Health Insurance Exchange

Draft 2020 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey

Proposed QRS and QHP Enrollee Experience Survey Program Refinements

March 2020

Contents

List of Exhibits

1.0 Purpose of the 2020 QRS and QHP Enrollee Survey Call Letter

The *Draft 2020 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Draft 2020 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 temporary adjustments to the QRS weighting approach, proposed refinements to the QRS measure set, the process for modifying the QHP Enrollee Survey sample frame, and potential refinements for future years.

This document does not include all potential refinements to the QHP Enrollee Survey program. For example, other types of 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 2020 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 Call Letter to Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-Draft 2020 QRS and QHP Enrollee Survey Letter" in the subject line by the close of the comment period (April 20, 2020). After reviewing stakeholder feedback, CMS will finalize decisions on these proposed changes, and will communicate final changes about the QRS program in the *Final 2020 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Final 2020 QRS and QHP Enrollee Survey Call Letter), which CMS anticipates publishing in the spring of 2020. In the fall of 2020, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2021* (hereafter referred to as the 2021 QRS and QHP Enrollee Survey Guidance) and the *2021 Quality Rating System Measure Technical Specifications*, reflecting applicable finalized changes announced in the Final 2020 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 March through May) timeline as shown in Exhibit 1 below, followed by the publication of the QRS and QHP Enrollee Survey Guidance in the fall.

[1] The QRS and QHP Enrollee Survey requirements for the 2020 ratings year (the 2020 QRS) are detailed in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2020* (2020 QRS Guidance), which was released in October 2019 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.

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

Date	Description
March	**Publication of Draft Call Letter:** CMS proposes changes to the QRS and QHP Enrollee Survey and provides stakeholders with the opportunity to submit feedback via a 30-day public comment period.
April – May	**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.
August/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 Exchanges (Exchanges).

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 2020 ratings year (the 2020 QRS) generally represent calendar year 2019 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 2019. ▪ For QRS survey measure data in the 2020 QRS, the QHP Enrollee Survey is fielded based on enrollees who are currently enrolled as of January 1, 2020, but the survey requests that enrollees report on their experience "in the last 6 months."
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, "2020 QRS" refers to the 2020 ratings year. ▪ As part of the 2020 plan year certification process, which occurred during the spring and summer of 2019, QHP issuers attested that they will adhere to 2020 quality reporting requirements, which include requirements to report data for the 2020 QRS and QHP Enrollee Survey. ▪ Requirements for the 2020 QRS, and details as to the data collection, validation, and submission processes, are documented in the 2020 QRS Guidance, which was published in October 2019. ▪ Ratings calculated for the 2020 QRS are displayed for QHPs offered during the 2021 plan year, in time for open enrollment, to assist consumers in selecting QHPs.

2.0 Proposed QRS Revisions for the 2020 Ratings Year

CMS is proposing the incorporation of a temporary explicit weighting approach for the Patient Safety domain for the 2020 ratings year.[2]

2.1 Explicit Weighting for Patient Safety

In the Final 2019 QRS and QHP Enrollee Survey Call Letter, CMS finalized the removal of the *Annual Monitoring for Patients on Persistent Medication* (MPM) measure and the inclusion of the *International Normalized Ratio Monitoring for Individuals on Warfarin* (INR) measure in the QRS measure set beginning in 2020.[3] CMS takes an incremental approach when implementing measures in an effort to be responsive to issuer and other stakeholder feedback. Therefore, though CMS will begin data collection of INR measure data in 2020; because it is a new measure, the INR measure will not be included in the calculation of QRS ratings until the 2021 ratings year.

As a result of these refinements, the Patient Safety composite and domain will include only one measure for scoring in the 2020 ratings year: the *Plan All-Cause Readmission* (PCR) measure. In future years, CMS intends to incorporate additional meaningful measures into the Patient Safety composite that align with the CMS priority of reducing harm caused in the delivery of care.[4]

In the interim, for the 2020 ratings year, CMS proposes an explicit weighting structure in which the domains in the Clinical Quality Management summary indicator reflect the amount of underlying measure data within the composites and domains, and to mitigate the influence of the PCR measure on the overall global score. Currently, CMS applies explicit weights at the summary indicator level, but does not apply explicit weights at the domain level. Therefore, the three domains in the Clinical Quality Management summary indicator currently have equal weight on the global score (22.2 percent). Exhibit 3 includes the proposed temporary weighting structure for the domains in the Clinical Quality Management summary indicator for the 2020 ratings year.

Exhibit 3. Proposed Explicit Weighting Structure for Clinical Quality Management Summary Indicator

Summary Indicator	Explicit Weight	Domain	Proposed Explicit Weight	Current Implicit Weight
S1: Clinical Quality Management	66.7%	D1: Clinical Effectiveness	27.8%	22.2%
		D2: Patient Safety	11.1%	22.2%
		D3: Prevention	27.8%	22.2%

[2] The Final 2019 QRS and QHP Enrollee Survey Call Letter includes refinements for the QRS that will take effect beginning with the 2020 ratings year. These refinements include the inclusion of the INR measure in the QRS measure set and the removal of the MPM and the *Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication* (ADD) measures from the QRS measure set. The Final 2019 QRS and QHP Enrollee Survey Call Letter is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2019_Call_Letter_for_QRS_and_QHP_Enrollee_Experience_Survey_508.pdf

[3] As detailed in the Final 2019 QRS and QHP Enrollee Survey Call Letter, CMS will begin collecting data for the INR measure in the 2020 ratings year and will begin scoring the measure in the 2021 ratings year.

[4] For example, as detailed in Section 3.2.1, CMS is proposing to add the *Annual Monitoring for Persons on Long-term Opioid Therapy* (AMO) measure to the Patient Safety composite beginning with the 2021 QRS ratings year.

With this weighting adjustment, the PCR measure will carry the same weight in 2020 as it did during the 2019 ratings year. Additionally, the measures in the Clinical Effectiveness and the Prevention domains will have a slightly increased weight with this adjustment. The anticipated incorporation of the INR measure into scoring starting in the 2021 ratings year would reduce the implicit weight of the PCR measure back to 11.1 percent. Thus, CMS believes this temporary weighting structure will balance the influence of individual measures on the global score and maintain the current contribution of the PCR measure.

3.0 Proposed QRS and QHP Enrollee Survey Revisions for the 2021 Ratings Year

In alignment with proposed retirement by the measure steward, CMS is proposing to remove two measures from the QRS measure set beginning with the 2021 ratings year: *Adult Body Mass Index (BMI) Assessment* (ABA) and *Medication Management for People with Asthma* (75% of Treatment Period) (MMA).

Additionally, CMS is proposing to incorporate one patient safety-related clinical measure and one asthma care-related clinical measure into the QRS measure set beginning with the 2021 ratings year. CMS is also soliciting comments on potential modifications to the QHP Enrollee Survey beginning with the 2021 ratings year.

Appendix A includes the proposed hierarchy for the 2021 QRS ratings year, which reflects these proposed removals and additions of measures.

3.1 Potential Removal of Measures

3.1.1 Removing the Adult BMI Assessment (ABA) Measure from the QRS Measure Set

For the 2021 ratings year and beyond, CMS proposes removing the ABA measure from the QRS measure set due to the recommended retirement of this measure by the National Committee for Quality Assurance (NCQA).[5] The recommended retirement of the ABA measure stems from a recent change to the ICD-10 Official Guidelines for Coding and Reporting, which allows providers to document BMI codes only if the patient had a clinically relevant condition (e.g., obesity).

This coding change has a significant impact on the administrative reporting method for the ABA measure. CMS would continue to collect the ABA measure and use it for scoring in the 2020 ratings year.

Additionally, CMS is investigating alternative measures to replace the ABA measure and solicits comments regarding other BMI-related preventive care measures that could be incorporated into the QRS.

[5] See the Proposed Retirement for HEDIS® MY 2020 *Adult BMI Assessment* (ABA), available at: https://www.ncqa.org/wp-content/uploads/2020/02/20200212_02_ABA.pdf

3.1.2 Removing the Medication Management for People with Asthma (MMA) Measure from the QRS Measure Set

For the 2021 ratings year and beyond, CMS proposes removing the MMA measure from the QRS measure set. The NCQA is recommending retirement of this measure because emerging evidence suggests that high performance on the MMA measure is not necessarily associated with improved clinical outcomes.[6] CMS would continue to collect the MMA measure and use it for scoring in the 2020 ratings year. Incorporating this change beginning with the 2021 ratings year aligns the QRS with the measure steward's (i.e., NCQA's) recommendation.

CMS recognizes that removal of the MMA measure would leave no measure used for scoring in the Asthma Care composite beginning with the 2021 ratings year. As detailed in Section 3.2.2, CMS is proposing the addition of a different asthma-related measure in the Asthma Care composite beginning with the 2021 ratings year and is investigating options for potential adjustments to the hierarchy for the 2021 ratings year, as may be necessary, in the interim.

CMS is also investigating potential options for adjusting the hierarchy for the 2021 ratings year (e.g., adjustments to the QRS explicit weighting structure and/or temporary removal of the Asthma Care composite) to mitigate the impact of the removal of the MMA measure and may propose such refinements during the 2021 Call Letter cycle.

3.2 Potential Addition of Measures

Beginning with the 2021 ratings year, CMS is considering the addition of two measures to the QRS measure set: *Annual Monitoring for Persons on Long-term Opioid Therapy* (AMO) (formerly the *Annual Monitoring for Patients on Chronic Opioid Therapy* [COT] measure) and *Asthma Medication Ratio* (AMR). CMS is proposing these measures for potential inclusion in the QRS measure set beginning with the 2021 ratings year to increase reporting on patient safety-related and medication management-related topics and to address high-priority areas in the Meaningful Measures Framework.

If CMS incorporates the measures proposed in this section into the QRS measure set, an initial year of data collection would occur before the measures are included in the calculation of QRS scores and ratings; i.e., if the measures are added as proposed, data collection would begin with the 2021 QRS but CMS would not include the measures in scoring until the 2022 ratings year, at the earliest. After the first year of data collection, CMS would conduct additional analyses to confirm that the placement of these measures in the hierarchy is statistically appropriate and intends to provide the raw measure rates for these measures in the QRS proof sheets in the first year of data collection.

3.2.1 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) Measure

The Pharmacy Quality Alliance (PQA) serves as the measure steward for the AMO measure, a process measure that calculates the percentage of patients age 18 years and older who are prescribed long-term opioid therapy and have not received a drug test during the measurement

[6] See the Proposed Retirement for HEDIS® MY 2020 *Medication Management for People With Asthma* (MMA), available at: https://www.ncqa.org/wp-content/uploads/2020/02/20200212_03_MMA.pdf

year. CMS is proposing to incorporate the AMO measure in the QRS measure set to align with CMS' priority of combating the opioid epidemic by promoting safe and responsible pain management and identifying opioid use disorder.

Drug test results are critical sources of information for providers of patients receiving long-term opioid therapy. Monitoring the proportion of patients on long-term opioid therapy who have not received drug testing during the measurement year encourages monitoring of patients on long-term opioid therapy, as recommended in clinical practice guidelines, and aids QHP issuers and providers in identifying such patients whose monitoring could be improved. This process will help QHP issuers and clinicians to identify patients on long-term opioid therapy who engage in aberrant drug-related behaviors and patients who need referrals for opioid use disorder.

During measure testing, CMS determined that the data elements for AMO are available in QHP administrative data. Therefore, CMS anticipates that incorporating the AMO measure into the QRS measure set will impose minimal burden on QHP issuers. In the winter of 2020, the NQF Behavioral Health and Substance Use Standing Committee voted in favor of recommending endorsement for the AMO measure, agreeing that the measure was sound, useful, and warranted endorsement. The committee agreed that there is an opportunity for improvement in the area of opioid use monitoring. CMS anticipates the Consensus Standards Approval Committee (CSAC) will concur with the Standing Committee's determination. CMS proposes to add this measure to the Patient Safety composite, as shown in Appendix A.

The draft measure specifications for AMO are included in Appendix B.[7]

3.2.2 Asthma Medication Ratio (AMR) Measure

Due to the retirement of the MMA measure, CMS is proposing to add the AMR measure to the Asthma Care composite to retain an asthma-related measure in the QRS measure set, as shown in Appendix A. Studies have consistently shown that controller medications are associated with improved asthma control, and that overuse of reliever medications is indicative of poor asthma control. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication.

NCQA serves as the measure steward for the AMR measure, a process measure that calculates the percentage of patients 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

CMS anticipates the change from the AMR measure to the MMA measure will impose minimal burden on issuers due to similarities between the two measures and the AMR measure's current use in other measure sets. Both measures address the same population (adults and children 5 to 64 years of age who were identified as having persistent asthma) and measurement concepts (asthma medication management).

[7] The AMO measure technical specifications included in Appendix B are subject to change from those published in the 2021 QRS Measure Technical Specification.

The two measures also have similar numerator criteria, the provision of asthma controller medications, with the AMR measure assessing the ratio of controller medications to total asthma medications and the MMA measure assessing the proportion of days covered by at least one asthma controller medication prescription. In addition to similarities between the AMR and MMA measures, CMS anticipates the issuer community will be already familiar with the AMR measure, as it is included in the Medicaid Adult and Child Core Sets, thus further reducing the burden imposed on issuers by this measure set change.

CMS is proposing to add the AMR measure to the QRS measure set to align with CMS' priority of promoting effective communication and coordination of care: medication management.

To obtain the measure specifications for the AMR measure, please see the following instructions:

1. Log in to your My.NCQA account and select the **Ask A Question** button.
2. Select the **PCS** (Policy/Program Clarification Support) button.
3. In the Product/Program Type dropdown, select the **HEDIS QRS** option.
4. In the General Content dropdown, select the **HEDIS QRS Measure Specifications** option.

3.3 Inclusion of QHP Enrollee Survey Sample Frame Variables

For the 2020 QHP Enrollee Survey, CMS added the enrollee education and enrollee employment variables to the sample frame file layout.[8] CMS included these variables to help confirm that the respondent corresponds to the individual in the sample frame and to evaluate the data for potential future case mix adjustment.

Many of the variables CMS uses for case mix adjustment are collected through the sample frame file. Therefore, CMS added completeness thresholds (i.e., not missing) to the 2020 sample frame file layout for each sample frame variable to ensure that sample frame data are populated fully and can be used to accurately conduct case mix adjustment.

In response to stakeholder feedback, CMS proposes removing the completeness thresholds for the enrollee education and enrollee employment variables from the 2021 QHP Enrollee Survey sample frame file layout. CMS proposes to permit issuers to optionally report education and employment data to avoid increased issuer burden and level of effort when generating survey sample frames.

CMS is interested in receiving feedback, in response to this Draft Call Letter, on the enrollee demographic data issuers currently collect that could be used as case mix adjusters in future survey years. For future survey administration years, CMS will include any proposed changes to the variables included in QHP Enrollee Survey sample frame file layout as part of the Call Letter process to solicit stakeholder feedback and notify issuers prior to publishing the QHP Enrollee Survey Technical Specifications, published annually in October.

[8] See Appendix C of the *2020 Quality Rating System and QHP Enrollee Experience Survey: Operational Instructions*, available at: https://www.cms.gov/files/document/2020-quality-rating-system-and-qhp-enrollee-experience-survey-operational-instructions.pdf.

4.0 Proposed QRS and QHP Enrollee Survey Revisions for Future Years

CMS is also soliciting comments on potential modifications to the QHP Enrollee Survey and QRS for future years. Topics for future consideration and evaluation include, but are not limited to:

- Considering alternative strategies and changes to the framework of the QRS, specifically regarding potential modifications to increase the year-to-year stability of individual issuer performance,
- Removing items from the QHP Enrollee Survey Questionnaire,
- Refining items in the QHP Enrollee Survey to improve response rate and utility of results for issuer quality improvement,
- Proposing changes to the QHP Enrollee Survey sample frame layout in the QRS and QHP Enrollee Survey Call Letter,
- Potentially modifying the QRS clustering and cut point methodologies,
- Removing levels from the QRS hierarchy (specifically, the composite and domain levels), and
- Considering a strategy to risk adjust QRS measures for sociodemographic status.[9]

CMS anticipates including these proposed refinements in future Draft Call Letters, through the rule-making process 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 potential future proposals.

4.1 Refinements to the QHP Enrollee Survey Questionnaire

The QHP Enrollee Survey is designed to help CMS and consumers understand enrollees' experience with their health plan and care. The data received are an important part of QHP issuers' quality improvement activities.

In 2020, CMS intends to conduct focus groups with issuers and consumers, followed by cognitive testing, to identify potential survey refinements and questions for possible removal, including those with low reliability. CMS anticipates that refining the QHP Enrollee Survey questionnaire may improve enrollee response rates.

CMS may incorporate changes informed by these results into the 2022 QHP Enrollee Survey and will comply with PRA requirements, as applicable. CMS will comply with the PRA requirements and anticipates posting an information collection request for public comment in March 2020 for the 2021 QHP Enrollee Survey.

CMS is interested in receiving feedback in response to this Call Letter on suggested potential refinements to current questions that would maximize the actionable information available to issuers (i.e., issuers should be able to use the data to make concrete changes that would show

[9] See the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019; Final Rule, at 83 16930 FR at 17029- 17030 (April 17, 2018), available at: https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019

improvement) while also providing consumers with comparable and useful information about the quality of health care services and enrollee experience. CMS is also interested in receiving similar feedback about survey questions that should be considered for removal. CMS is interested in comments that would potentially increase the response rate of the survey.

4.2 Future Modification of the QRS Clustering and Cut Point Methodologies

CMS is investigating potential refinements to the QRS clustering and cut point methodologies for future years. In response to stakeholder feedback, CMS intends to incorporate refinements that increase the stability and predictability of cut points between years and reduce sensitivity to changes in the underlying data, while still maintaining a fundamentally data-driven methodology.

CMS is interested in soliciting comments and suggestions regarding mathematical approaches to assigning star ratings respective to QHP performance. Possible mathematical approaches include the following:

- Setting an anticipated distribution of star ratings each year (e.g., 10 percent receive a 1-star, 20 percent receive a 2-star)
- Defining cut points as percentiles of global scores based on a normal distribution (e.g., 10^{th} percentile, 30^{th} percentile, 50^{th} percentile, 70^{th} percentile cut points)
- Defining cut points based on a metric like standard deviation from the mean global score
- Using a modified or different clustering algorithm that provides stable cut points

4.3 Revisions to the QRS Hierarchy

To further balance the influence of individual survey and clinical measures on the global score and support alignment with other CMS quality reporting programs, CMS is considering removing one or more levels of the QRS hierarchy. Currently, measures within components that only contain one or two measures contribute a considerable amount of influence on the global score due to the scoring methodology, which generally uses an average of averages approach to aggregate measure and component scores up each level of the hierarchy.

Additionally, there are instances in the hierarchy where only one composite feeds into a domain, leading to repetition in composite and domain scores. For example, there is no difference between the composite and domain scores under the Enrollee Experience and the Plan Efficiency, Affordability, & Management summary indicators.

CMS believes that a simplified hierarchy (e.g., removing the composite and/or domain levels) may help to streamline and/or improve consumer understanding of the quality rating information. In addition, CMS currently only requires Exchanges to display the global and the summary indicator levels for consumers on their respective websites.

Please note that CMS does not anticipate that these changes will impact the individual measures or data collection process for these measures.

CMS is interested in receiving feedback in response to this Draft Call Letter on consolidation of the QRS hierarchy, such as the removal of one or more levels in the current hierarchy. Exhibit 4

includes an example of the 2020 QRS hierarchy with the composite and domain level removed. Appendix A includes the current QRS hierarchy structure.

Exhibit 4. Proposed QRS Hierarchy Structure (Composite and Domain Level Removed)

QRS Summary Indicator	Measure Title
Clinical Quality Management (Weight 2/3)	Medication Management for People With Asthma (75% of Treatment Period)
	Antidepressant Medication Management
	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	Controlling High Blood Pressure
	Proportion of Days Covered (RAS Antagonists)
	Proportion of Days Covered (Statins)
	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
	Comprehensive Diabetes Care: Medical Attention for Nephropathy
	Proportion of Days Covered (Diabetes All Class)
	Plan All-Cause Readmissions (1/rate)
	INR Monitoring for Individuals on Warfarin (INR)
	Breast Cancer Screening
	Cervical Cancer Screening
	Colorectal Cancer Screening
	Prenatal and Postpartum Care (Postpartum Care)
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)
	Adult BMI Assessment
	Chlamydia Screening in Women
	Flu Vaccinations for Adults Ages 18-84
	Medical Assistance With Smoking and Tobacco Use Cessation
	Annual Dental Visit
	Childhood Immunization Status (Combination 3)
	Immunizations for Adolescents (Combination 2)
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
	Well-Child Visits in the First 15 Months of Life (6 or More Visits)
Enrollee Experience (Weight 1/6)	Access to Care
	Care Coordination
	Rating of All Health Care
	Rating of Personal Doctor
	Rating of Specialist
Plan Efficiency, Affordability, & Management (Weight 1/6)	Appropriate Testing for Pharyngitis
	Appropriate Treatment for Upper Respiratory Infection
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
	Use of Imaging Studies for Low Back Pain
	Access to Information
	Plan Administration
	Rating of Health Plan

4.4 Risk Adjustment Based on Sociodemographic Status

CMS continues to consider development of a strategy to risk adjust QRS measures for sociodemographic status. In alignment with other quality ratings programs (e.g., the Medicare Part C & D Star Ratings Program), CMS intends to monitor the latest research to inform discussions regarding potential risk adjustment of QRS measures based on sociodemographic status for future years.

For example, as of 2020, CMS implemented an interim analytical adjustment for the Medicare Part C & Part D Star Ratings Program called the Categorical Adjustment Index (CAI) and indicated that measure stewards are currently undertaking a comprehensive review of all measures in the Star Ratings program to identify additional risk adjustment methods.[10] The CAI factor is added to or subtracted from a contract's Overall and/or Summary ratings to adjust for the average disparity in performance associated with a contract's percentages of beneficiaries with Low Income Subsidy/Dual Eligible (LIS/DE) and disability status. The CAI adjustment is applied to all clinical measure scores that are not adjusted for socio-economic status using a beneficiary-level logistic regression model with contract fixed effects and beneficiary-level indicators of LIS/DE and disability status, similar to the approach currently used to adjust CAHPS patient experience measures. Unadjusted Overall and Summary Star Ratings are also determined per contract. Below is a list of all QRS measures used in the Medicare Stars 2020 CAI adjustment calculation.

- *Breast Cancer Screening* (Part C)
- *Colorectal Cancer Screening* (Part C)
- *Annual Flu Vaccine* (Part C)
- *Adult BMI Assessment* (Part C)
- *Comprehensive Diabetes Care: Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy*
- *Plan All-Cause Readmissions* (Part C)
- *Proportion of Days Covered (Diabetes All Class, Renin Angiotensin System (RAS) Antagonists, and Statins*)

CMS is interested in receiving feedback in response to this Call Letter on potential strategies to risk adjust QRS measures for sociodemographic status. CMS is also interested in understanding the types of sociodemographic data QHP issuers are currently collecting in their administrative data.

[10] See the *Medicare 2020 Part C & D Star Ratings Technical Notes*, available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf

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 hierarchical components (composites, domains, summary indicators) to form a single global rating.

Exhibit 5 illustrates the proposed 2021 ratings year QRS hierarchy.[11] Measures denoted with a strikethrough (–), if removed as proposed, would not be collected for the 2021 ratings year. Measures denoted with an asterisk (*), if finalized as proposed, would be collected, but not included, in 2021 QRS scoring.

Exhibit 5. Proposed 2021 Ratings Year QRS Hierarchy

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	M#
Clinical Quality Management (Weight 2/3)	Clinical Effectiveness	Asthma Care	~~Medication Management for People With Asthma (75% of Treatment Period)~~	1
			Asthma Medication Ratio*	50
		Behavioral Health	Antidepressant Medication Management	2
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	3
			Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	5
		Cardiovascular Care	Controlling High Blood Pressure	6
			Proportion of Days Covered (RAS Antagonists)	7
			Proportion of Days Covered (Statins)	8
		Diabetes Care	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	9
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	10
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	12
			Proportion of Days Covered (Diabetes All Class)	13
	Patient Safety	Patient Safety	Plan All-Cause Readmissions (1/rate)	15
			INR Monitoring for Individuals on Warfarin (INR)	48
			Annual Monitoring for Persons on Long-term Opioid Therapy*	49
	Prevention	Checking for Cancer	Breast Cancer Screening	16
			Cervical Cancer Screening	17
			Colorectal Cancer Screening	18

[11] For information on the 2020 QRS hierarchy, see Appendix E in the 2020 QRS Guidance, available on CMS' MQI website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	M#
		Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	19
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	20
		Staying Healthy Adult	~~Adult BMI Assessment~~	21
			Chlamydia Screening in Women	23
			Flu Vaccinations for Adults Ages 18-84	24
			Medical Assistance With Smoking and Tobacco Use Cessation	25
		Staying Healthy Child	Annual Dental Visit	26
			Childhood Immunization Status (Combination 3)	27
			Immunizations for Adolescents (Combination 2)	47
			Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	30
			Well-Child Visits in the First 15 Months of Life (6 or More Visits)	31
Enrollee Experience (Weight 1/6)	Access + Care Coordination	Access to Care + Care Coordination	Access to Care	33
			Care Coordination	34
	Doctor and Care	Doctor and Care	Rating of All Health Care	36
			Rating of Personal Doctor	37
			Rating of Specialist	38
Plan Efficiency, Affordability, & Management **(Weight 1/6)**	Efficiency & Affordability	Efficient Care	Appropriate Testing for Pharyngitis	39
			Appropriate Treatment for Upper Respiratory Infection	40
			Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	41
			Use of Imaging Studies for Low Back Pain	42
	Plan Service	Enrollee Experience with Health Plan	Access to Information	43
			Plan Administration	44
			Rating of Health Plan	45

Appendix B. AMO Measure Technical Specifications

Exhibit 6. Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

Description

The percentage of individuals 18 years and older who are prescribed long-term opioid therapy and have not received a drug test at least once during the measurement year.

A lower rate indicates better performance.

Intended Use	
Intended Use	Performance measurement for Qualified Health Plans (QHPs).

Definitions	
Opioid Analgesics	See Medication Table AMO: Opioid Analgesics. Includes opioid medications indicated for pain.
Long-Term Opioid Therapy	≥90 days' cumulative supply of any combination of opioid analgesics (See Medication Table AMO: Opioid Analgesics) during the measurement year identified using prescription claims.
Measurement Year	The calendar year (January 1 through December 31) when the measure is assessed.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Hospice Exclusion	Any individual in hospice care indicated by institutional or noninstitutional claims any time during the measurement year. To identify individuals in hospice: • See the Hospice Value Set. • Include any institutional or noninstitutional claims indicating hospice care during the measurement year
Cancer Diagnosis Exclusion	Any individual with a cancer diagnosis indicated by institutional or noninstitutional claims at any time during the measurement year. • See the Cancer Value Set. • A Cancer diagnosis is defined as having at least one claim with Cancer in the primary diagnosis or any other diagnosis fields during the measurement year.
Drug Test	Identified through specified Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes, or Logical Observation Identifiers Names and Codes (LOINC) for presumptive or definitive drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids. • See the Drug Test Value Set.

Eligible Population	
Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	Individuals must be continuously enrolled in a QHP for 11 out of 12 months during the measurement year, with no gaps in enrollment until the month of death during the measurement year. For QHPs in the Health Insurance Marketplace, switching between QHP products is considered continuous enrollment if enrollment and claims/encounter data are available for 11 of 12 months. The measure score is attributed to the last enrolled QHP product.
Allowable Gap	None.
Benefit	Medical, Pharmacy.
Event/Diagnosis	Individuals who are prescribed long-term opioid therapy. Use the steps below to determine the eligible population.
Step 1	Identify individuals aged 18 years and older as of the last day of the measurement year.
Step 2	Identify individuals meeting the continuous enrollment criteria.
Step 3	Identify individuals who are prescribed ≥90 days' cumulative supply of any combination of opioid analgesics (See Medication Table AMO: Opioid Analgesics) during the measurement year. • NOTE: Days' supply is calculated by summing the days' supply for every prescription during the measurement year for opioid analgesics. Individuals qualify for the measure denominator if this sum is at least 90 days.
Step 4	Exclude individuals who met ≥1 of the following during the measurement year: • Hospice • Cancer

Administrative Specification	
Data Sources	Medical claims, Prescription claims.
Denominator	The eligible population.
Numerator	Individuals in the denominator who have not received a drug test during the measurement year.
Step 1	Identify individuals from the denominator who do not have a drug during the measurement year (see the Drug Test Value Set).
Measure Rate	Divide the numerator by the denominator and multiply by 100.

Stratification	None.

Medication Table

Table AMO: Opioid Analgesics [a,b]

Opioids		
• benzhydrocodone	• hydrocodone	• oxycodone
• buprenorphine	• hydromorphone	• oxymorphone
• butorphanol	• levorphanol	• pentazocine
• codeine	• meperidine	• tapentadol
• dihydrocodeine	• methadone	• tramadol
• fentanyl	• morphine	

[a] Includes opioid medications indicated for pain; includes combination products.
[b] Excludes the following: medications prescribed or provided as part of medication-assisted treatment for opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products); and formulations delivered by the intravenous (IV) or epidural (EP) route (IV and EP routes are excluded because they are not commonly prescribed as chronic pain medications).

This measure was developed by IMPAQ International, LLC and Health Services Advisory Group, Inc. (HSAG).