and 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 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 are 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. Since 2022, WA carriers have been required to include cervical cancer screening as a measure on their QIS, and WAHBE set a performance standard for this measure. Given our marketplace's focus on this measure, it is important that the carriers' efforts are calculated as part of the 2026 RY.

Proposed Revisions to the QHP Enrollee Survey Sample Frame Variables

We support 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

Our three states support 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, rulemaking or PRA 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.

CA, OR, and WA recommend that CMS re-evaluate the scoring of the Member Experience and Plan Administration domains. Because most of 2024 Rating Units (RU) received a star rating of 4 or 5 for Member Experience and Plan Administration, the star ratings for these domains are not meaningful as a signal to customers that a plan is performing high. A more effective methodology would result in a wider range of star ratings where a 4- or 5-star rating is reserved for carriers with above average to excellent performance.

2024 Global and Summary Indicator Ratings Distribution (N=315 Ratings-Eligible RUs)

	Global Rating	Medical Care Rating	Member Experience Rating	Plan Administration Rating
Star Rating	Percent of RUs	Percent of RUs	Percent of RUs	Percent of RUs
1-star	1% (3)	3.5% (11)	0% (0)	0% (0)
2-star	6% (19)	17.8% (56)	0% (0)	0.6% (2)
3-star	35.6% (112)	34.3% (108)	0% (0)	19.7% (62)
4-star	39.7% (125)	29.5% (93)	12.4% (39)	61.3% (193)
5-star	6.7% (21)	5.7% (18)	51.7% (163)	10.5% (33)
NR	11.1% (35)	9.2% (29)	35.9% (113)	7.9% (25)

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.[6] Knowing this is a common experience, QRS would be remiss to exclude these options, however, at a minimum, we recommend consideration of a new selection choice of “appearance” to allow tracking.

Another question CMS could consider adding is about the customer’s experience with using the provider directory. An ongoing challenge for customers is inaccuracies in the provider directory which cause difficulties with shopping and in some cases, out-of-date, which leads the customer to select a plan that does not cover their provider.

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 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 6 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 6 months, how often did he or she have your medical records or other information about your care?

- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

- In the last 6 months, how often were the forms from your health plan easy to fill out?

- In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?

Finally, our three states agree with adding an email reminder for the survey instrument and adjusting the email title of the survey to improve response rates.

For the QRS Measure Set, we 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 which are 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 Exchange 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. Simply adding more 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,

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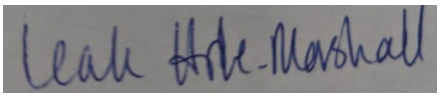

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