Health Insurance Marketplace℠

Draft 2017 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey

Proposed QRS and QHP Enrollee Experience Survey Program Refinements

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1.0 Purpose of the 2017 QRS Call Letter

This document, the *Draft 2017 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)* for Qualified Health Plans (QHPs) (referred to hereafter as the 2017 QRS Call Letter), serves to communicate changes and request comment on the Centers for Medicare & Medicaid Services' (CMS') proposed refinements to the QRS and QHP Enrollee Survey programs.[1] The topics in this document focus on the removal of QRS measures; removal of items from the QHP Enrollee Survey questionnaire; and topics for future evaluation regarding the QRS measure set, hierarchy, and rating methodology.[2] This document does not include all potential refinements to the QHP Enrollee Survey program (e.g., other types of survey revisions may be addressed through the information collection request process per the Paperwork Reduction Act (PRA) requirements, as appropriate).

This 2017 QRS Call Letter does not propose changes to regulation; rather, it offers details on proposed changes to QRS and QHP Enrollee Survey program operations.

1.1 Instructions for Submitting Comments and Questions

We encourage interested parties to submit comments on the information presented here to Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QRS Call Letter" in the subject line by the close of the comment period (3/22/2017). After reviewing stakeholder feedback, CMS will finalize decisions on these proposed changes, and communicate final changes about the QRS program in the final 2017 QRS Call Letter (anticipated to be published in spring 2017). In fall 2017, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2018* and the *2018 Quality Rating System Measure Technical Specifications*, reflecting applicable finalized changes announced in the final 2017 QRS Call Letter.

Exhibit 1 provides descriptions of key terms used throughout this document.

[1] The QRS and QHP Enrollee Survey requirements for the 2017 ratings year (the 2017 QRS) are detailed in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017* (2017 QRS Guidance), which was released in September 2016 and is 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.

[2] 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.

Exhibit 1. Key Terms for the QRS Call Letter

Term	Description
Measurement Year	The term *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 also include years prior to 2016. ▪ For QRS survey measure data in the 2017 QRS, the survey is fielded based on enrollees who are enrolled as of January 1, 2017, but the survey requests that enrollees report on their experience "in the last 6 months."
Ratings Year	The term *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 Guidance (released 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.

1.2 Timeline for Call Letter Publication

The anticipated annual cycle for the QRS Call Letter follows a winter-to-spring (approximately January/February through April/May) timeline as shown in Exhibit 2, followed by the publication of the QRS Guidance in September.

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

Date	Description
January/February	**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 - April	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS program.
April/May	**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).[3]

2.0 Revisions to the QRS for 2017 and 2018 Ratings Years

CMS is proposing to update the QRS measure set for 2018 to align with the Healthcare Effectiveness Data and Information Set (HEDIS®) 2017 measure recommendations.[4] The HEDIS

[3] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the U.S. Department of Health & Human Services.

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

specifications are the main source for the QRS Measure Technical Specifications. The proposed changes to the QRS measure set announced as part of the 2017 QRS Call Letter – to reflect the National Committee for Quality Assurance (NCQA) finalized decisions related to the HEDIS 2017 measures – would go into effect for the 2018 ratings year (data submission in summer 2018).[5]

In addition, CMS is proposing to change the minimum denominator size requirement, beginning with the 2017 ratings year, for the QRS clinical measures captured through the QHP Enrollee Survey. Measures that do not meet the minimum denominator size are excluded from QRS scoring.

2.1 Removing the Aspirin Use and Discussion Measure from the QRS

In December 2016, NCQA announced the retirement of the Aspirin Use and Discussion (ASP) measure due to misalignment with updated recommendations from the United States Preventive Services Task Force (USPSTF). CMS then announced through a frequently asked questions document (FAQ) that it would take steps to align the 2017 QRS with these changes made by the measure steward. Specifically, the ASP measure will not be used for scoring in the 2017 ratings year. The FAQ is available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

CMS proposes to remove the Aspirin Use and Discussion measure from the 2018 QRS measure set. Incorporating this change allows the QRS to align with the latest clinical standards.

2.2 Removing the Relative Resource Use Measure from the QRS

In December 2016, NCQA suspended collection of the *Relative Resource Use for People with Diabetes (Inpatient Facility)* measure (RRU measure) due to decreased usefulness and costs that exceed value. CMS then announced through an FAQ that it would take steps to align the 2017 QRS with these changes made by the measure steward. Specifically, the RRU measure will not be used for scoring in the 2017 ratings year; and QHP issuers are not required to submit data for the RRU measure in 2017. The FAQ is available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

CMS proposes to remove this measure from the 2018 QRS measure set to align with the measure steward's recommendation.

[5] In frequently asked question documents (FAQs) released on January 6, 2017, CMS announced that it would take steps to align the 2017 QRS with these changes made by the measure steward. Specifically, neither the Aspirin Use and Discussion (ASP) nor the *Relative Resource Use for People with Diabetes (Inpatient Facility)* (RRU) measure will be used for scoring in the 2017 ratings year; and QHP issuers are not required to submit data for the RRU measure in 2017. The FAQs are available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

2.3 Proposed Revision to the Denominator Criterion for QRS Clinical Measures Captured Through the QHP Enrollee Survey

For the 2017 ratings year and beyond, CMS proposes applying the QRS clinical measure denominator criterion of 30 to all QRS clinical measures, including those captured in the QHP Enrollee Survey such as the Flu Vaccinations for Adults Ages 18-64 and the Medical Assistance with Smoking and Tobacco Use Cessation measures. As outlined in the 2017 QRS Guidance, the current minimum denominator size is 30 for QRS clinical measures and 100 for QRS survey measures. CMS conducted testing to confirm that reliability for these survey measures is not compromised by applying the 30 denominator criterion. CMS believes this is a more appropriate denominator criterion for measures that are clinical in nature, including HEDIS-based measures collected via the QHP Enrollee Survey. Further, CMS expects this refinement will allow a greater number of reporting units to meet the minimum denominator criteria and therefore be eligible for scoring.

3.0 Proposed QHP Enrollee Survey Revisions for 2018 Ratings Year

3.1 Removing Items from the QHP Enrollee Survey Questionnaire

Through a variety of channels, CMS has received stakeholder feedback that the QHP Enrollee Survey questionnaire (survey questionnaire) should be shortened to reduce respondent burden. While CMS is currently reviewing additional possibilities for shortening the survey questionnaire, CMS has identified some proposed initial revisions to the survey questionnaire that are discussed below. Specifically, there are several questions CMS proposes removing from the 2018 QHP Enrollee Survey. If finalized as proposed, CMS will comply with the Paperwork Reduction Act (PRA), as applicable, in implementing these changes.

3.1.1 Removing Access to After Hours Care Questions

*7. In the last 6 months, did you need to visit a doctor's office or clinic **after** regular office hours?*

*8. In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic **after** regular office hours?*

In the Draft 2016 QRS Call Letter, CMS proposed removing the Access to After Hours Care assessment question from the Access to Care QRS survey measure beginning with the 2018 QRS due to low screen-in rates, which lead to small denominators for this survey question. Commenters agreed with this proposal and this change was adopted in the Final 2016 Call Letter.[6]

Given that this question (#7 above) will no longer be utilized for the QRS and has a low screen-in rate of less than nine percent, CMS proposes dropping this survey question from the 2018 QHP Enrollee Survey. The accompanying screener question (#8 above) used to determine if the

[6] The *Final 2016 Call Letter for the QRS and QHP Enrollee Survey* is 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.

enrollee needed to visit a doctor after regular office hours would also be removed from the 2018 QHP Enrollee Survey.

3.1.2 Removing Question about Recommending Health Plan to Friends and Family

53. Using any number from 0 to 10, where 0 is not at all likely and 10 is extremely likely, how likely is it that you would recommend this health plan to a friend or family member?

Based on stakeholder feedback, CMS added a question about the respondents' likelihood of recommending their current health plan to friends or family (i.e., "recommend question") to the 2016 QHP Enrollee Survey. The recommend question had previously been included in the questionnaire for the 2014 psychometric test, but CMS dropped it from the questionnaire used for the 2015 Beta Test to limit respondent burden.

During analysis of the 2016 QHP Enrollee Survey, CMS found a strong, positive correlation (0.96) between the recommend question and the Consumer Assessment of Healthcare Providers & Systems (CAHPS) Health Plan Survey global rating question at the reporting unit level. Given that the recommend question is not used by the QRS, whereas the CAHPS Health Plan Survey global rating question is used by the QRS, CMS proposes eliminating this question (#53 above) from the 2018 QHP Enrollee Survey.

3.1.3 Removing Survey Questions for Aspirin Use and Discussion Measure

65. Do you take aspirin daily or every other day?

66. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

67. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

68. Are you aware that you have any of the following conditions? Mark one or more.
- *a. High cholesterol*
- *b. High blood pressure*
- *c. Parent or sibling with heart attack before the age of 60*

69. Has a doctor ever told you that you have any of the following conditions? Mark one or more.
- *a. A heart attack*
- *b. Angina or coronary heart disease*
- *c. A stroke*
- *d. Any kind of diabetes or high blood sugar*

As discussed in section 2.1, CMS is proposing to retire the Aspirin Use and Discussion Measure for the 2018 QRS Measure set. Accordingly, CMS is also proposing to remove the survey questions associated with this measure (#65 through #69 above) beginning with the 2018 QHP Enrollee Survey.

4.0 Potential Revisions for Future Years

CMS is considering additional refinements for potential incorporation in future years. Topics for future consideration and evaluation may include, but are not limited to: refinements to the QRS

measure set and/or hierarchy, use of an explicit weighting structure, the replacement of the RRU measure, and/or use of a geographic reference group. This section does not include all potential future refinements to the QRS or QHP Enrollee Survey program. CMS anticipates including these proposed refinements in future draft Call Letters or through the information collection request process per the PRA requirements (as appropriate), but is soliciting general comments at this time to help inform the development of these future proposals. For more information regarding the current QRS rating methodology, QRS measure set, or the QRS hierarchy, see the 2017 QRS Guidance.[7]

4.1 Future Evaluation of Measures with High Levels of Missing Data

CMS is investigating the effect missing measure data has on the QRS, and how missing data should be handled in future years. Missing measure data refers to data that are missing for any of the QRS measures that QHP issuers are required to report for the QRS or as part of the QHP Enrollee Survey. Missing data originates most often from insufficient denominator sizes. Missing measure data for a reporting unit may result in fewer calculable composites for the respective QHP issuer's reporting unit and, ultimately, no calculable QRS global score or rating. The impact of missing data depends on both the number of measures missing and the particular measures affected.

Based on the information gathered through initial data collection in 2015 and 2016, CMS will continue to monitor missing data patterns to determine drivers of missing QRS measure data (e.g., Marketplace demographics), and develop criteria for management of measures with continuously high levels of missing data. CMS solicits comments and suggestions regarding the handling of missing data in the future and/or the potential development of criteria for managing measures with high levels of missing data.

4.2 QRS Weighting Structure and Potential Changes to the QRS Hierarchy

The current QRS methodology does not include an explicit weighting structure. The measures are grouped into hierarchy components (i.e., composites, domains, summary indicators) to form a single global rating. The 2017 QRS hierarchy is available for reference in Appendix A. The hierarchy averages together equally all measures and components to calculate higher-level component scores.

The use of a hierarchy creates implicit weighting. Each level of the QRS hierarchy, or component (i.e., measure, composite, domain, and summary indicator), has a variable weight and influence due to its position in the hierarchy. The amount of influence each QRS measure has on the QRS global result is affected by the number of measures and components within each layer of the hierarchy, as well as the amount of missing data for each measure.

While placing more QRS measures in a component may convey a sense of importance for that component, due to implicit weighting, the individual measures within that component would

[7] The *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017* (2017 QRS Guidance) is 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.

actually carry relatively less influence on the QRS global result than components composed of fewer measures. For example, based on the current QRS hierarchy and as a result of implicit weighting, QRS survey measures have a greater impact on the global score than clinical measures.

CMS is investigating methods to address implicit weighting for the QRS. For example, the QRS could assign explicit weights at the measure level, similar to the Medicare Parts C and D Star Rating program. Alternatively, CMS could assign explicit weights at one of the other QRS component levels (e.g., summary indicator level).

Additionally, CMS may investigate collapsing the QRS hierarchy by removing one or two levels (e.g., the composite and/or domain components). Under a revised hierarchy where two levels are removed, QRS measures would be grouped into summary indicators used to calculate the global score and rating. CMS would investigate the impact of the revised hierarchy on the reliability of QRS components and weighting disparities.

CMS solicits feedback regarding potential methods for addressing implicit weighting, including the possibility of assigning explicit weights to the QRS measures or other component levels. CMS also welcomes public input on the possibility of removing levels of the QRS hierarchy.

4.3 Alternative Efficiency, Cost, and Resource Use Measures for the QRS

CMS has halted data collection of the RRU measure for 2017 to align with the measure steward's recommendation and proposes to finalize this change as part of the 2018 QRS measure set. The RRU measure was initially included in the QRS measure set to address efficiency, cost, and resource use, along with other measures related to efficiency (e.g., Use of Imaging Studies for Low Back Pain, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis). Moving forward, CMS will investigate alternative measures to replace the RRU measure and solicits comments regarding other potential cost, resource, and efficiency-related measures for incorporation into the QRS.

4.4 Geographic Reference Group

CMS currently calculates QRS results based on one national, all-product reference group. CMS solicits comments on alternative geographic areas (other than national) for calculating the QRS (e.g., Medicare Contact Service Areas, counties, States, regions) and the potential advantages or disadvantages to an alternative approach for geographic reference groups.

4.5 Measure Areas of Interest

CMS continues to evaluate measure gaps and has sought Measures Application Partnership (MAP) review of the QRS and conducted several environmental scans. Specific areas of interest identified through these processes include plan level measures for both clinical concerns, such as addressing drug safety and/or addressing care coordination in follow up care after emergency room visits, and non-clinical concerns, such as health care cost and access. CMS solicits comments on areas in the QRS measure set and/or hierarchy where there may be perceived gaps. Appendix A shows all 2017 QRS measures within the 2017 QRS hierarchy

CMS is also investigating the appropriateness of adding additional outcome based health plan level measures to the QRS measure set. CMS solicits comments regarding potential outcome measures to supplement the existing QRS measure set.

Appendix A. QRS Hierarchy

The QRS measures are organized into a hierarchical structure that serves as a foundation of the QRS rating methodology (the QRS hierarchy). The measures are grouped into hierarchy components (composites, domains, summary indicators) to form a single global rating.

Exhibit 3 illustrates the 2017 QRS hierarchy. The survey measures in the QRS measure set are noted with an asterisk (*). Shown in grey are the measures that will not be included in QRS scoring for 2017.

Exhibit 3. 2017 QRS Hierarchy

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
Clinical Quality Management	Clinical Effectiveness	Asthma Care	Medication Management for People With Asthma (75% of Treatment Period)	1799
		Behavioral Health	Antidepressant Medication Management	0105
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	0576
			Follow-Up Care for Children Prescribed ADHD Medication	0108
			Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004
		Cardiovascular Care	Controlling High Blood Pressure	0018
			Proportion of Days Covered (RAS Antagonists)	0541
			Proportion of Days Covered (Statins)	0541
		Diabetes Care	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062
			Proportion of Days Covered (Diabetes All Class)	0541
	Patient Safety	Patient Safety	Annual Monitoring for Patients on Persistent Medications	2371
			Plan All-Cause Readmissions	1768
	Prevention	Checking for Cancer	Breast Cancer Screening	2372
			Cervical Cancer Screening	0032
			Colorectal Cancer Screening	0034
		Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	1517
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517
		Staying Healthy Adult	Adult BMI Assessment	Not Endorsed
			Chlamydia Screening in Women	0033
			Aspirin Use and Discussion*	Not Endorsed

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
			Flu Vaccinations for Adults Ages 18-64*	0039
			Medical Assistance With Smoking and Tobacco Use Cessation*	0027
		Staying Healthy Child	Annual Dental Visit	Not Endorsed
			Childhood Immunization Status (Combination 3)	0038
			Immunizations for Adolescents (Combination 2)	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
Enrollee Experience	Access	Access to Care	Access to Care*	Not Endorsed
	Care Coordination	Care Coordination	Care Coordination*	Not Endorsed
	Doctor and Care	Doctor and Care	Cultural Competence*	Not Endorsed
			Rating of All Health Care*	0006
			Rating of Personal Doctor*	0006
			Rating of Specialist*	0006
Plan Efficiency, Affordability, & Management	Efficiency & Affordability	Efficient Care	Appropriate Testing for Children With Pharyngitis	0002
			Appropriate Treatment for Children With Upper Respiratory Infection	0069
			Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058
			Use of Imaging Studies for Low Back Pain	0052
	Plan Service	Enrollee Experience with Health Plan	Access to Information*	Not Endorsed
			Plan Administration*	Not Endorsed
			Rating of Health Plan*	0006
Not included for purposes of QRS scores or ratings				
N/A	N/A	N/A	Relative Resource Use for People with Diabetes (Inpatient Facility)	1557