Health Insurance Marketplace℠

Draft 2016 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey

Proposed QRS and QHP Enrollee Experience Survey Program Refinements

July 2016

Contents

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1.0 Purpose of the 2016 QRS Call Letter

This document, the draft 2016 Call Letter for the Quality Rating System (QRS) and the Enrollee Experience Survey (QHP Enrollee Survey) for Qualified Health Plans (QHPs) ("2016 QRS Call Letter"), serves to communicate and request comment on the Centers for Medicare & Medicaid Service's (CMS's) proposed refinements to the QRS and QHP Enrollee Survey programs for QHPs for future data submissions and ratings years (i.e., for 2017 and beyond). The refinements proposed in this document focus on stakeholder engagement, QRS and QHP Enrollee Survey participation requirements, and the QRS rating methodology.[1] Proposed refinements to the participation requirements in Section 2.1 apply to both the QRS and the QHP Enrollee Survey programs. This document does not include all potential refinements to the QHP Enrollee Survey program (e.g., other types of survey revisions will be addressed through the information collection request process per the Paperwork Reduction Act requirements, as appropriate).

We encourage interested parties to submit comments on the information presented here to Marketplace_Quality@cms.hhs.gov by the close of the comment period (7/28/2016). After reviewing stakeholder feedback, CMS will finalize its decisions on these proposed changes, and communicate final changes about the QRS program in the final 2016 QRS Call Letter (anticipated to be published in summer 2016). In fall 2016, CMS intends to publish the QRS and QHP Enrollee Survey Guidance and Measure Set Technical Specifications for 2017, reflecting applicable finalized changes announced in the final 2016 QRS Letter.

This QRS Call Letter does not propose changes to regulation, rather it offers details on proposed changes to QRS and QHP Enrollee Survey program operations.

Exhibit 1. Key Terms for the QRS Call Letter provides descriptions of key terms used throughout this document.

Exhibit 1. Key Terms for the QRS Call Letter

Term	Description
Measurement Year	The measurement year refers to the year reflected in the data submission. All measure data are retrospective. The exact period of time represented by the measure is dependent on the technical specifications of the measure. ▪ QRS clinical measure data submitted for the 2017 ratings year (the 2017 QRS) generally represent calendar year 2016 data as the measurement year. Some measures require more than one year of continuous enrollment for data collection so the measurement year for those measures will include years prior to 2016. ▪ For QRS survey measure data in the 2017 QRS, the survey is fielded based on enrollees who are currently enrolled as of January 1, 2017, but the survey requests that enrollees report on their experience "in the last 6 months."

[1] The QRS and QHP Enrollee Survey requirements for the 2016 ratings year (the 2016 QRS) are detailed in Version 2.0 of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016* (2016 QRS Guidance) available on CMS' Marketplace Quality Initiatives (MQI) website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html. The proposed changes outlined in this document would not apply to or otherwise change the 2016 QRS Guidance or Measure Set Technical Specifications.

Term	Description
Ratings Year	The ratings year refers to the year the data are collected (including fielding of the QHP Enrollee Survey), validated, and submitted, and ratings are calculated. For example: ▪ "2017 QRS" refers to the 2017 ratings year. ▪ As part of the certification process for the 2017 plan year, which occurs during the spring and summer of 2016, QHP issuers attest that they will adhere to 2017 quality reporting requirements, which include requirements to report data for the 2017 QRS and QHP Enrollee Survey. ▪ Requirements for the 2017 QRS, and details as to the data collection, validation, and submission processes, are released in the 2017 QRS and QHP Enrollee Survey Technical Guidance (anticipated release in September 2016). ▪ Ratings calculated for the 2017 QRS are displayed for QHPs offered during the 2018 plan year, in time for open enrollment, to assist consumers in selecting QHPs.

For questions and comments concerning this Call Letter, please contact:
Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QRS Call Letter" in the subject line.

1.1 Establishment of an Annual Call Letter Process

CMS is establishing an annual cycle for soliciting stakeholder feedback on proposed refinements to the QRS program. Each year, CMS will use the Call Letter to communicate proposed refinements to QRS program operations, including changes related to the QRS and QHP Enrollee Survey participation criteria, measure set, and/or methodology.

CMS will communicate proposed QRS refinements via the release of a draft QRS Call Letter on CMS's MQI website with a defined period of time for public comment. Once stakeholder feedback is received, CMS will review comments received, make final determinations regarding the proposed refinements, and communicate final changes via the final QRS Call Letter. The final QRS Call Letter will also address themes in comments received on the draft QRS Call Letter. CMS anticipates annually issuing QRS and QHP Enrollee Survey Guidance and Measure Set Technical Specifications for each ratings year, reflecting applicable finalized changes announced in the final QRS Letter.

1.1.1 Timeline for Call Letter Publication

Due to the timeframes for analyses during the 2015 beta test, CMS is following a different schedule for the 2016 QRS Call Letter than anticipated for future years. The condensed schedule this year includes an abbreviated public comment period and release of the final 2016 QRS Call Letter later in the calendar year than is anticipated for future years. CMS will not implement the proposed changes in this particular Call Letter (see Sections 2.0 and 3.0 for proposed changes) until the 2017 ratings year at the earliest.

Going forward, the anticipated annual cycle for the QRS Call Letter will follow a winter-to-spring (approximately December through April) timeline as shown in Exhibit 2. The use of a QRS Call Letter, and the timeline for its release, is informed by the Medicare Advantage and prescription drug (Part D) star rating system's approach for soliciting feedback on proposed program changes.

Exhibit 2. Anticipated Annual Cycle for Soliciting Public Comment via the QRS Call Letter Process

Date	Description
December/January	**Publication of draft QRS Call Letter:** CMS proposes changes to the QRS and provides stakeholders with the opportunity to submit feedback via a 30-day public comment period.
January - March	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS program.
March/April	**Publication of final QRS Call Letter:** CMS communicates final changes to the QRS program and addresses the themes of the public comments.
September	**Publication of QRS and QHP Enrollee Survey Guidance:** CMS provides technical guidance regarding the QRS and QHP Enrollee Survey and specifies requirements for QHP issuers offering coverage through the Health Insurance Marketplaces℠ (Marketplaces). [2]

1.1.2 Timeline for Incorporation of Refinements into the QRS and QHP Enrollee Survey

CMS' timeline for incorporating refinements to the QRS and QHP Enrollee Survey programs in future years will depend on the type of refinement proposed. Beginning with the 2017 QRS Call Letter cycle (anticipated winter 2016 to spring 2017):

- Refinements to the QRS rating methodology[3] proposed in the draft QRS Call Letter (and finalized in the final QRS Call Letter) could take effect in the current ratings year[4] at the earliest. However, the refinements could take effect later if the proposed changes are significant (e.g., see Section 2.2 for an example of a proposed refinement that would take effect on a more delayed timeline).
- Refinements to the QRS and QHP Enrollee Survey participation requirements, measure set, or other significant program refinements proposed in the draft QRS Call Letter (and finalized in the final QRS Call Letter) could take effect in the *following* ratings year at the earliest. The refinements could take effect later if the proposed changes are more significant.

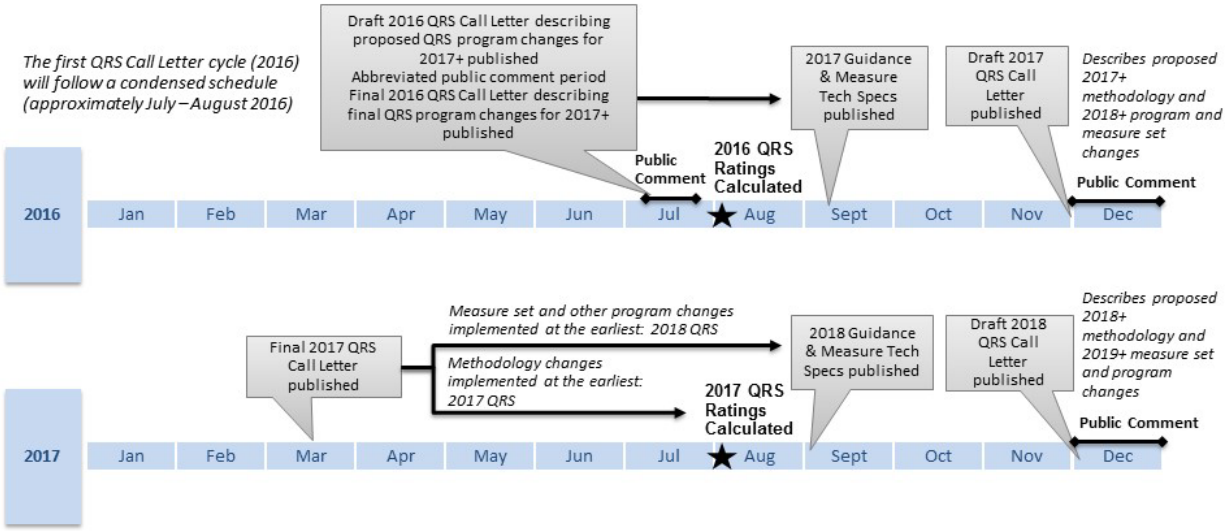
For example, the draft 2017 QRS Call Letter anticipated to be released in December 2016 and final 2017 QRS Call Letter anticipated to be released in April 2017 could include:

- Methodological changes that apply (at the earliest) to the 2017 QRS ratings year. This timing would allow CMS to use QRS measure data from the 2015 measurement year to inform methodological changes to be implemented in the 2017 QRS.
- Measure set or participation requirements changes that apply (at the earliest) to the 2018 QRS ratings year. This timing means these changes would appear in the QRS and QHP Enrollee Survey Guidance for the following year (the 2018 QRS Guidance).
- Refinements to be implemented in future years (2019 QRS ratings year and beyond).

[2] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.
[3] CMS applies 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.
[4] However, the proposed changes communicated in the 2016 QRS Call Letter would not go into effect until the 2017 ratings year or 2018 ratings year at the earliest.

Exhibit 3 below highlights the cycle for the 2017 QRS ratings year.

Exhibit 3. Sample Timeline for Proposing and Incorporating Refinements to the QRS



2.0 Proposed QRS and QHP Enrollee Survey Refinements for 2017 Ratings Year

During the 2015 beta test, CMS tested QRS and QHP Enrollee Survey implementation processes, including data collection, data validation, data submission, data scoring, and data preview. CMS analyzed 2015 beta test data to inform refinements to the QRS for future years. The proposed changes communicated in this Call Letter are based on the results and analysis of the beta test and will not go into effect until the 2017 ratings year or the 2018 ratings year (described in Sections 2.0 and 3.0, respectively) at the earliest.

The QRS and QHP Enrollee Survey requirements for the 2016 ratings year are detailed in Version 2.0 of the 2016 QRS Guidance, which is available on CMS' MQI website. The proposed changes outlined in this document would not apply to or change the 2016 QRS Guidance or 2016 Measure Set Technical Specifications.

2.1 Proposed Changes to the QRS and QHP Enrollee Survey Participation Requirements for 2017 Ratings Year

CMS proposes the following refinements to the QRS and QHP Enrollee Survey requirements for QHP issuers offering coverage through the Marketplaces. Unless the context indicates otherwise, the term "Marketplaces" refers to the Federally-facilitated Marketplaces (FFMs) inclusive of States performing plan management functions, State-based Marketplaces (SBMs), and SBMs on the Federal Platform (SBM-FPs). These proposed requirements would be in addition to the current requirements listed in the QRS participation criteria section of Version 2.0 of the 2016 QRS Guidance and would take effect at the earliest beginning in the 2017 ratings year.

2.1.1 Clarification for QRS and QHP Enrollee Survey Reporting Unit Participation Criteria

CMS proposes including clarifying language to address QRS and QHP Enrollee Survey participation criteria for QHP issuers impacted by a change in control event (e.g., merger, acquisition). Reporting units impacted by a QHP issuer's change in control event would be subject to QRS and QHP Enrollee Survey requirements for a given ratings year under the gaining QHP issuer (i.e., the issuer that continues to operate the reporting units in the ratings year) if the change in control event is effective as of January 1 of the ratings year. In these instances of change in control events, the acquiring QHP issuer should include these new enrollees in its applicable reporting unit (e.g., include enrollees previously aligned to the ceding QHP issuer) for purposes of determining whether the participation criteria for the reporting year have been met.

2.1.2 Additional Minimum Enrollment Threshold for Year of Data Submission

QHP issuers are currently required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data for exclusive provider organization (EPO), health maintenance organization (HMO), point of service (POS), and preferred provider organization (PPO) product types offered through a Marketplace in the previous year. For the 2016 ratings year, QHP issuers are required to submit validated data for each of the above noted product types offered through a Marketplace in 2016 that had more than 500 enrollees as of July 1, 2015.

During 2016 QHP Enrollee Survey implementation, CMS identified reporting units that met the minimum enrollment threshold for the prior year (as of July 1, 2015), yet experienced a substantial decline in enrollment as of January 1, 2016 (i.e., the start of the ratings year).[5] As a result, CMS is proposing the application of an additional minimum enrollment threshold to QRS and QHP Enrollee Survey participation criteria for the 2017 QRS; specifically, eligible reporting units must have more than 500 enrollees as of July 1 of the prior year *and* more than 500 enrollees as of January 1 of the ratings year to be required to participate in the QRS and the QHP Enrollee Survey.

The existing policy in place for the 2016 ratings year creates a situation in which QHP issuers must field the QHP Enrollee Survey, even if they may not have sufficient enrollees to receive valid survey measure results if such a drop in enrollment occurs. To mitigate unnecessary burden for QHP issuers and to avoid surveying enrollees unnecessarily, CMS is proposing the application of the additional minimum enrollment threshold to the QRS and QHP Enrollee Survey participation criteria for the 2017 QRS. Given this additional threshold, eligible reporting units must have more than 500 enrollees as of July 1 of the prior year and more than 500 enrollees as of January 1 of the ratings year to be required to participate in the QRS and the QHP Enrollee Survey.

This proposed additional enrollment threshold also means reporting units that do not meet both minimum enrollment thresholds would not be required to submit QRS measure data (including both the QRS clinical measure data and QHP Enrollee Survey response data). Further, reporting

[5] QRS clinical measure data is collected based on events and services in the year prior to ratings calculation. However, for QRS survey measures, CMS obtains data from the QHP Enrollee Survey that is fielded to enrollees who are currently enrolled as of January 1 in the ratings year.

units that do not meet the new participation criteria would be ineligible for QRS scoring (i.e., would not receive QRS scores and ratings).

Exhibit 4 is an illustrative example showing a fictional QHP issuer certified to offer family medical coverage in two states: West Virginia (WV) and Maryland (MD). The exhibit shows the characteristics of the issuer's reporting units for the 2017 ratings year. In accordance with the proposed refinements to the 2017 QRS and QHP Enrollee Survey participation criteria, this QHP issuer would be required to collect validated QRS clinical measure data and QHP Enrollee Survey response data and submit it to CMS for the 2017 QRS for only the following reporting units: WV PPO. The other reporting units either did not have a sufficient number of enrollees as of July 1, 2016; did not have a sufficient number of enrollees as of January 1, 2017; or were discontinued before June 15, 2017.

Exhibit 4. Example Reporting Units for a QHP Issuer Assessed against Proposed 2017 QRS and QHP Enrollee Survey Participation Criteria

Reporting Unit	Enrollment as of July 1, 2016 (total and per individual market vs. SHOP)	Offered in 2017 as of June 15, 2017	Enrollment as of January 1, 2017 (total and per individual market vs. SHOP)	Meet participation criteria? (i.e., required to submit QRS and QHP Enrollee Survey measure data)?
WV PPO	505 (505 individual, 0 SHOP)	Yes	505 (505 individual, 0 SHOP)	Yes
WV HMO	601 (501 individual, 100 SHOP)	No – discontinued as of December 31, 2016	N/A	No – not operating in ratings year
MD PPO	100 (55 individual, 45 SHOP)	Yes	100 (55 individual, 45 SHOP)	No – insufficient enrollment size in both years

2.1.3 Handling of Voluntary Data Submissions

According to the 2016 QRS Guidance, CMS accepts voluntary submissions from QHP issuers who are not required to submit QRS and QHP Enrollee Survey data, but these submissions are not scored. Consistent with guidance to date, reporting units must meet the defined QRS participation criteria for their data submissions to be used for scoring. For the 2017 ratings year, CMS proposes to not accept voluntary submissions from QHP issuers.

CMS is revisiting its policy about voluntary submissions given the technical level of effort and dedicated resources required for issuers to submit and CMS to accept such data submissions , combined with the low volume of voluntary submissions during the 2016 data collection process. Specifically, CMS proposes that voluntary data submissions for QHP Enrollee Survey response data and QRS clinical measure data would not be accepted beginning with the 2017 ratings year.

2.2 Proposed Refinements to the QRS Methodology and Measure Set for 2017

CMS will not revise the QRS rating methodology for the 2016 ratings year. In this section, CMS describes proposed refinements for the QRS rating methodology for 2017.

For the 2017 ratings year, CMS will include all measures in the QRS measure set in scoring, except the Relative Resource Use (RRU) measure. Consistent with the 2015 and 2016 QRS Guidance, CMS will not include the RRU measure in scoring due to the additional testing CMS intends to conduct with this measure.

For the 2015 and 2016 QRS, CMS only included in scoring those measures that required one year of data per the continuous enrollment criteria as defined in the measure technical specifications. For the 2017 QRS, CMS will include in scoring those measures that required one year of data and those that require multiple years of continuous enrollment.

CMS proposes making changes to QRS clinical measures in the QRS measure set for 2017 in alignment with the Healthcare Effectiveness Data and Information Set (HEDIS) 2017 measures. The HEDIS specifications are the main source for the QRS Measure Technical Specifications, released alongside the QRS Guidance each fall. During its own, separate public comment process, the National Committee for Quality Assurance (NCQA) considered updates to HEDIS 2017 measures for the next iteration of the HEDIS 2017 measure set. The proposed changes to the QRS measure set – to reflect NCQA finalized updates to the HEDIS 2017 measures – would go into effect for the 2017 ratings year (data submission in summer 2017).

The NCQA proposed changes for HEDIS 2017 would result in changes to three QRS clinical measures:

1. Use of Imaging Studies for Low Back Pain (LBP)
2. Immunizations for Adolescents (IMA)
3. Human Papillomavirus Vaccine for Female Adolescents (HPV)

NCQA proposed to combine the IMA and HPV measures, to assess receipt of all recommended vaccines (meningococcal, Tdap, and HPV) for males and females in one IMA measure. NCQA proposes to retire the current HPV measure. Details of the proposed HEDIS 2017 updates are provided at http://www.ncqa.org/homepage/ncqa-public-comments/hedis-2017-public-comment.

For the 2017 QRS, CMS proposes aligning the QRS measure specifications with the HEDIS 2017 specifications once the proposed changes to the HEDIS 2017 measures are finalized. Incorporating these specification changes as recommended by the measure steward allows the QRS to align with the latest clinical standards. The combination of the IMA and HPV measures affects QRS scoring, but the proposed change to the LBP measure will not affect QRS scoring.

As shown below in Exhibit 5, in the current QRS hierarchy the IMA and HPV measures are distinct measures within the Staying Healthy Child composite. CMS proposes to align the QRS measure specifications with the final HEDIS 2017 specifications: IMA measure (Combination 2). Additionally, CMS proposes to not include the updated IMA measure in scoring for one year (for the 2017 QRS/2017 ratings year).

Exhibit 5. Extract from QRS Hierarchy Demonstrating Impact of Proposed Incorporation of HEDIS Update to Immunizations for Adolescents (IMA) Measure

QRS Composite	Measure	National Quality Forum (NQF) Endorsement
Staying Healthy Child	Annual Dental Visit	Not Endorsed
	Childhood Immunization Status (Combination 3)	0038
	~~Human Papillomavirus Vaccination for Female Adolescents~~ - ***REMOVED***	~~1959~~
	~~Immunizations for Adolescents (Combination 1)~~ - ***REMOVED*** Immunizations for Adolescents (Combination 2) - ***NEW***	~~1407~~ 1407
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024
	Well-Child Visits in the First 15 Months of Life (Six or More Visits)	1392
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516

This approach would allow CMS to align the QRS measure specifications with those of measure stewards, while also assessing the effect of this change on QRS scoring. This approach would align with the Medicare Stars policy for handling similar significant measure specification changes.[6] CMS would continue to include the LBP measure (as updated) in scoring for the 2017 ratings year.

3.0 Proposed Revisions for 2018 and Beyond

CMS is also beginning to consider refinements for the 2018 ratings year and beyond. Topics for future evaluation or consideration may include, but are not limited to: recommended refinements to the QRS survey measures, the use of an explicit weighting structure, and/or development of a strategy to risk adjust QRS measures for socioeconomic status. This section does not include all potential future refinements to the QHP Enrollee Survey program. We anticipate including these proposed refinements in future draft Call Letters or through the information collection request process per the Paperwork Reduction Act requirements (as appropriate), but would like to solicit general comments at this time to help inform the development of these future proposals.

3.1 Proposed Revision to Access to Care QRS Survey Measure for Future Years

At this time, CMS is considering implementing the following proposed change to a QRS survey measure for the 2018 ratings year:

- CMS recommends altering which questions from the QHP Enrollee Survey are included in the QRS survey measure Access to Care due to the low screen-in rate. This change would align the questions included in the QRS survey measure Access to Care with the questions included in other programs (i.e., would align with the questions included in

[6] In Medicare Stars, if the specification change is announced during the measurement period and impacts the denominator or population covered by the measure, the measure will be moved to the display page for at least one year (i.e., the measure is collected, but not included in scoring).

other CAHPS® surveys). This change would not impact which questions would be fielded as part of the QHP Enrollee Survey.

The Access to Care measure currently consists of five questions as shown in Exhibit 6. The Access to Care QRS survey measure, as it is derived from the QHP Enrollee Survey, is based on items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[7] surveys.

Exhibit 6. Proposed Updates to QRS Survey Measure Access to Care Questions

QRS Survey Measure	CAHPS Health Plan 5.0	Question
Access to Care	Getting Care Quickly	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
		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?
	Getting Needed Care	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
		In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
	~~Supplemental Item~~	~~In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic after regular hours?~~

CMS proposes removal of the supplemental item from the QRS survey measure, Access to Care, due to low item Inter-Unit Reliability (IUR), low item screen-in rate (8%), and low covariance coverage. CMS analyzed and confirmed, using 2015 beta test data, that there are no negative consequences at the measure level for dropping this item (i.e., measurement properties remain good). Additionally, the supplemental item is not included in other CAHPS® surveys. The remaining four questions (those associated with the first two items in the second column of Exhibit 6) make up the two standard CAHPS® Health Plan 5.0 measures for reporting. CMS intends to further analyze Marketplace QHP Enrollee Survey data to determine if the QRS Access to Care measure should be made into two separate QRS survey measures for scoring – Getting Care Quickly and Getting Needed Care.

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