Health Insurance Exchange Consumer Experience Surveys: Qualified Health Plan Enrollee Experience Survey

Federal Register Notice 60-Day Comments

OMB Control Number: 0938-1221

Centers for Medicare & Medicaid Services

PUBLIC SUBMISSION

Comment on CMS-2023-0044-0001

Posted by the **Centers for Medicare&Medicaid Services** on Apr 17, 2023

Comment

Vaccine data shouldn’t be included in data collection people should not be under surveillance over there vaccine choices.

Comment ID

CMS-2023-0044-0002

Tracking Number

lfi-x2kq-24an

Comment Details **Submitter Info**

Submitter Name

Anonymous Anonymous

Category

Consumer Group

Submitted via Federal e-Rulemaking Portal: http://www.regulations.gov

William N. Parham, III
Director, Paperwork Reduction Staff
Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development
Centers for Medicare & Medicaid Services
Attention: Form Number: CMS-R-246 (OMB control number: 0938- 0732), Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

May 4, 2023

Re: CMS-10488: Consumer Experience Survey Data Collection

Director Parham,

Elevance Health appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) "Consumer Experience Survey Data Collection" information collection request, published on March 20, 2023.

Elevance Health is a lifetime, trusted health partner fueled by its purpose to improve the health of humanity. The company supports consumers, families, and communities across the entire care journey – connecting them to the care, support, and resources they need to lead healthier lives. Elevance Health's companies serve more than 118 million people through a diverse portfolio of industry-leading medical, digital, pharmacy, behavioral, clinical, and complex care solutions. For more information, please visit www.elevancehealth.com or follow us @ElevanceHealth on Twitter and Elevance Health on LinkedIn.

Executive Summary

Serving beneficiaries and ensuring access to equitable, high-quality healthcare, supports, and services is at the center of all that we do. The beneficiary is the core of our focus and, as such, we recommend revisions to the Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) to ensure that it is meaningful for beneficiaries and actionable for health plans.

Specifically, we urge CMS to address a health plan's potential to oversample members, survey length, response rates, and mode of response. Elevance Health also supports additional survey content revisions, including removal of the term "Qualified Health Plan" from the survey, incorporating a question near the beginning of the survey that asks about member utilization of the health plan within the last six months, and removal of the emergency room as a site of service referenced on the survey.

Lastly, we strongly urge CMS to consider survey and quality measure alignment when revising the QHP Enrollee Survey. Because there is significant survey content overlap between the QHP Enrollee Survey and other surveys used by health plans in CMS programs, including the Medicare Advantage and Prescription Drug Plan (MA-PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, we urge CMS to align survey revision efforts of the QHP Enrollee Survey and the MA-PDP CAHPS survey to ensure comparability and efficacy.

Detailed Comments

Survey Length and Response Rates

While response rates are not publicly available for the QHP Enrollee Survey, we believe that response rates for the survey have declined steadily over the past few years, consistent with response rates for other member and patient experience surveys used by CMS and for health plan accreditation, as beneficiaries experience survey fatigue.[1] The 70-question QHP Enrollee Survey, which can be completed via mail, email, or phone, is the longest member/patient experience survey used by CMS across its quality reporting and value-based programs. This places a significant burden on respondents and contributes to survey fatigue and low response rates. For many plans, declining response rates lead to non-reportable results which must still be filed but provide no value or actionable insights to improve enrollee experience. As evidenced by the 2020 and 2021 Measurement Years (MY) Public Use Files, an increasing number of plans are unable to report scoreable Enrollee Experience Summary indicators on HealthCare.gov. For example, in MY 2021, 58 of the 264 QHPs did not have a scoreable Enrollee Experience Summary indicator, compared to just 17 of 209 plans in MY 2020.[2] This indicates that plans are increasingly unable to meet the case and denominator minimums

---

[1] Medicare Advantage and Prescription Drug Plan CAHPS Survey: *CAHPS Survey National Response Rates. MA-PDP CAHPS* (July 1, 2022): https://www.ma-pdpcahps.org/globalassets/ma-pdp/comparative-data/2022/current-and-historic-cahps-overall-response-rates.pdf

[2] Public Use Files. Nationwide QRS PUF for Plan Years 2023 and 2022. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/aca-mqi/downloads/mqi-downloads

required to calculate scores. This is problematic for several reasons but particularly because it leaves consumers with limited or no comparable data for making informed decisions.

To collect more data and allow plans to meet the minimum requirements for calculating an Enrollee Experience Summary indicator, we strongly urge CMS to eliminate the 30% cap on oversampling. Currently, the standard sample size for QHP issuers is limited to 1,300 enrollees. Even with the 30% oversampling allowance, QHP issuers are still limited to a total sample size of 1,690 enrollees. This oversampling limitation, coupled with the minimum number of 100 responses at the question level for public reporting, severely restrains the ability of plans to provide critical performance data to consumers. For example, in Ratings Year 2022, half of our plans did not meet the minimum number of 100 responses at the question level for at least half of the measures (QRS half-scale rule) to generate publicly reported Enrollee Experience Summary indicators on HealthCare.gov. Eliminating the cap on oversampling would allow QHP issuers to survey significantly more enrollees, thereby increasing the number of question-level and total survey responses, in addition to generating more publicly reported performance data. This critical revision should not result in additional administrative burden for QHP issuers or CMS since the survey vendors field the survey, including sampling, quality control, and data submission. Notably, eliminating the cap on oversampling would also align QHP Enrollee Survey oversampling procedures with the MA-PDP CAHPS survey, which does not have an oversampling cap.

Additionally, we support any efforts to shorten the length of the questionnaire, including revisions to the survey to remove non-essential survey items (such as those that are not scored). We also recommend removal of the *Assistance with Smoking and Tobacco Use Cessation* questions due to limited survey responses on these measures.

CMS has previously expressed interest in adding new survey questions related to sexual orientation and gender identity to the QHP Enrollee Survey. Elevance Health strongly supports – and shares – the goal of advancing health equity. However, we urge CMS to clarify the purpose of collecting this data before potentially adding questions to the survey, such as whether this information would be used in risk adjustment and/or case-mix adjustment. We do not believe this data would be useful in health plans' efforts to advance health equity because it cannot be used at the member level. When we try to stratify or segment existing data by demographic elements, we experience barriers related to the number of members that are included in these analyses, limiting the information that can be gathered for both informational and improvement purposes. Given individuals' hesitancy to respond to questions like these, we urge CMS to more fully evaluate the usefulness of these questions, especially given the current survey length. Instead, CMS should work to collect this information at enrollment.

Regarding survey mode, we are pleased that CMS has already incorporated a web-based option to the QHP Enrollee Survey administrative protocols. However, we encourage CMS to allow prenotifications and survey invitations via text message and/or other electronic means.

Recommendation: Elevance Health recommends the following policies to address QHP Enrollee Survey length and response rates:

- Eliminating the cap on oversampling;
- Reducing the number of survey questions by removing non-essential survey items (such as those that are not scored);
- Removing the *Assistance with Smoking and Tobacco Use Cessation* questions;
- Evaluating the potential addition and usefulness of questions on sexual orientation and gender identity and, instead, work to collect this information at enrollment; and,
- Allowing survey prenotifications and invitations via text message and/or other electronic means.

Survey Content

We also believe that survey response rates, and therefore publicly reported data on HealthCare.gov, would improve with multiple revisions to the QHP Enrollee Survey content to result in a smaller, more effective set of questions. First, we encourage CMS to remove the “Qualified Health Plan” term from the survey. “Qualified Health Plan” is not a line of business and members are not familiar with the acronym. This could increase confusion and potentially lead to a higher rate of survey abandonment.

Second, the QHP Enrollee Survey does not accommodate members who did not use their health plan within the last six months. For example, if the survey respondent did not use their health plan within the last six months, they would still be asked to complete questions 3-17, 20-44, and 49-53, as there is no “Skip” or “I did not use my health plan” response option. Members are repeatedly asked to indicate – at the question level – whether certain aspects of their experience are applicable to them. This increases the time it takes for the member to answer the survey, even if they have not used their plan within the last six months, and could lead to survey fatigue and lower response rates. Moreover, the respondent cannot effectively rate a plan, personal doctor, or specialist if they did not recently have contact with them or use their health plan. Instead, we recommend CMS incorporate a question near the beginning of the survey that asks whether the member used their health plan within the last six months, immediately followed by questions that are applicable to all members, including those that may have not used their health plan within that last six months.

We also support the removal of the flu vaccine measure. This information may be difficult for members to recall, especially if the vaccine was administered outside of the health plan, such as through a community event or a local pharmacy. Additionally, the measure source for the *Flu Vaccinations for Adults Ages 18–64* measure (flu vaccine measure) is the Healthcare Effectiveness Data and Information Set (HEDIS) CAHPS survey, which the National Committee for Quality Assurance (NCQA) has removed from the HEDIS measure set for Measurement Year 2023.

We also recommend aligning any race and ethnicity questions with the Office of Management and Budget's (OMB) updates to its Race and Ethnicity data standards, once they are finalized, for greater data standardization and accuracy.

Lastly, the QHP Enrollee Survey includes questions about care received at a clinic, emergency room, doctor's office, or by telephone or video. However, we encourage CMS to remove the emergency room as a site of service for the purposes of the survey. In addition to the QHP Enrollee Survey being used by CMS, the data is also used to support health plan accreditation standards related to appointment accessibility. However, unlike clinics or doctors' offices, the emergency room is not an appropriate site for measuring appointment accessibility and is not comparable.

Recommendation: Elevance Health strongly supports the following revisions to the QHP Enrollee Survey content:

- Removing the term "Qualified Health Plan" from the survey;
- Adding a survey question near the beginning of the survey that asks the member whether they used their health plan within the last six months, immediately followed by questions that are applicable to all members;
- Removing the flu vaccine measure;
- Aligning race and ethnicity questions with OMB's updates to its Race and Ethnicity data standards; and,
- Removing the emergency room as a site of service.

Survey and Quality Measure Alignment

Given CMS' focus on meaningful measures and quality measure alignment, such as through the introduction of the Universal Foundation, we strongly urge CMS to consider these goals when revising the QHP Enrollee Survey. Elevance Health supports CMS' goals in developing a Universal Foundation core set of quality measures, as well as narrowing the set of measures used in CMS programs over time to a more focused set of clinical quality measures. There is significant survey content overlap between the QHP Enrollee Survey and other surveys used by health plans in CMS programs, including the MA-PDP CAHPS survey. As a result, we urge CMS to align survey revision efforts of both the QHP Enrollee and MA-PDP CAHPS surveys to ensure comparability and efficacy. This alignment should include both survey content and technical specifications. For example, revisions to technical specifications could include aligning the survey languages offered for both the QHP Enrollee and the MA-PDP CAHPS surveys, as well as limits on oversampling, addressed above.

Recommendation: Elevance Health strongly urges alignment of survey revision efforts and full transparency of these efforts.

***

Elevance Health supports revisions to the QHP Enrollee Survey, and we would like to collaborate with CMS and measure stewards like the Agency for Healthcare Research and Quality (AHRQ) to update and improve the survey to ensure it provides an accurate portrayal of the enrollees' experience and considers the evolving healthcare system, health equity, and the diversity of the QHP enrollee population.

We value the partnership that we have developed with CMS and welcome the opportunity to discuss our recommendations. Should you have any questions or wish to discuss our comments further, please contact Hilary Dempsey at 417-597-6918 or hilary.dempsey@elevancehealth.com.

Sincerely,

Elizabeth P. Hall

Vice President, Public Policy and Issues Management, Elevance Health

AHIP
Guiding Greater Health

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

May 18, 2023

Nidhi Singh Shah
CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: Document Identifier/OMB Control Number: CMS–10488
Room C4–26–05
7500 Security Boulevard, Baltimore, Maryland 21244–1850
Submitted via

RE: CMS–10488 Agency Information Collection Activities: Proposed Collection; Comment Request

Dear Ms. Shah:

AHIP appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services's notice under the Paperwork Reduction Act (PRA) concerning the "Consumer Experience Survey Data Collection" published by the Centers for Medicare & Medicaid Services (CMS) in the *Federal Register* (87 FR 1752) on March 20, 2023. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. Thank you for the opportunity to provide comments and feedback.

Section 1311(c)(4) of the Affordable Care Act (ACA) required the development of an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through the Exchanges (Marketplaces). We have worked closely with CMS to implement this requirement and welcome the opportunity to continue to improve the instrument to ensure the collection of meaningful information about enrollee experience. We share the Agency's goal of gathering actionable information that can be used to improve QHP performance, help consumers compare and select a health plan, and support oversight activities.

Health insurance providers value the data generated by patient experience surveys and strive to provide the best experience possible for their members. We recognize that assessing experience is an important facet of ensuring consumers have access to high-quality care and coverage that meet their needs, and determining where to focus efforts to improve the health care system. However, experience data must be collected in a consumer-friendly way that minimizes the burden on respondents. As survey response rates continue to decline, we must ensure that we are collecting data that will benefit consumers and is actionable by health insurance providers, ensuring the length of the survey is reasonable, and using consistent data standards where possible to promote data interoperability so consumers can provide information like demographic data once rather than be repeatedly asked. With this shared commitment in mind, we offer the following comments to improve the QHP Enrollee Satisfaction Survey (EES).

Maintain Assessment of Influenza Vaccination through the Enrollee Survey

In our response to the Draft 2023 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey, we note concerns about the feasibility of CMS's proposal to retire the Flu Vaccinations for Adults Ages 18-64 measure and to replace it with a new measure, Adult Immunization Status (AIS-E), beginning with the 2024 ratings year. AHIP acknowledges the importance of promoting compliance with all Advisory Committee on Immunization Practices (ACIP) recommendations. However, we have concerns that the use of a single rate assessing members who are compliant for all indicators could create unfair penalties for issuers. A single all-or-nothing rate could miss important regional and/or cultural variation in vaccine acceptance. The use of a single combination rate could necessitate the addition of exclusion criteria to account for patient choice as well as the consideration of a grace period to account for delays in vaccinations caused by consumer reluctance over fears for contracting COVID-19.

We also are concerned about the feasibility of implementing this measure and the completeness of the data it will generate. Immunization information is often not captured electronically, and data elements such as immunization status are not consistently or accurately coded. Data collection for these measures can be difficult for health insurance providers operating in states with limited or no immunization registries or where they do not have access to immunization registries as health insurance providers may not get information on vaccines received in non-traditional settings (e.g., an employer-sponsored event or event managed by a public health department).

We also do not support mandatory HEDIS Electronic Clinical Data System (ECDS) reporting. Health insurance providers have expressed difficulty getting provider buy-in on current digital approaches such as NCQA's ECDS measure reporting. Clinicians may be reluctant or unwilling to share information contained in those records with public or private sector payers or may not use electronic health records. CMS should work with NCQA to develop a hybrid version of this measure to allow health insurance providers to report using alternative data sources.

Given the challenges of implementing the AIS-E measure and the importance of assessing rates of flu vaccination, CMS should not remove the flu vaccine question from the Enrollee Survey to support continued data collection for the Flu Vaccinations for Adults Ages 18-64 measure.

Implement Consistent Race and Ethnicity Data Standards

AHIP strongly supports CMS' efforts to advance accurate and reliable demographic data collection that allows individuals to share information on a voluntary basis about their race and ethnicity that aligns with how they identify themselves. Robust, accurate, actionable demographic patient data that is standardized and interoperable is fundamental to advancing health equity and improving health outcomes. Such data is necessary to detect disparities, inform solutions that take cultural preferences and socioeconomic circumstances into account, and assess what interventions are most impactful effectively and efficiently. The collection and analysis of this information will aid health insurance providers' efforts to identify and address health care disparities.

However, we are concerned with the use of conflicting data standards across federal programs. Using different data standards for different forms and instruments will limit the interoperability and accuracy of data. Given the Office of Management and Budget (OMB) recently proposed revised race and ethnicity data standards, aligning with the 2011 HHS Data Collection Standard risks collecting information differently across instruments.

Standardizing and improving demographic data has been a priority of the health insurance industry. Between 2020 and 2022, AHIP sought to develop improved demographic data standards that are more aligned, patient-centered, and actionable than the various standards that exist today. AHIP employed an evidence-based and stakeholder-driven process to conduct this work by convening diverse groups of health insurance providers and other stakeholders (e.g., patients representing different communities, providers, community-based organizations, others). In addition to race and ethnicity, our workgroup also developed recommended data standards for language, sexual orientation, gender, pronouns, relationship status, disability status, military experience, and spirituality. We hope this work will lead to high-level data standardization and alignment across the health care ecosystem while allowing for local granular customization. This will ensure organizations can collect a reasonable amount of data that is actionable and relevant for their local communities while still aggregating and exchanging data seamlessly with appropriate entities.

We encourage CMS to work with stakeholders to standardize these types of data collection across programs. A consistent approach to data collection across federal programs and across public and private stakeholders would lead to more accurate, complete, and interoperable data for all. We recommend CMS make several revisions to the race categories to allow individuals to report as they identify and to reduce the number of "Unknown" or "Other", including:

- Add a category in the race question for those who identify as "Arab, Middle Eastern, North African";
- Add an option for "I only identify as Hispanic/LatinX" in the question on race;
- Change "American Indian or Alaska Native" to "Native American, Alaska Native, or Indigenous" given the cultural inappropriateness of the term "American Indian;"
- Allow organizations to get more granular on race and ethnicity based on populations that are most common in their respective service areas to gather more relevant and actionable information as opposed to getting more granular based on national numbers that may not be relevant or helpful to local organizations;

- Provide granularity for other population groups, such as allowing African Americans and Black immigrant populations to identify separately based on their preference, experience, and/or history. Similar granularization should be applied to other groups, such as White; Arab, Middle Eastern, or North African; and Native American, Alaska Native, or Indigenous.
- Add a response choice on "I choose not to respond" to both the race and ethnicity questions to ensure individuals can maintain their personal autonomy whether to disclose personal information or not. Having a response choice on "I choose not to respond" would still allow health insurance providers to collect data on administered questions and differentiate from "skipped" questions.

CMS should work with health insurance providers and other stakeholders to identify ways to improve demographic data collection across the healthcare industry. For example, improvements should be made to the application and enrollment processes for health insurance to collect this data more directly, as well as to standardize and include more data than what is typically collected at the state level, i.e., age and gender. There is also a need for additional standardized categories that could provide health care and health insurance providers with more information about the relative disadvantages a person may be experiencing, or information that would provide for more predictive analysis for a patient. An important component of this could be to align race and ethnicity assessments and categories across states and with the standards maintained by the Office of Management and Budget (OMB). Currently, it is challenging to align with OMB categories when state files do not align. CMS should also work with state Medicaid agencies to improve the consistency of data collection at the time of Medicaid enrollment.

CMS should also consider removing the demographic items from the QHP Enrollee Survey that duplicate information submitted at enrollment and rely on the 834-enrollment file instead. Removing these items would decrease respondent burden and improve the reliability of the data as enrollees will provide more accurate and consistent information about language, race, and income at enrollment.

Conduct a Wholesale Review of the QHP Enrollee Survey to Determine Additions and Removals

AHIP agrees with the potential value of consumer-reported data to drive quality improvements. However, we remain concerned about the utility and efficiency of the QHP Enrollee Survey and appreciate CMS's efforts to ensure it provides actionable information for improvement while minimizing the response burden on consumers. We agree there is a need to shorten the Enrollee Survey to reduce burden and fatigue on respondents and increase the rate of completion of remaining questions, producing more accurate and reliable results. Currently, the length of the survey is not consumer friendly and certain questions are repetitive or confusing. A long survey

not only results in lower response rates but introduces bias into the survey—survey respondents who answer the full set of questions are more likely to provide polarized responses.
In the Draft 2021 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey,[1] CMS proposed the potential removal of 13 items in future from the QHP Enrollee Survey. We generally supported the Agency's proposal as removing the identified items would be an important first step towards reducing the burden associated with the QHP Enrollee Survey. However, in the draft 2022 Call Letter,[2] CMS noted that stakeholders agreed the survey should be shorter there was not agreement on which items to remove and did not remove any items. Additionally, CMS requested feedback on additionally topics that should be added to the QHP Enrollee Survey.

We appreciate the need to modify the survey to address emerging quality and equity concerns and to ensure stakeholder consensus on whether items should be included on the survey. However, the inclusion of new items and retention of items of limited value must be balanced with the concern of overburdening respondents and with the resources required to administer the survey. To address these concerns, we recommend a wholesale new review of the QHP Enrollee Survey in collaboration with stakeholders through a more transparent and fulsome process. Additionally, we request CMS release details of its 2020 "in-depth review" of the survey to inform stakeholders of the rationales for selecting certain survey items for removal. The additional detail would permit more informed decision-making by stakeholders in devising positions and developing comments.

As part of this review, CMS should ensure items on the QHP Enrollee Survey generate actionable information that can be used to drive improvements in quality. As currently written these items are framed in ways that are difficult for health insurance providers to influence or out of a health insurance provider's control or may be written in a way that biases the enrollee's response. For example, several items ask about the enrollee's doctor's communication style and skills. Health insurance providers have limited ability to change a doctor's communication skills but may choose to keep a doctor in-network if he or she performs well on other metrics of quality. Additionally, CMS should consider aligning the questions that are on the QHP survey with the CAHPS survey questions when possible to allow comparisons across Commercial and Exchange members and allow health insurance providers to be scored on the same or similar measures across populations

We recommend CMS work with stakeholders, including AHIP members, to identify the information that is most important to generate from QHP Enrollee Survey, confirm the survey measures aspects of care health insurance providers can influence, ensure items are written appropriately, and determine that the survey does not place undue burden on respondents.

---

[1] https://www.cms.gov/files/document/draft-2021-call-letter-qrs-qhp-enrollee-survey.pdf
[2] https://www.cms.gov/files/document/2022-call-letter-qrs-qhp-enrollee-survey.pdf

Once again, we thank you for the opportunity to comment on the proposed changes to the QHP Enrollee survey and hope that the comments above will be considered in order to ensure effective, consumer-centric data collection. If you have any questions, please contact me at (202) 778-3246 or at dlloyd@ahip.org.

Sincerely,

Danielle A. Lloyd

Danielle A. Lloyd
Senior Vice President, Private Market Innovations & Quality Initatives