Health Insurance Exchange

Draft 2022 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey

Proposed QRS and QHP Enrollee Survey Program Refinements

February 2022

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List of Exhibits

1. Purpose of the 2022 QRS and QHP Enrollee Survey Call Letter

The *Draft 2022 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Draft 2022 QRS and QHP Enrollee Survey Call Letter) serves to communicate changes and request comments 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:

- A proposed temporary rule for the QRS scoring methodology for the 2022 ratings year,
- Proposed refinements to measures in the QRS measure set,
- Proposed new data collection and reporting methods,
- Proposed revisions to the QRS rating methodology beginning with the 2023 ratings year, and
- Potential QRS and QHP Enrollee Survey refinements for the 2024 ratings year and beyond.

This document does not include all potential refinements to the QRS and QHP Enrollee Survey. For example, other types of QHP Enrollee Survey revisions may be addressed through the information collection request process per the Office of Management and Budget (OMB) and Paperwork Reduction Act (PRA) requirements, as appropriate.

This Draft 2022 QRS and QHP Enrollee Survey Call Letter does not propose changes to regulation; rather, it offers details on proposed changes to the 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 in this Draft 2022 QRS and QHP Enrollee Survey Call Letter to Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-Draft 2022 QRS and QHP Enrollee Survey Call Letter" in the subject line by the close of the comment period (March 9, 2022).

After reviewing stakeholder feedback, CMS will finalize decisions on these proposed changes, and will communicate final changes about the QRS and QHP Enrollee Survey programs in the *Final 2022 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Final 2022 QRS and QHP Enrollee Survey Call Letter), which CMS anticipates publishing in the late spring of 2022.

In the early spring of 2022, CMS intends to publish the *2023 Quality Rating System Measure Technical Specifications* (referred to hereafter as 2023 QRS Measure Technical Specifications), which will include the measure specifications for all potential measures in the 2023 QRS measure set (i.e., any measures proposed for addition or removal in this Draft 2022 QRS and QHP Enrollee Survey Call Letter).

[1] The QRS and QHP Enrollee Survey requirements for the 2022 ratings year (the 2022 QRS) are detailed in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022* (2022 QRS and QHP Enrollee Survey Technical Guidance), which was released in October 2021 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.

In the fall of 2022, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023* (hereafter referred to as the 2023 QRS and QHP Enrollee Survey Technical Guidance), reflecting applicable finalized changes announced in the Final 2022 QRS and QHP Enrollee Survey Call Letter. The 2023 QRS and QHP Enrollee Survey Technical Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2023 ratings year. Additionally, CMS will release an updated version of the 2023 QRS Measure Technical Specifications that includes guidance on the finalized data submission requirements for the 2023 QRS measure set. Specifically, CMS will include callout boxes summarizing the final decision regarding measures and/or measure rates finalized for addition or removal via the Final 2022 QRS and QHP Enrollee Survey Call Letter.

1.2 Timeline for Call Letter Publication

The anticipated annual cycle for the QRS and QHP Enrollee Survey Call Letter follows a winter-to-spring (approximately February through May) timeline as shown in Exhibit 1, followed by the publication of the QRS and QHP Enrollee Survey Technical Guidance in the fall.

Exhibit 1. Annual Cycle for Soliciting Public Comment via the QRS and QHP Enrollee Survey Call Letter Process

Date	Description
February	**Publication of Draft Call Letter:** CMS proposes changes to the QRS and QHP Enrollee Survey program operations and provides stakeholders with the opportunity to submit feedback via a 30-day public comment period.
March	**Publication of QRS Measure Technical Specifications:** CMS provides measure specifications for all potential measures in the QRS measure set (i.e., any measures proposed for addition and removal in this Call Letter).
March–April	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS and QHP Enrollee Survey program operations.
May	**Publication of Final QRS and QHP Enrollee Survey Call Letter:** CMS communicates final changes to the QRS and QHP Enrollee Survey program operations and addresses the themes of the public comments.
September/October	**Publication of QRS and QHP Enrollee Survey Technical Guidance:** CMS provides technical guidance regarding the QRS and QHP Enrollee Survey and specifies requirements for QHP issuers offering coverage through the Health Insurance Exchanges (Exchanges). **Publication of Updated QRS Measure Technical Specifications:** CMS publishes an updated version of the QRS Measure Technical Specifications, as needed, that indicates final decisions regarding changes to the measures and/or measure rates (i.e., any measures finalized for addition or removal in the Final Call Letter).[2]

[2] CMS anticipates releasing an updated version of the QRS Measure Technical Specifications to provide guidance on the measure specifications and guidelines for years when refinements to QRS measures and/or measure rates are addressed via the QRS and QHP Enrollee Survey Call Letter process and finalized via the Final Call Letter.

1.3 Key Terms for the QRS and QHP Enrollee Survey Call Letter

Exhibit 2 provides descriptions of key terms used throughout this document.

Exhibit 2. Key Terms for the QRS and QHP Enrollee Survey 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 a measure is dependent on the technical specifications of the measure. ▪ QRS clinical measure data submitted for the 2022 ratings year (the 2022 QRS) generally represent calendar year 2021 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 2021. ▪ For QRS survey measure data in the 2022 QRS, the QHP Enrollee Survey is fielded based on enrollees who are currently enrolled as of January 6, 2022, but the survey requests that enrollees report on their experience "from July through December 2021."
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, "2022 QRS" refers to the 2022 ratings year. ▪ As part of the 2022 plan year certification process, which occurred during the spring and summer of 2021, QHP issuers attested that they will adhere to 2022 quality reporting requirements, which include requirements to report data for the 2022 QRS and QHP Enrollee Survey. ▪ Requirements for the 2022 QRS, and details as to the data collection, validation, and submission processes, are documented in the 2022 QRS and QHP Enrollee Survey Technical Guidance, which was published in October 2021. ▪ Ratings calculated for the 2022 QRS are displayed for QHPs offered during the 2023 plan year, in time for open enrollment, to assist consumers in selecting QHPs.

2. Proposed QRS Revisions for the 2022 Ratings Year

For the 2022 ratings year, CMS is proposing the retention of the temporary rule to limit star rating declines in the QRS methodology.

2.1 Retention of the QRS Temporary Rule to Limit Star Rating Declines

For the 2022 ratings year, CMS is proposing to retain the temporary rule to limit star rating declines at the summary indicator and global rating levels. This rule would prevent health plans from decreasing by more than one star at the global and summary indicator levels from the 2021 ratings year to the 2022 ratings year.

In the Final QRS and QHP Enrollee Survey 2021 Call Letter, CMS finalized two temporary methodology refinements to mitigate the impact of the COVID-19 public health emergency (PHE) on the 2021 ratings year.[3] These temporary refinements included:

1) Incorporation of a policy-based distribution for the overall global rating and three underlying summary indicator categories that mirrors the historic data-driven distribution of QRS ratings based on the three-year average using the 2017–2019 ratings; and

[3] The Final 2021 QRS and QHP Enrollee Survey Call Letter is available at: https://www.cms.gov/files/document/final-2021-call-letter-qrs-and-qhp-enrollee-survey.pdf.

2) A rule that precluded health plans from decreasing in their overall global rating and summary indicator ratings by more than one star (e.g., if a plan received a four-star overall global rating in ratings year 2019, the lowest overall global rating the plan would receive in ratings year 2021 would be three stars).

For the 2022 ratings year, CMS is discontinuing use of the policy-based distribution and will resume calculation of quality ratings at the global and summary indicator levels using the clustering cut point methodology.[4] Because the policy-based distribution was used to determine the global and summary indicator star ratings, CMS did not assign cut points at the global and summary indicator levels for 2021. CMS' discontinuation of the policy-based distribution is in alignment with similar decisions made by other CMS quality reporting programs (e.g., the Medicare Part C & D Star Rating Program) to remove methodology refinements implemented to reduce the impact of the COVID-19 PHE.

However, CMS is proposing to retain the temporary methodology refinement to limit star ratings declines. Beginning with the 2022 ratings year, CMS finalized the incorporation of the Benchmark Ratio Approach via the Final 2021 Call Letter for the QRS and QHP Enrollee Survey.[5] Retention of this temporary rule to limit star ratings declines would provide stability in ratings as CMS transitions to this new scoring methodology. More specifically, CMS' continuing implementation of the temporary rule would prevent significant changes in health plans' star ratings during the transition while allowing plans to more immediately realize the benefits of the Benchmark Ratio Approach (e.g., interpretable scores, increased stability).

Under this approach, CMS would first apply the clustering algorithm to calculate the quality ratings and then, if finalized, implement the temporary rule to limit star rating declines at the global and summary indicator levels. CMS would adjust ratings for cases where a reporting unit lost more than one star from the 2021 ratings year to the 2022 ratings year.

CMS solicits comments on its proposal to retain the temporary rule to limit star rating declines at the summary and global rating levels from the 2021 ratings year to the 2022 ratings year.

3. Proposed QRS and QHP Enrollee Survey Revisions for the 2023 Ratings Year and Beyond

CMS is also soliciting comments on a series of proposed refinements to the QRS and QHP Enrollee Survey that would apply beginning with the 2023 ratings year, including:

- Addition of a measure to the QRS measure set,
- Refinements to a measure,
- Temporary removal of a measure from scoring,
- Incorporation of an optional data reporting method,
- QRS cut point methodology refinements, and
- Stratification of race and ethnicity data to advance health equity.

[4] See Section 7 of the 2022 QRS and QHP Enrollee Survey Technical Guidance available at: https://www.cms.gov/files/document/2022-qrs-and-qhp-enrollee-survey-technical-guidance.pdf.
[5] See supra note 3.

3.1 Adding the Kidney Health Evaluation for Patients with Diabetes Measure

CMS is considering the addition of the *Kidney Health Evaluation for Patient with Diabetes* measure to the QRS measure set. CMS is proposing this measure for potential inclusion in the QRS measure set beginning with the 2023 ratings year.

Beginning with the 2022 QRS, CMS removed the *Comprehensive Diabetes Care: Medical Attention for Nephropathy* measure in alignment with the measure steward's (i.e., National Committee for Quality Assurance's [NCQA]) retirement of the measure, as finalized in the Final 2021 Call Letter for the QRS and QHP Enrollee Survey. In response to CMS' proposal to remove the *Comprehensive Diabetes Care: Medical Attention for Nephropathy* measure, stakeholders recommended the addition of the *Kidney Health Evaluation for Patient with Diabetes* measure to the QRS measure set.

The *Kidney Health Evaluation for Patient with Diabetes* measure was developed by the measure steward, NCQA, to replace the *Comprehensive Diabetes Care: Medical Attention for Nephropathy* measure. This measure specifically evaluates the percentage of members ages 18-85 with diabetes (type 1 and type 2) who received a kidney health evaluation. The *Kidney Health Evaluation for Patient with Diabetes* measure more closely aligns with the clinical practice guidelines and recommendations related to kidney care and health. Incorporation of the *Kidney Health Evaluation for Patient with Diabetes* measure supports CMS' goal of alignment with other CMS quality reporting programs (e.g., Medicare Stars) and considers stakeholder feedback. Addition of the *Kidney Health Evaluation for Patient with Diabetes* measure also addresses CMS' Meaningful Measures quality priority area of promoting effective prevention, treatment, and management of chronic conditions.

If CMS adds this measure to the QRS measure set, an initial year of data collection would occur before the measure is included in the calculation of QRS scores and ratings (i.e., if the measure is added as proposed, data collection would begin in the 2023 QRS, but CMS would not include the measure in scoring until the 2024 ratings year at the earliest).

The draft measure specifications for the *Kidney Health Evaluation for Patient with Diabetes* measure is included. [6]

3.2 Proposed Refinements to the Colorectal Cancer Screening Measure

For the 2022 measurement year, CMS is proposing to align with the measure steward, NCQA, and update the specification for the *Colorectal Cancer Screening* measure to add members ages 45–49 to the eligible population in alignment with updated guidelines released by the U.S. Preventive Services Task Force (USPSTF). These updated guidelines expanded the recommended ages for colorectal cancer screening because of the increased incidence of colorectal cancer in younger adults. [7] As a result, the USPSTF now recommends that adults 45–75 years of age are screened for colorectal cancer. The updated measure specifies performance

[6] The *Kidney Health Evaluation for Patient with Diabetes* measure technical specifications included in Appendix B is subject to change and may differ from those published in the 2023 QRS Measure Technical Specifications to align with changes made by the measure steward.

[7] See USPSTF's *Final Recommendation Statement on Screening for Colorectal Cancer*, available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening..

rates stratified by ages 45–49 years of age and 50–75 years of age, as well as a total rate. CMS does not consider this a significant change to the eligible population, so CMS would continue to include the refined measure in scoring for the 2023 ratings year, if finalized as proposed.[8]

3.3 Temporary Removal of the Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment Measure from 2023 Scoring

For the 2023 ratings year (i.e., 2022 measurement year), the measure steward, NCQA, updated the specifications for the *Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment* measure from a member-based measure to an episode-based measure. This revision allows treatment episodes to be measured independently. NCQA made further updates[9] to the measure to better align with current clinical practice guidelines and best practices for early identification, evaluation, and treatment for substance use disorders.

In concurrence with these revisions, the title of this measure will change from the *Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment* measure to the *Initiation and Engagement of Substance Use Disorder Treatment* measure.

CMS assessed these revisions and has determined these specification changes result in significant changes to the measure. Therefore, CMS is proposing to temporarily remove the *Initiation and Engagement of Substance Use Disorder Treatment* measure from scoring for the 2023 ratings year.

The proposal to remove this measure from scoring does not impact the 2023 data submission requirements for the *Initiation and Engagement of Substance Use Disorder Treatment* measure (i.e., under this proposal, QHP issuers would still be required to collect and report validated data for this measure for 2023 following the measure steward's updated specifications). Temporary removal of this measure from scoring for one year would allow QHP issuers to adapt to the updated measure data collection and reporting requirements while reducing the impact on scores during this transition. Temporary removal of this measure is also consistent with the previously finalized policies for incorporating refinements that involve significant changes.[10] CMS anticipates incorporation of this measure in scoring beginning with the 2024 ratings year.

3.4 Incorporation of Optional Electronic Clinical Data System Reporting

NCQA introduced optional Electronic Clinical Data System (ECDS) reporting for the *Colorectal Cancer Screening*, *Breast Cancer Screening*, *Immunization for Adolescents (Combination 2)*,

[8] For information on the timeline for incorporating refinements into the QRS program (including the approach for significant and non-significant changes), see the Final 2016 Call Letter for the QRS and QHP Enrollee Survey and the Final 2018 Call Letter for the QRS and QHP Enrollee Survey, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Downloads/MQI-Downloads.

[9] See page 13 of NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) Volume 2 MY 2022 for the summary of changes to the *Initiation and Engagement of Substance Use Disorder Treatment* measure and for more information on the measure updates that will be included in the 2023 QRS Measure Technical Specifications: https://www.ncqa.org/wp-content/uploads/2021/08/202010802_Summary_Table_of_HEDIS_Volume_2_MY2022.pdf.

[10] See supra note 8.

and *Childhood Immunization Status (Combination 10)* measures. ECDS is a reporting standard for health plans collecting and submitting quality measures that defines data sources and the types of structured data acceptable for use for a measure.[11]

Beginning with the 2023 ratings year, CMS proposes to incorporate optional ECDS reporting alongside hybrid or administrative reporting for these measures to align with the measure steward's specifications. CMS is also interested in gaining feedback from stakeholders on further implementing ECDS reporting in the QRS by requiring ECDS reporting for select measures (i.e., *Breast Cancer Screening* and *Colorectal Cancer Screening*) in future years.

3.5 QRS Cut Point Methodology Refinements

CMS finalized the transition to the Benchmark Ratio Approach in the Final 2021 Call Letter for the QRS and QHP Enrollee Survey to be implemented beginning with the 2022 ratings year.[12] The Benchmark Ratio Approach improves stability of measure scores and provides QHP issuers with measure-level performance targets and improved interpretability of measure and component scores.

CMS is now proposing refinements to the QRS cut point approach to align with the methodological transition to the Benchmark Ratio Approach, further improve the stability of the QRS ratings, ensure that ratings are tied more closely to underlying measure-level performance, and improve interpretability of star ratings. Beginning with the 2023 ratings year, CMS proposes transitioning from the current clustering approach, which applies a data-driven clustering algorithm to assign star ratings at the global and summary indicator levels of the QRS hierarchy[13], to a policy-driven static cut point approach. This new proposed approach would use threshold values of 60, 70, 80, 90 to define the star rating categories. These proposed refinements to the cut point methodology were developed in consideration of stakeholder comments and continued feedback from the QRS Technical Expert Panel (TEP).

CMS anticipates that implementing the proposed static cut points would help further stabilize ratings over years, provide stakeholders with more interpretable ratings, and establish greater insight into QHP issuers' absolute and relative performance when paired with the Benchmark Ratio Approach.

CMS tested alternative cut point methodologies on measure data submitted in the 2017, 2018, and 2019 ratings years, in combination with the Benchmark Ratio Approach and streamlined QRS hierarchy. Testing showed that benefits of the static cut point approach include:

- **Evaluation on independent performance.** The 60, 70, 80, 90 static cut point thresholds define the star ratings given to health plans without requiring a certain distribution of ratings, allowing the star ratings to better reflect underlying health plan performance. Static cut points

[11] More information on ECDS reporting is available at: https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/.
[12] See supra note 3.
[13] For an overview of the process for calculating QRS scores and ratings, including the current clustering approach, see Section 7.3 of the 2022 QRS and QHP Enrollee Survey Guidance available at: https://www.cms.gov/files/document/2022-qrs-and-qhp-enrollee-survey-technical-guidance.pdf.

allow for all reporting units to receive high ratings if merited based on their individual performance. This is in contrast to the current clustering methodology, which, by design, requires that all five of the star ratings be populated regardless of underlying performance (i.e., clustering forces high and low performers regardless of the global and/or summary indicator component score ranges).

- **Meaningfulness.** When paired with the Benchmark Ratio Approach, static cut points define consistent performance standards to achieve star ratings that tie back to measure-level performance. For example, the cut point that delineates the 5-star category is 90, meaning that a reporting unit must satisfy ≥90% performance across all underlying measure benchmarks, on average, to receive a 5-star rating in the current ratings year.
- **Clear and consistent performance targets.** Setting static cut points provides QHP issuers with stable and interpretable performance targets to achieve a given star rating each year. With stable cut points, measure-level performance will be the main driver of star ratings.

CMS' testing further showed that pairing the static cut point approach with the Benchmark Ratio Approach provides value by minimizing the risk of artificially inflating star ratings over time due to the fact that ratings would be more closely tied to and assigned based on annual performance.

3.6 Reporting of Stratified Race and Ethnicity Data to Advance Health Equity

CMS is committed to advancing health equity. CMS continues to explore ways to analyze health equity and disparities among the Exchange population through the reporting of stratified measure data potentially including race, ethnicity, and socioeconomic factors (e.g., income, employment status, education). Reporting of stratified data would provide insight and awareness for QHP issuers into the quality of care among members of different demographics enrolled in each health plan and thereby allow issuers to advance health equity. As a preliminary approach to addressing health equity, CMS is initially considering collection and reporting of stratified race and ethnicity data.

Beginning with the 2023 ratings year (2022 measurement year), CMS is proposing to update the form and manner in which QHP issuers must submit validated data for 5 measures in the QRS measure set. More specifically, CMS is proposing that QHP issuers would be required to collect and report stratified race and ethnicity data for the following five measures set: *Colorectal Cancer Screening, Controlling High Blood Pressure, Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control* (<8.0%)*, Prenatal and Postpartum Care,* and *Child and Adolescent Well-Care Visits* as a part of the 2023 QRS Measure Technical Specifications to align with the measure steward's (i.e., NCQA) refinements to these HEDIS®[14] measures.[15]

CMS anticipates a phased-in approach for implementing stratifications to race and ethnicity measure data. Initially, CMS is considering that all QHP issuers would be required to report measure performance by race and ethnicity using directly collected enrollee data by the 2024 measurement year. In the 2022 and 2023 measurement years, QHP issuers would be allowed to report the stratification using their own directly collected member data for race and ethnicity as

[14] HEDIS® is a registered trademark of NCQA.
[15] This is consistent with NCQA's approach and timeline for stratification of select HEDIS® measures. For more information, see: https://www.ncqa.org/about-ncqa/health-equity/data-and-measurement/

outlined in HEDIS® measure specifications. Additionally, plans would be able to supplement directly collected data with indirect race and ethnicity data (i.e., assigned or imputed from secondary data sources such as assignment by geographic location, surname analysis, and geocoding). Plans would not be required to use a specific method for imputation when reporting stratified race and ethnicity data using indirect data sources and would not be required to use direct data sources until the 2024 measurement year, at the earliest.

4. Potential QRS and QHP Enrollee Survey Revisions for Future Years

CMS is also soliciting comments on potential modifications to the QRS and QHP Enrollee Survey for future years (e.g., the 2024 ratings year and beyond). Topics under consideration and evaluation for potential revisions in future years include, but are not limited to:

- Modifying and removing questions from the QHP Enrollee Survey, and
- Potential refinements to the QRS scoring methodology.

CMS anticipates including these proposed refinements in future Draft Call Letters, through the rulemaking process, or through the information collection request process per the PRA requirements (as appropriate). CMS is soliciting general comments at this time to help inform the development of potential future proposals.

4.1 Revisions to the QHP Enrollee Survey Questionnaire

In the Draft 2021 Call Letter for the QRS and QHP Enrollee Survey, CMS sought public comment on items to consider for removal from the QHP Enrollee Survey. Stakeholders generally agreed that CMS should reduce the length of the survey, but disagreed on the specific domains or items that should be eliminated. CMS also sought feedback from the QHP Enrollee Survey TEP on potential changes to the survey. Additionally, CMS is currently utilizing data from the 2021 QHP Enrollee Survey to further assess the impact of potential changes to the survey questionnaire. CMS welcomes additional public comment on potential questions for removal to assist the agency as it continues to consider potential revisions to the survey questionnaire.

CMS is also considering whether there are additional topics that are not currently measured by the QHP Enrollee Survey that should be added and may inform ways to advance health equity. Some potential topics CMS has identified based on existing Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[16] supplemental items include:

- Access to mental health/behavioral health care,
- Experience accessing prescription drug benefits,
- Information about the health plan (e.g. CAHPS Health Literacy items),
- Ability to seek after-hours care,
- Availability of an interpreter when speaking with health plan's customer service, and
- Reasons it was not easy to access specialty care.

[16] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

In response to this Draft Call Letter, CMS is interested in feedback on these specific topics as well as other topics that should be considered for inclusion.

CMS will comply with the PRA, as applicable, for implementing changes to the QHP Enrollee Survey, currently authorized under OMB number 0938-1221.

4.2 Adding and Modifying QHP Enrollee Survey Questions to Support Analysis of Health Equity and Disparities

In response to *Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, [17] CMS is considering adding and modifying QHP Enrollee Survey questions and response options to facilitate analysis of health equity and disparities within QHPs offered through the Health Insurance Marketplace®.[18] These revisions would provide insight and awareness for QHP issuers into the quality of care and satisfaction among members of different demographics enrolled in each health plan, thereby, allowing issuers to advance health equity.

CMS is proposing to revise the race question in the QHP Enrollee Survey to align the response options with the 2011 Department of Health and Human Services (HHS) Data Standard.[19] The revised question and response options would read as follows:

What is your race? Mark one or more.

- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Black or African American
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- White

[17] *Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* is available at: https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government.
[18] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.
[19] For more information regarding the 2011 HHS Data Standard, see: https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0.

CMS believes that adding these race categories is important to facilitate analysis of health equity and disparities amongst these subpopulations that would not be feasible without this level of granularity.

These expanded race categories were used in previous iterations of the QHP Enrollee Survey but were removed after consideration of the burden placed on respondents completing the survey by telephone. To limit this burden, CMS proposes implementing skip patterns for telephone survey instrument respondents. Initially, respondents would be asked the question with only the current five race categories. Respondents who indicate that they are Asian or Native Hawaiian/Pacific Islander would be asked follow-up questions to determine which specific race categories apply to them. CMS believes that this approach would limit the additional burden placed on respondents completing the survey by telephone while allowing data collection at the level of detail necessary to better promote health equity and address any health disparities.

CMS is also proposing to expand the response options for the ethnicity question in the QHP Enrollee Survey to similarly collect additional detail regarding subpopulations. The proposed question and response options would read:

Are you Hispanic, Latino/a, or Spanish Origin? Mark one or more.

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, or Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Another Hispanic, Latino/a, or Spanish origin

Similar to the race question, CMS is proposing that the telephone survey instrument would use skip patterns to limit the burden of administering the expanded question over the telephone. CMS proposes that respondents would be asked initially if they are of Hispanic, Latino/a, or Spanish origin with Yes/No response options. If a respondent indicates that they are of Hispanic, Latino/a, or Spanish origin, they would subsequently be asked which specific ethnicity categories apply to them. CMS also believes that adding these categories is important to facilitate analysis of health equity and disparities amongst these subpopulations that would not be feasible without this level of granularity.

In addition to seeking comment through this Draft Call Letter, CMS will seek public comment through a Federal Register Notice published as part of the PRA clearance process in advance of the 2024 QHP Enrollee Survey.

4.3 Potential Refinements to the QRS Methodology Half-Scale Rule

CMS continues to investigate ways to refine the QRS methodology for future years, such as potential revisions to the half-scale rule. The half-scale rule is a scoring rule that requires at least half of the lower-level component scores to be present and valid in order for the higher-level

component score to be calculated.[20] The half-scale rule is applied at the summary indicator component level (i.e., each of the three summary indicator component scores can only be calculated if at least half [≥50%] of the associated measures have a score).

For example, under the 2023 QRS hierarchy, 25 QRS measures are included in the calculation of the Clinical Quality Management summary indicator.[21] In order to meet the current half-scale rule, 13 of the 25 measures must have valid data in order for the Clinical Quality Management summary indicator score to be calculated. This rule is intended to ensure comparability of component scores across reporting units, mitigate the impact of missing data within each reporting unit, and guarantee that higher-level scores reflect a minimum number of underlying quality performance measures.

In part 2 of the HHS Notice of Benefit and Payment Parameters for 2022 Final Rule,[22] CMS finalized the removal of the composite level and domain level from the QRS hierarchy to support alignment with other CMS quality reporting programs (e.g., Medicare Part C & D Star Rating Program) and help improve balancing the influence of individual measures on the overall quality score.

As part of the consideration of potential refinement to the current half-scale rule, CMS is interested in gaining feedback from stakeholders on the percentage of measures that should be present in order for the associated summary indicator components to receive a score under the streamlined QRS hierarchy finalized in part 2 of the HHS Notice of Benefit and Payment Parameters for 2022 Final Rule.[23] Particularly, CMS is requesting feedback on whether the same percentage of measures used in the current half-scale rule (i.e., ≥ 50% of measures) should continue to apply under the streamlined QRS hierarchy.

CMS is further interested in receiving comments on alternative percentages that stakeholders may consider more appropriate for the streamlined hierarchy compared to the current half-scale rule. This potential refinement is particularly important for the largest and most impactful summary indicator (i.e., Clinical Quality Management) as it contains the most underlying measures and encompasses approximately 67 percent of the global score.

[20] The half-scale rule is applied independently of the explicit weighting structure. Modifications to the half-scale rule would not impact the explicit weighting used to calculate global scores. For more information on the current half-scale rule, see the discussion of the QRS Rating Methodology in Section 7 of the 2022 QRS and QHP Enrollee Survey Technical Guidance.

[21] See Appendix A for the 2023 QRS hierarchy and underlying measures in the Clinical Quality Management summary indicator.

[22] See the HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Standards; Final Rule, 86 FR 24140 at 24253–24256 (May 5, 2021), available at https://www.federalregister.gov/documents/2021/05/05/2021-09102/patientprotection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022-and.

[23] *Id*.

Appendix A. QRS Hierarchy

The QRS measures are organized into a hierarchal structure that serves as a foundation of the QRS rating methodology (the QRS hierarchy). The measures are grouped into summary indicators to form a single global rating.[24]

Exhibit 3 illustrates the proposed ratings year 2023 QRS hierarchy, which is the organization of measures into summary indicators and ultimately, a single global rating. Measures denoted with a strikethrough (–), if removed as proposed, would not be collected for the 2023 ratings year. Measures denoted with an asterisk (*), if finalized as proposed, would be collected, but not included in 2023 QRS scoring. Measures not currently endorsed by the National Quality Forum (NQF) are noted as ¥.

Exhibit 3. Proposed 2023 QRS Hierarchy

QRS Summary Indicator	Measure Title	NQF ID (¥ indicates not currently endorsed)
Clinical Quality Management	Asthma Medication Ratio	1800
	Antidepressant Medication Management	0105
	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)	0576
	Initiation and Engagement of Substance Use Disorder Treatment*[25]	0004
	Controlling High Blood Pressure	0018
	Proportion of Days Covered (RAS Antagonists)	0541
	Proportion of Days Covered (Statins)	0541
	Eye Exam for Patient with Diabetes (formerly Comprehensive Diabetes Care: Eye Exam (Retinal) Performed)[26]	0055
	Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control (<8.0%) (formerly Comprehensive Diabetes Care: Hemoglobin A1c [HbA1c] Control [<8.0%])[27]	0575
	Proportion of Days Covered (Diabetes All Class)	0541

[24] In communicating total measure counts, the totals presented here represent the perspective of the scoring methodology, rather than the perspective of the measure steward. If counting based the perspective of the scoring methodology, there are 39 measures that are collected and used in scoring (rather than 36). The difference of three measures in this count comes from two factors. First, Prenatal and Postpartum Care is split into two distinct measures for the QRS hierarchy: *Timeliness of Prenatal Care* and *Postpartum Care*. Similarly, Proportion of Days Covered (NQF #0541) is split into three distinct measures: *Diabetes All Class, Renin Angiotensin System (RAS) Antagonists*, and *Statins.*

[25] Beginning with the 2023 QRS (i.e., 2022 measurement year), NCQA will rename the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure to the *Initiation and Engagement of Substance Use Disorder Treatment* measure.

[26] Beginning with the 2023 QRS (i.e., 2022 measurement year), NCQA will rename the *Comprehensive Diabetes Care: Eye Exam (Retinal) Performed* to the *Eye Exam for Patient with Diabetes* measure and the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%*) as the *Hemoglobin A1c Control for Patient with Diabetes* measure. In alignment with the measure steward, these measures will now be reported in the QRS as the *Eye Exam for Patient with Diabetes* and *Hemoglobin A1c Control for Patient with Diabetes* measures.

[27] *Id*.

QRS Summary Indicator	Measure Title	NQF ID (¥ indicates not currently endorsed)
	Kidney Health Evaluation for Patients with Diabetes*	N/A[28]
	International Normalized Ratio Monitoring for Individuals on Warfarin	0555
	Annual Monitoring for Persons on Long-term Opioid Therapy	3541
	Plan All-Cause Readmissions	1768 ¥
	Breast Cancer Screening	2372
	Cervical Cancer Screening	0032
	Colorectal Cancer Screening	0034
	Prenatal and Postpartum Care (Postpartum Care)	1517 ¥
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517 ¥
	Chlamydia Screening in Women	0033
	Flu Vaccinations for Adults Ages 18-64	0039
	Medical Assistance with Smoking and Tobacco Use Cessation	0027 ¥
	Annual Dental Visit	1388 ¥
	Childhood Immunization Status (Combination 10)	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 30 Months of Life	1392
	Child and Adolescent Well-Care Visits	N/A
Enrollee Experience	Access to Care	0006
	Care Coordination	0006
	Rating of All Health Care	0006
	Rating of Personal Doctor	0006
	Rating of Specialist	0006
Plan Efficiency, Affordability, & Management	Appropriate Testing for Pharyngitis	0002 ¥
	Appropriate Treatment for Upper Respiratory Infection	0069
	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	0058
	Use of Imaging Studies for Low Back Pain	0052 ¥
	Access to Information	0007 ¥
	Plan Administration	0006
	Rating of Health Plan	0006

[28] The measure steward, NCQA, anticipates seeking NQF endorsement for the *Kidney Health Evaluation for Patients with Diabetes* measure at a later date.

Appendix B. Draft Kidney Health Evaluation for Patients With Diabetes Measure Technical Specification

Kidney Health Evaluation for Patients With Diabetes*

***This measure was developed by NCQA with input from the National Kidney Foundation.**

Description

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.

Eligible Population

Product lines	Exchange.
Ages	18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate: • 18–64. • 65–74. • 75–85. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Follow the steps below to identify the eligible population.
Step 1	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

  Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	– Acarbose	– Miglitol	
Amylin analogs	– Pramlintide		
Antidiabetic combinations	– Alogliptin-metformin – Alogliptin-pioglitazone – Canagliflozin-metformin – Dapagliflozin-metformin – Empagliflozin-linagliptin	– Empagliflozin-metformin – Glimepiride-pioglitazone – Glipizide-metformin – Glyburide-metformin – Linagliptin-metformin	– Metformin-pioglitazone – Metformin-repaglinide – Metformin-rosiglitazone – Metformin-saxagliptin – Metformin-sitagliptin
Insulin	– Insulin aspart – Insulin aspart-insulin aspart protamine – Insulin degludec – Insulin detemir – Insulin glargine – Insulin glulisine	– Insulin isophane human – Insulin isophane-insulin regular – Insulin lispro – Insulin lispro-insulin lispro protamine – Insulin regular human – Insulin human inhaled	

Description	Prescription		
Meglitinides	– Nateglinide	– Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	– Albiglutide – Dulaglutide – Exenatide	– Liraglutide (excluding Saxenda®) – Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	– Canagliflozin	– Dapagliflozin (excluding Farxiga®)	– Empagliflozin
Sulfonylureas	– Chlorpropamide – Glimepiride	– Glipizide – Glyburide	– Tolazamide – Tolbutamide
Thiazolidinediones	– Pioglitazone	– Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	– Alogliptin – Linagliptin	– Saxagliptin – Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Step 2: Required exclusions Exclude members who meet any of the following criteria:

- Members with evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Step 3: Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

  - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
    3. Identify the discharge date for the stay.
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
  - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.
  - A dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	– Donepezil – Galantamine – Rivastigmine
Miscellaneous central nervous system agents	– Memantine
Dementia combinations	– Donepezil-memantine

Administrative Specification

Denominator The eligible population.

Numerator

Kidney Health Evaluation Members who received ***both*** an eGFR and a uACR during the measurement year on the same or different dates of service:

- At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set).
- At least one uACR identified by either of the following:
  - ***Both*** a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) ***and*** a urine creatinine test (Urine Creatinine Lab Test Value Set) ***with*** service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
  - A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).

Exclusions *(optional)*

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Data Elements for Reporting

Organizations that submit HEDIS® data to NCQA must provide the following data elements.

Table KED-1/2/3: Data Elements for Kidney Health Evaluation for Patients With Diabetes

Metric	Age	Data Element	Reporting Instructions
KidneyHealthEvaluation	18-64	EligiblePopulation	For each Stratification
	65-74	ExclusionAdminOptional	For each Stratification
	75-85	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)