March 20, 2026

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, the Oregon Health Insurance Marketplace, and the Washington Health Benefit Exchange appreciate the opportunity to submit the following comments in response to the Centers for Medicare & Medicaid Services (CMS) Draft 2026 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 care, but also to improve the quality of care provided to our residents. Our efforts are rooted in a strong commitment to accountability and continuous improvement, ensuring that the QHPs 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 our enrollees, and making strides toward the triple aim of better health, better care, and lower costs.

We share the comments below related to the specific topics of:

Proposed Removal of Select Measures

Removing Asthma Medication Ratio (AMR) Measure

We agree with the removal of the Asthma Medication Ratio measure, as the specifications no longer align with current clinical guidelines. We agree with exploring a replacement measure given the prevalence of asthma in the Exchange population.

Removing the Childhood Immunization Status (CIS-E) and Immunization for Adolescents (IMA-E) Measures

The stability of the QRS measure set is critical for tracking performance trends and implementing population health interventions that keep Marketplace enrollees healthy. Importantly, many states have already implemented multi-year programs that hold health plans accountable for delivering more preventive care to improve the overall health of the enrolled

population. These state programs rely on the CMS QRS measure set as foundational to reduce administrative burden, wasteful duplicative reporting, and cost. Therefore, CMS's decision to abruptly remove these measures undermines current state-led health plan accountability programs and leads to the proliferation of multiple reporting pathways.

While we understand the agency's priorities have shifted away from preventive care, such as immunizations, we strongly oppose the proposed approach to the Childhood Immunization Status (CIS-E) and Immunizations for Adolescents (IMA-E) measures. To preserve the autonomy of State-Based Marketplaces and health plan accountability for preventive care and population health, we recommend that CMS move CIS-E and IMA-E to reporting-only measures. The data should then be included in QHP issuer submissions to CMS via NCQA's Interactive Data Submission System (IDSS) and reported in the QRS Proof Sheets, along with the percentiles and benchmarking, as would be typical for any reporting-only measure. This would allow the agency to remove the measures from health plan scoring as desired but minimize the other adverse impacts.

Removing the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) Measure

We support CMS's proposal to remove the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure from the QRS measure set beginning with the 2027 ratings year. Continuing to collect and score MSC through the 2026 ratings year provides an appropriate transition period for issuers and supports continuity in quality monitoring while plans prepare for the implementation of the replacement measure. This phased approach balances stability in the QRS program with alignment to evolving clinical quality standards.

Proposed Addition of Select Measures

Adding the Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E) Measure

While we support the exploration of a new asthma replacement measure, we caution that often measures that function well in large group or other lines of business have structural issues in a "high churn" population present in Exchanges. Generally, follow-up measures have low denominators because meeting the requirements for collecting data on the same individual over multiple years is difficult in Exchanges where enrollees frequently change carriers or move in and out of the market. Therefore, we would recommend that the Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E) measure be first tested on enrollee-level External Data Gathering Environment (EDGE) data before being implemented, and then, if implemented, remain as reporting-only for at least one year to allow learning.

Adding the Tobacco Use Screening and Cessation Intervention (TSC-E) Measure

We support CMS's proposal to add the Tobacco Use Screening and Cessation Intervention (TSC-E) measure beginning with the 2027 ratings year as a replacement for the MSC measure. TSC-E is a strong and timely measure because it reflects the evolving landscape of nicotine use and reinforces a comprehensive, evidence-based approach to prevention and cessation. By requiring both screening and documented intervention, the measure appropriately emphasizes not only identification of tobacco use but also clinical follow-through, which is essential to improving health outcomes and reducing long-term morbidity and costs.

Importantly, the measure's inclusion of commercial tobacco products, including electronic cigarettes (vapes), significantly strengthens its clinical relevance. Given the rise in vaping among adolescents and young adults, capturing e-cigarette use ensures the measure keeps pace with emerging nicotine delivery products rather than focusing solely on combustible

tobacco. The expanded age range, beginning at age 12, supports early identification and intervention during a critical period of risk, while the use of Electronic Clinical Data Systems (ECDS) advances modernization of quality reporting and the integration of tobacco and vaping cessation efforts into routine clinical care.

Potential Revisions to the QHP Enrollee Survey

We support the addition of five screener questions to the QHP Enrollee Survey. This approach helps reduce enrollee burden and survey fatigue, which should lead to an increase in survey completion rates. Additionally, we support extending the survey telephone dialing timeframe and initiating calls earlier to improve response rates as current response rates are insufficient for many carriers to calculate reliable results.

We also support CMS's proposal to align the QHP Enrollee Survey with the updated *OMB Statistical Policy Directive (SPD) No. 15 Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*. Specifically, we agree with combining the currently separate race and ethnicity questions and revising the response options to reflect the updated federal standards. The proposed approach would continue to provide QHP issuers with meaningful insight into member experience across populations. This proposal would also reduce respondent confusion with the two-question structure, especially among respondents who identify as Hispanic or Latino and do not identify with the 1997 SPD 15 race categories.

Potential QRS and QHP Enrollee Survey Revisions for Future Years

We continue to support CMS's transition to ECDS-based reporting, including a period of dual reporting for key measures. As emphasized in previous QRS draft call letter responses, adopting dual reporting with both traditional and ECDS methods during a transitional period will facilitate industry-wide learning, adjustments, and investments by QHP issuers and providers. This phased approach is critical to ensuring continuity in evaluating performance on key quality indicators, safeguarding against gaps in scoring or benchmarking. Maintaining momentum remains a cornerstone of an effective quality program. Therefore, we urge CMS to calculate and share benchmarks, performance distributions, and comparative results for these measures even in the initial year before ECDS measures are incorporated into QRS scoring.

We also support CMS's reconsideration of the QRS measure set and urge alignment of measures across Medicaid, Exchange, and Medicare to reduce clinician burden and streamline reporting of clinically appropriate measures. We recommend narrowing the measure set and concentrating on a targeted set of high-impact metrics that demonstrably reduce morbidity and advance overall health, wellness, and well-being. Our three states have previously submitted a list of measures that align with the agency-wide priorities in our 2025 CMS QRS Draft Call Letter comments.

Finally, we agree with CMS's exploration into potential refinements to the QRS Survey methodology in future years that would more meaningfully capture distinctions in QHP performance. A small performance spread in star ratings limits consumers' ability to effectively differentiate QHPs based on quality and value. Refinements that lead to a wider distribution of star ratings will increase QHP accountability, transparency, and performance, enabling members to make more informed decisions when selecting a QHP.

We appreciate your consideration of these comments and your partnership in ensuring the ACA continues to improve care for all Americans. Several marketplaces, including Covered

California, have successfully used the current QRS measure set to drive measurable quality improvements; we encourage CMS to convene a joint learning session with State-Based Marketplaces and the Federally Facilitated Marketplace to share these results and identify scalable strategies to improve health nationwide.

Thank you for the opportunity to comment.

Sincerely,

S. Monica Soni, MD
Chief Medical Officer, Covered California

Chiqui Flowers
Director, Oregon Health Insurance Marketplace

Leah Hole-Marshall
General Counsel, Chief Strategist, Washington Health Benefit Exchange