

Health Insurance Exchange

Draft 2021 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

February 2021

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1.0 Purpose of the 2021 QRS and QHP Enrollee Survey Call Letter

The *Draft 2021 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Draft 2021 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 for the 2021 ratings year,
- Proposed refinements to the QRS measure set,
- Modifications to the QRS scoring methodology beginning with the 2022 ratings year, and
- Potential QRS and QHP Enrollee Survey refinements for future years

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 2021 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 2021 QRS and QHP Enrollee Survey Letter” in the subject line by the close of the comment period (March 10, 2021).

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 2021 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Final 2021 QRS and QHP Enrollee Survey Call Letter), which CMS anticipates publishing in the late spring of 2021.

In the early spring of 2021, CMS intends to publish the *2022 Quality Rating System Measure Technical Specifications* that will include the measure specifications for all potential measures in the 2022 QRS measure set (i.e., any measures proposed for addition and removal in this Draft Call Letter).

In the fall of 2021, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022* (hereafter referred to as the 2022 QRS and QHP Enrollee Survey Guidance), reflecting applicable finalized changes announced in

¹ The QRS and QHP Enrollee Survey requirements for the 2021 ratings year (the 2021 QRS) are detailed in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2021* (2021 QRS Guidance), which was released in September 2020 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>.

the Final 2021 QRS and QHP Enrollee Survey Call Letter. The 2022 QRS and QHP Enrollee Survey Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2022 ratings year.

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 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). ²
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.
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	<p>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.</p> <ul style="list-style-type: none"> ▪ QRS clinical measure data submitted for the 2021 ratings year (the 2021 QRS) generally represent calendar year 2020 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 2020. ▪ For QRS survey measure data in the 2021 QRS, the QHP Enrollee Survey is fielded based on enrollees who are currently enrolled as of January 6, 2021, but the survey requests that enrollees report on their experience “from July through December 2020.”

² Beginning with the 2022 ratings year, CMS will align with the new National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS[®]) timeline and publish the 2022 QRS Measure Technical Specifications in the spring of 2021. More information on the HEDIS schedule change is available at: <https://www.ncqa.org/hedis/the-future-of-hedis/schedule-change/>

Term	Description
Ratings Year	<p>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, “2021 QRS” refers to the 2021 ratings year.</p> <ul style="list-style-type: none"> ▪ As part of the 2021 plan year certification process, which occurred during the spring and summer of 2020, QHP issuers attested that they will adhere to 2021 quality reporting requirements, which include requirements to report data for the 2021 QRS and QHP Enrollee Survey. ▪ Requirements for the 2021 QRS, and details as to the data collection, validation, and submission processes, are documented in the 2021 QRS Guidance, which was published in October 2020. ▪ Ratings calculated for the 2021 QRS are displayed for QHPs offered during the 2022 plan year, in time for open enrollment, to assist consumers in selecting QHPs.

2.0 Proposed QRS Revisions for the 2021 Ratings Year

For the 2021 ratings year, CMS is proposing the following modifications to the QRS:

- Explicit weighting for domains in the Clinical Quality Management summary indicator,
- Temporary removal of the *Child and Adolescent Well-Care Visit* measure from 2021 scoring, and
- Temporary QRS methodology changes to mitigate the impact of COVID-19 on the QRS ratings.

2.1 Explicit Weighting for Domains in the Clinical Quality Management Summary Indicator

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 Patient Safety composite beginning in 2020.³ Due to the suspension of QRS clinical data and QHP Enrollee Survey data collection for the 2020 ratings year,⁴ the 2021 ratings year will be the first year of data collection for the INR measure.

In the Final 2020 QRS and QHP Enrollee Survey Call Letter, CMS finalized the inclusion of the *Annual Monitoring for Persons on Long-term Opioid Therapy* (AMO) measure in the Patient Safety composite beginning with the 2021 QRS ratings year.⁵ CMS will not include the INR and AMO measures in scoring until the 2022 ratings year, at the earliest. As a result of these changes,

³ The Final 2019 QRS and QHP Enrollee Survey Call Letter includes refinements for the QRS that took effect beginning with the 2020 ratings year. 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 Exp erience Survey 508.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2019%20Call%20Letter%20for%20QRS%20and%20QHP%20Enrollee%20Exp%20Experience%20Survey%20508.pdf)

⁴ In April 2020, CMS released the COVID-19 Marketplace Quality Initiatives Memo announcing that CMS was exercising enforcement discretion to adopt a temporary policy of relaxed enforcement and directing all eligible QHP issuers to discontinue the collection of clinical quality measure data and survey measure data that would normally be reported between May and June 2020. This memo is available at: <https://www.cms.gov/files/document/covid-qrs-and-marketplace-quality-initiatives-memo-final.pdf>.

⁵ See Section 3 of the Final 2020 QRS Call Letter, available at <https://www.cms.gov/files/document/final-2020-call-letter-quality-rating-system-qrs-and-qualified-health-plan-enrollee-experience.pdf>.

the Patient Safety composite and domain will include only one measure for scoring in the 2021 ratings year: the *Plan All-Cause Readmission (PCR)* measure.

To mitigate the influence of the PCR measure on the overall global score for the 2021 ratings year, CMS proposes a temporary explicit weighting structure that reflects the amount of underlying measure data within the Patient Safety domain in the Clinical Quality Management summary indicator.⁶ Currently, CMS applies explicit weights at the summary indicator level, but does not apply explicit weights at any other level of the QRS hierarchy.⁷ Therefore, the three domains in the Clinical Quality Management summary indicator currently have equal weight when generating the summary indicator score (22.22 percent) and combined weight of 66.67 percent of the global score. Exhibit 3 outlines the proposed temporary weighting structure for the domains in the Clinical Quality Management summary indicator for the 2021 ratings year and compares the proposal to the established current approach.

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%

With this proposed temporary weighting adjustment, the PCR measure would carry the same weight in 2021 as it did during the 2019 ratings year (11.1%). In return, the measures in the Clinical Effectiveness and the Prevention domains will have increased weight with this adjustment. This proposed temporary weighting adjustment for the 2021 ratings year would balance the influence of individual measures on the global score and maintain the current contribution of the PCR measure.

The anticipated incorporation of the INR and AMO measures into scoring starting in the 2022 ratings year would remove the need for explicit weighting as these other measures would balance out the impact of the PCR measure on the global score.

CMS is also continuing to explore removing levels of the QRS hierarchy to balance the influence of individual survey and clinical measures on the global score and support alignment with other CMS quality reporting programs (i.e., by aligning with the structure of the hierarchy used for the Medicare Part C & D Star Rating Program). 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. CMS sought comment

⁶ In the Draft 2020 Call Letter, CMS proposed to adopt the same explicit weighting structure for the domains in the Clinical Quality Management summary indicator for the 2020 ratings year. CMS did not finalize the change for the 2020 ratings year due to the suspension of 2020 data collection.

⁷ See the 2021 QRS Guidance, Appendix E. QRS Hierarchy at: <https://www.cms.gov/files/document/quality-rating-system-and-qualified-health-plan-enrollee-experience-survey-technical-guidance-2021.pdf>

on the removal of one or more levels of the QRS hierarchy through the rulemaking process in the 2022 Notice of Benefit and Payment Parameter proposed rule.⁸

2.2 Temporary Removal of the Child and Adolescent Well-Care Visit measure from 2021 Scoring

For the 2021 ratings year, CMS proposes the removal of the *Child and Adolescent Well-Care Visit* measure (formerly the *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* measure) from 2021 QRS scoring. For the 2020 measurement year, the measure steward, the National Committee for Quality Assurance (NCQA), updated the specifications for the QRS measure *Well-Visits in the Third, Fourth, Fifth, and Sixth Years of Life* to add the rate for the *Adolescent Well-Care Visits* measure and to add members age 7–11 years old.⁹

The *Adolescent Well-Care Visits* measure was not previously included in the QRS measure set. As a result of the measure specification changes, the measure now assesses the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a primary care physician (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.

CMS has continued to assess these specification changes and has determined this a significant change to the population covered by the measure.¹⁰ Therefore, CMS is proposing to temporarily remove the *Child and Adolescent Well-Care Visit* measure from scoring for the 2021 ratings year. The proposed removal of this measure from scoring would not otherwise impact the 2021 data submission requirements for the *Child and Adolescent Well-Care Visit* measure (i.e., QHP issuers are required to collect and report validated data for this measure for 2021). CMS anticipates that incorporating the *Child and Adolescent Well-Care Visit* measure in scoring beginning with the 2022 ratings year.

2.3 Temporary QRS Methodology Changes to Mitigate the Impact of COVID-19 on the 2021 QRS Ratings

In April 2020, CMS published the COVID-19 Marketplace Quality Initiatives Memo,¹¹ which announced CMS' temporary policy of relaxed enforcement and directed all eligible QHP issuers to discontinue the collection of clinical quality measure data and survey measure data that would normally be reported between May and June 2020 and used to calculate 2020 quality ratings for

⁸ See the HHS Notice of Benefit and Payment Parameter for 2022 and Pharmacy Benefit Manager Standards Proposed Rule, 85 FR 78642–78643, for more information: <https://www.govinfo.gov/content/pkg/FR-2020-12-04/pdf/2020-26534.pdf>

⁹ As a result of the measure specification changes, NCQA modified the measure name of the *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* to the *Child and Adolescent Well-Care Visits*. See the 2021 QRS Guidance for information related to the modifications to the *Child and Adolescent Well-Care Visit* measure, available at: <https://www.cms.gov/files/document/2021-qrs-measure-technical-specifications.pdf>.

¹⁰ As noted in the 2021 QRS Guidance, CMS has been assessing the impact of these specification changes and might propose to remove the *Child and Adolescent Well-Care Visits* measure from 2021 scoring in the 2021 Call Letter.

¹¹ See supra note 4.

display on Exchange websites beginning during the Plan Year 2021 open enrollment period for the individual market.¹²

Similar to most CMS quality reporting programs, QRS ratings typically reflect clinical measure data that are collected one year prior to the ratings year. Thus, 2021 QRS and QHP Enrollee Survey data reflect clinical services and enrollee experience during the 2020 measurement year. CMS anticipates that these data will likely be impacted by the COVID-19 pandemic as the volume of ambulatory care visits may have decreased during the 2020 measurement year due to public health emergency response efforts (e.g., shelter-in-place orders, social distancing guidance) and reallocation of health care resources.

In alignment with other CMS quality reporting programs (e.g., Medicare Part C & D Star Rating Program), CMS is proposing temporary QRS methodology adjustments in recognition of the impact the COVID-19 pandemic has had on health plan and provider operations. For the Medicare Part C & D Star Rating Program, CMS has introduced a number of refinements to minimize the impact of the COVID-19 pandemic on ratings across Medicare contracts nationwide, and on individual contract ratings (e.g., delaying the implementation of the 5-percentage cut point caps, expanding the hold harmless approach).¹³ Similarly, for the QRS, CMS is proposing to apply the following two temporary refinements for the 2021 ratings year:

- (1) **Policy-Based Distribution:** Set 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 (e.g., using averages across the past three ratings years).¹⁴
- (2) **Limit Star Ratings Declines:** Introduce a rule that precludes 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 rating in ratings year 2019, the lowest rating the plan could receive in ratings year 2021 is three stars).

CMS proposes to first apply the policy-based distribution and then adjust the ratings for individual reporting units that lost more than one star to limit star rating declines for the overall global rating and summary indicator ratings.

2.3.1 Policy-based Distribution

CMS is proposing to adopt a temporary policy-based distribution of ratings at the global and summary indicator levels of the QRS hierarchy for the 2021 ratings year. CMS would retain the current clustering algorithm applied to scores to create cut points at the composite and domain levels.¹⁵ Additionally, CMS will continue to calculate QRS scores at all levels of the QRS hierarchy as described in the 2021 QRS Guidance.¹⁶ At the summary indicator and global levels

¹² *Id.*

¹³ 85 FR 33796, available at <https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program>.

¹⁴ The three underlying summary indicator categories are Medical Care, Member Experience, and Plan Administration.

¹⁵ For more information on the current clustering algorithm, see Appendix D of the [2021 QRS and QHP Enrollee Survey: Technical Guidance](#).

¹⁶ See *supra* note 1.

of the QRS hierarchy, CMS proposes to replace the current clustering algorithm with a set distribution of star ratings based on the historic distribution of QRS ratings. For example, using the ratings distribution from 2017–2019, CMS calculated the average percent of QHP issuers in each star rating category. Exhibit 4 includes a proposed 2021 distribution based on the three-year average using 2017–2019 ratings.¹⁷

Exhibit 4. Proposed 2021 Rating Distribution Example (2017–2019 Average)

	Global Rating	Clinical Quality Management Rating	Enrollee Experience Rating	Plan Affordability, Efficiency, & Management Rating
Star Rating	Percent of Reporting Units	Percent of Reporting Units	Percent of Reporting Units	Percent of Reporting Units
1-star	1%	4%	7%	1%
2-star	16%	14%	19%	10%
3-star	42%	45%	38%	49%
4-star	31%	33%	28%	28%
5-star	10%	4%	8%	12%

As an alternative, CMS is considering adoption of a single year ratings distribution using the 2019 ratings distribution for the 2021 ratings year. Exhibit 5 includes a proposed distribution based on the 2019 distribution.

Exhibit 5. Proposed 2021 Rating Distribution Example (2019 Distribution)

	Global Rating	Clinical Quality Management Rating	Enrollee Experience Rating	Plan Affordability, Efficiency, & Management Rating
Star Rating	Percent of Reporting Units	Percent of Reporting Units	Percent of Reporting Units	Percent of Reporting Units
1-star	2%	6%	5%	3%
2-star	18%	24%	13%	8%
3-star	47%	48%	58%	59%
4-star	27%	22%	20%	20%
5-star	6%	1%	4%	10%

CMS solicits comments on both of these approaches, including any potential advantages or disadvantages of adopting a multi-year ratings distribution compared to adopting a single year (2019) ratings distribution.

2.3.2 Limit Star Ratings Declines

CMS is proposing to introduce a temporary rule for the 2021 ratings year that would limit the number of star ratings a reporting unit can drop at the overall global and summary indicator levels from the 2019 to the 2021 ratings year. As CMS anticipates that reporting units may experience decreases in ratings due to an overall decrease in the volume of ambulatory services during the 2020 calendar year as a result of the COVID-19 public health emergency, this rule would preclude health plans overall global rating and summary indicator ratings from decreasing

¹⁷ CMS is also proposing to introduce limits to the number of star ratings a single reporting unit can drop from the 2019 to the 2021 ratings year (see Section 2.3.2). If finalized as proposed, CMS would first apply the policy-based distribution and then adjust the ratings for individual reporting units that lost more than one star to limit star rating declines for the overall global rating and summary indicator ratings. Therefore, the actual distribution of 2021 ratings may change.

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).

After applying the temporary policy-based distribution to the 2021 scores, CMS would identify any reporting units that experienced a reduction of more than one star compared to 2019.¹⁸ CMS would then adjust the ratings for impacted reporting units such that no reporting unit's rating decreases by more than one star. Exhibit 6 offers an illustrative example of how CMS would apply this rule.

Exhibit 6. Reporting Unit Star Rating Decline Limit Example

Reporting Unit	2019 Global Rating	Original 2021 Global Rating	Adjusted 2021 Global Rating
12345-WV-HMO	4	2	3
12345-PA-PPO	3	2	No adjustment

3.0 Proposed QRS and QHP Enrollee Survey Revisions for the 2022 Ratings Year and Beyond

CMS is proposing a series of refinements to the QRS and QHP Enrollee Survey that would apply beginning with the 2022 ratings year. These refinements include:

- Potential removal of one measure from the QRS,
- Potential addition of measures to the QRS,
- Potential transition to alternative measures for the QRS, and
- QRS measure scoring methodology refinements.

3.1 Removing the Comprehensive Diabetes Care: Medical Attention from Nephropathy Measure from the QRS Measure Set

For the 2022 ratings year and beyond, CMS proposes removing the *Comprehensive Diabetes Care: Medical Attention from Nephropathy* measure from the QRS measure set. NCQA recommends retirement of this measure because it no longer aligns with clinical practice guideline recommendations and provides unclear indicators of quality care for kidney health.¹⁹ CMS will continue to collect the *Comprehensive Diabetes Care: Medical Attention from Nephropathy* measure and use it for scoring in the 2021 ratings year. Incorporating this change beginning with the 2022 ratings year aligns the QRS with the measure steward's (i.e., NCQA's) recommendation.

Additionally, CMS continues to holistically assess the QRS measure set to identify gaps in measures and health care quality priorities that would benefit the population seeking health care coverage through an Exchange. As a result, CMS is investigating potential measures to address priority conditions for the Exchange population and generally solicits comments regarding new

¹⁸ This adjustment will not apply to reporting units that did not receive a rating in 2019 for the 2020 Plan Year.

¹⁹ See Proposed Retirement for HEDIS[®] MY 2022 *Comprehensive Diabetes Care (CDC): Medical Attention for Nephropathy* available at: https://www.ncqa.org/wp-content/uploads/2020/02/20200212_05_CDC_Nephropathy.pdf.

measures that could be incorporated into the QRS for future benefit years. CMS may propose other measures to be incorporated into the QRS in a future Call Letter.

3.2 Adding a COVID-19 Vaccine Measure to the QRS Measure Set

CMS is soliciting comments on a potential new measure concept related to the COVID-19 vaccination beginning with the 2022 ratings year, at the earliest. As work continues to make a vaccine for COVID-19 available across the United States, CMS is considering options for a COVID-19 vaccine measure to be added as a survey measure or a clinical quality measure across CMS quality reporting programs.

CMS is considering developing and testing question(s) to add to the CAHPS survey administered for the Medicare Part C & D Star Ratings Program in early 2022, similar to the flu vaccine. Such question(s) may ascertain whether a beneficiary received the COVID-19 vaccine during a specified timeframe (e.g., in 2021) to therefore measure the percent of beneficiaries who received the COVID-19 vaccine.

In addition, CMS is in the process of developing three (3) clinical quality COVID-19 vaccine measures for various Medicare programs.²⁰ One of the clinical quality measures (*SARS-CoV-2 Vaccination by Clinicians*)²¹ will measure the percentage of patients who have ever received or reported having received a SARS-CoV-2 vaccination dose or a full SARS-CoV-2 vaccination course.²²

In alignment with quality programs across the Agency, CMS is considering incorporating a COVID-19 vaccine measure in the QRS measure set. Health plans play an important role to help educate and encourage their members to get a COVID-19 vaccine. CMS welcomes feedback on an appropriate COVID-19 vaccination measure for the QRS measure set (e.g., measure calculated from a subset of question(s) in the QHP Enrollee Survey, clinical quality measure) and any considerations CMS should account for including timeframe.

Pending the development timeline of these measures, CMS believes COVID-19 vaccination question(s) could be incorporated into the 2022 QHP Enrollee Survey and QRS measure set, at the earliest. Alternatively, CMS could focus efforts on incorporating a clinical quality measure beginning with the 2023 QRS measure set, at the earliest. If CMS incorporates a COVID-19 vaccination measure into the QRS measure set, at least one year of data collection would occur before the measure is included in the calculation of QRS scores and ratings.

CMS is soliciting feedback on considerations and approaches for health plan specification and attribution for a potential clinical quality measure, such as a *SARS-CoV-2 Vaccination by Clinicians* measure. In addition, CMS is soliciting feedback on considerations and approaches related to item content and reference time period for a potential survey measure. CMS solicits comments on both of these alternatives, including any potential advantages or disadvantages of

²⁰ For more information, please see the 2020 Measure Under Consideration (MUC) List, available at: <https://www.cms.gov/files/document/measures-under-consideration-list-2020-report.pdf>

²¹ See Appendix C for the draft measure specifications for the *SARS-CoV-2 Vaccination by Clinicians* measure for the Merit-based Incentive Payment System (MIPS) program.

²² CMS is also partnering with the CDC to develop quality measures to reflect both patient and personnel vaccination measures to be used as appropriate in programs such as those for nursing homes and dialysis facilities.

adding a COVID-19 vaccination measure to the QRS measure set and the appropriate data collection method (e.g., adding questions to the 2022 QHP Enrollee Survey, adopting a new clinical quality measure to the 2023 QRS measure set).

3.3 Proposed Transitions of Select Measures

3.3.1 Transitioning from the Childhood Immunization Status (CIS) Measure Combination 3 to the Combination 10 Rate

For the 2022 ratings year and beyond, CMS proposes transitioning from the *Childhood Immunization Status (Combination 3)* measure to *Childhood Immunization Status (Combination 10)*.²³

Childhood Immunization Status (Combination 3) assesses receipt of seven of the Advisory Committee on Immunization Practices (ACIP) recommended vaccines, including diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) by the age of 18 months.²⁴ The proposed transition from Combination 3 to Combination 10 would include three additional vaccine requirements, including one hepatitis A (HepA), two or three rotavirus (RV), and influenza by the age of 18 months.

NCQA recommends the transition from Combination 3 to Combination 10 in alignment with NCQA's retirement of eight of the nine Childhood Immunization Status measure combination rates (all combination rates except Combination 10), for the HEDIS Measurement Year (MY) 2021. In addition, stakeholders have indicated that most combination rates may no longer be useful and may increase reporting burden. If finalized, CMS would begin collecting the *Childhood Immunization Status (Combination 10)* measure for the 2022 ratings year, with scoring beginning with the 2023 ratings year.

3.3.2 Transitioning from the Follow-up After Hospitalization for Mental Illness (7-Day Follow-up) to the Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-up)

For the 2022 ratings year and beyond, CMS proposes to transition from the *Follow-up After Hospitalization for Mental Illness (7-Day Follow-up)* measure to the *Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-up)* measure. This transition would add the second rate to the *Follow-up After Hospitalization for Mental Illness* measure, the percentage of discharges for which the patient received follow-up within 30 days of discharge.

CMS initially included only the 7-day indicator in the QRS measure set because it exhibited a greater opportunity for improvement. Other CMS quality reporting programs that collect data for this measure (e.g., Medicare Part C & D Star Ratings, Medicaid Adult Core Set) include both the

²³See NCQA's *Proposed Changes to Existing Measure for HEDIS Measurement Year 2021: Childhood Immunization Status (CIS)* for information on ACIP's recommendations regarding Combination 3 and Combination 10 rates: https://www.ncqa.org/wp-content/uploads/2020/10/20201008_02_CIS.pdf

²⁴ *Id.*

7-day and 30-day follow-up indicators. Therefore, CMS is proposing this refinement to improve alignment with other CMS programs.

If finalized, CMS would begin collecting the *Follow-up After Hospitalization for Mental Illness (7-Day and 30-Day Follow-up)* measure for the 2022 ratings year, with scoring beginning with the 2023 ratings year.

3.3.3 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) Measure and Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Measure

CMS is assessing the use of the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)* measure in the QRS measure set and whether to replace with the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure.

The *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)* measure was initially included in the QRS measure set because it exhibited a greater opportunity for improvement than the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure in initial testing. Therefore, this measure was in part selected due to a performance gap.

Additionally, CMS identified that the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)* measure was being collected and submitted for NCQA accreditation, for the Office of Personnel Management (OPM) Federal Employee Health Benefits (FEHB) program, and for state-based programs.

However, CMS is assessing the current approach given that the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure is widely used across CMS quality reporting programs (e.g., Medicare Part C & D Star Ratings, Medicaid Adult Core Set).

CMS is soliciting comments from stakeholders on CMS' approach for the current *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)* measure and the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure. CMS requests stakeholders indicate their preference for reporting the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure, in alignment with other quality reporting programs, in contrast to maintaining the current measure (i.e., the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)* measure).

If finalized for inclusion in the QRS measure set, CMS would begin collecting the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* measure for the 2022 ratings year, with scoring for the measure beginning with the 2023 ratings year.

To obtain measure specifications for *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* 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.

3.4 QRS Measure Scoring Methodology Refinements

CMS is proposing changes to the QRS scoring methodology to increase transparency into QHP performance, and to improve interpretability and predictability of scores and cut points between years. CMS also seeks to reduce the sensitivity of the methodology to changes in the underlying data, while still maintaining a fundamentally data-driven methodology.

In the *Final 2018 Call Letter for the QRS and QHP Enrollee Survey*, CMS finalized the incorporation of the z-score approach to the methodology (replacing the SAS[®] procedure PROC RANK).²⁵ The z-score approach was intended to reduce the sensitivity of the QRS methodology to data set changes (e.g., changes to the reported rates within measures). While the z-score approach is widely accepted as an effective method for standardizing data, it does not allow QHP issuers' reporting units to be scored on absolute performance (i.e., if all reporting units have high performance, some reporting units that perform well on a measure will receive lower scores if they perform below average relative to their peers).

In an effort to further stabilize the QRS program and provide greater value to QHP issuers, consumers, CMS, and other key stakeholders, CMS is proposing to update the current z-score standardization approach with the Benchmark Ratio Approach beginning with the 2022 ratings year, at the earliest.

The Benchmark Ratio Approach was modeled after the ABC[™] methodology currently used in CMS Physician Compare star ratings quality program.²⁶ This approach builds on its QRS standardization predecessors and takes into consideration three dimensions of measure performance: position, distance, and absolute performance.

CMS believes this approach offers the potential of stabilizing scores across years, and will provide QHP issuers with more interpretable scores (measure through global) and greater insight into their performance, both relative to their peers and based on individual, absolute performance towards satisfying performance standards. The benefits of the Benchmark Ratio Approach, include:

- **Fairness:** Retains the peer comparison aspect of the current methodology, but provides targets for each measure in relative and absolute terms, allowing “everyone to score well” on a measure.

²⁵ The Final 2018 QRS and QHP Enrollee Survey Call Letter is available at:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2018-QRS-Call-Letter_July2018.pdf.

²⁶ See the *Physician Compare Benchmark and Star Rating Fact Sheet*, available here:

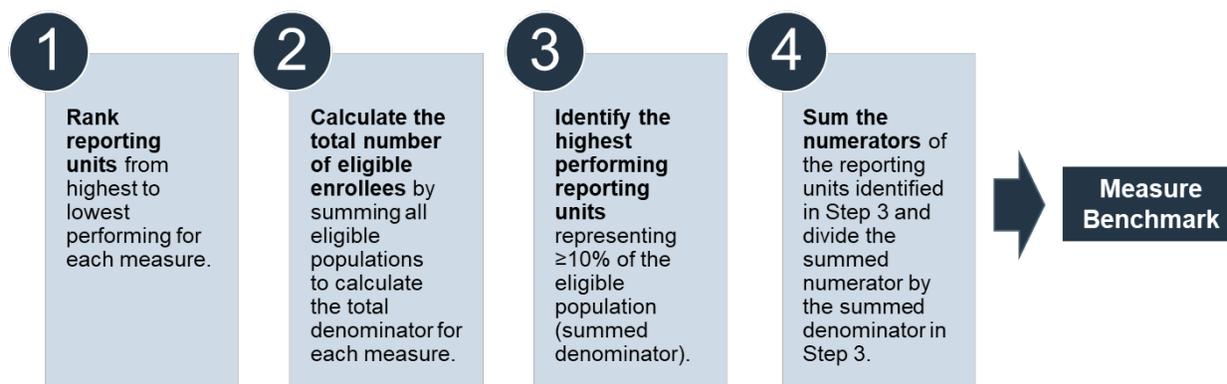
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Downloads/Benchmark-Star-Ratings.pdf>

- **Interpretable Scores:** Provides granular insight into performance for each component of the hierarchy, allowing interpretation of scores in terms of measure performance, which translates to actionable targets for QHP issuers.
- **Increased Stability Across Years:** Decreases the likelihood of significant changes to the benchmark, since the benchmark is defined by top-performing RUs and the total number of enrollees.
- **Flexibility:** Allows flexibility to adjust the definition of the benchmark if appropriate, without having to change the scoring methodology.

The Benchmark Ratio Approach consists of two distinct parts: 1) the calculation of the measure-specific performance targets (i.e., measure benchmarks) and 2) the calculation of the measure scores using the measure benchmark. Exhibit 7 is a high-level overview of the Benchmark Ratio Approach methodology. CMS proposes to apply the Benchmark Ratio Approach to all measures in the QRS methodology, regardless of measure type (e.g., process, outcome, patient experience). However, given the differences in the structure of measures, CMS is proposing different benchmark calculations for certain measures. The proposed expanded steps for calculating the benchmark for each measure type are included in Appendix B.

CMS would calculate measure benchmarks annually using measure data collected in a single ratings year. For example, for the 2022 ratings year, CMS would apply the Benchmark Ratio Approach to the 2021 measurement year data submitted to CMS between May and June 2022.

Exhibit 7. Overview of Benchmark Ratio Approach Calculation



$$RU \text{ Measure Score} = \frac{RU \text{ Reported Measure Rate}}{\text{Measure Benchmark}} * 100$$

Under the Benchmark Ratio Approach, a reporting unit would receive a measure score of 100 when the reporting unit meets the target benchmark. Therefore, the Benchmark Ratio Approach allows for the possibility of measure scores and, by extension, component level scores (e.g., global scores) to surpass 100.

To limit instances in which a reporting unit overperforms on one measure, thereby masking low performance on other measures when scores are aggregated up the QRS hierarchy, CMS is proposing to establish an upper cap of 110 on measure scores, meaning reporting units are able

to exceed the measure benchmark by 10 percent. CMS believes this proposed measure cap is appropriate as it allows the QRS methodology to capture high performance (i.e., performance exceeding the benchmark), while minimizing the potential for masking poor performance.

CMS' testing of the Benchmark Ratio Approach on measure data submitted in the 2017, 2018, and 2019 ratings years confirmed that this approach stabilizes measure scores and provides generally stable benchmarks (with some fluctuations driven by QHP issuers' performance in a given year, as expected). Additionally, testing revealed that there is diversity in the type of reporting units that define benchmarks (e.g., reporting units of different states, size, and product types define benchmarks), with wide variability across measures. For example, using 2019 data, CMS found that the number of reporting units that contributed to the measure benchmark ranged from 1 to 54, with an average of 23, and that 88 percent of reporting units contributed to at least one measure benchmark.

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 (e.g., the 2023 ratings year and beyond). Topics for future consideration and evaluation include, but are not limited to:

- Modifying and removing questions from the QHP Enrollee Survey,
- Potential refinements to the QRS cut point methodology,
- Considering a strategy to refine the QRS measure set, and
- Potentially assigning measure level weights.

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 these potential future proposals.

4.1 Modifying and Removing Questions from the QHP Enrollee Survey Questionnaire

CMS annually reviews feedback on the value and usability of the QHP Enrollee Survey from stakeholders through public comment and the QHP Enrollee Survey Technical Expert Panel (TEP). CMS also analyzes QHP Enrollee Survey results, including question response rates and reliability. In addition, in the summer of 2020, CMS conducted an in-depth review of the QHP Enrollee Survey, which included cognitive testing interviews with consumers and focus groups with some QHP issuers and consumers. Based on this feedback and findings from the cognitive testing interviews, CMS intends to modify questions, phrases, and definitions within the survey to improve consumers' understanding of survey questions.²⁷

CMS has received public comments in previous Call Letters and via QHP issuer focus groups expressing concerns about the length of the QHP Enrollee Survey and the impact on response

²⁷ The QHP Enrollee Survey uses questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and, when appropriate, CMS will update these questions to align with the most current version of the CAHPS Health Plan Survey.

rates. In addition, feedback from issuers and consumers in the focus groups identified questions both groups indicated as outside of the health plan's control (e.g., provider and patient interactions and experiences). For example, issuers indicated that patient wait times for provider appointments were outside of issuer control. Likewise, consumers also indicated that provider appointments were not within the issuer's control. Through the focus groups, cognitive testing interviews, and review of survey data, CMS identified the following questions to consider for potential removal from the QHP Enrollee Survey in future years:

- In the last 6 months, how often were the forms from your health plan easy to fill out?
- In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?
- In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?
- In the last 6 months, how often did your personal doctor spend enough time with you?
- When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service?
- In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?
- How many specialists have you seen in the last 6 months?
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
- How did that person help you? [Complete the survey]

CMS is interested in feedback regarding the removal of any or all of these questions from the QHP Enrollee Survey in the future. CMS will comply with the PRA as applicable for implementing all changes to the QHP Enrollee Survey under OMB number 0938-1221.

4.2 Potential Refinements to the QRS Cut Point Methodology

While the proposed Benchmark Ratio Approach, as detailed in Section 3.4, would produce stable measure scores across years, CMS is also considering refinements to the cut point methodology to further improve the stability of the QRS and mitigate the impact of underlying data changes. Specifically, CMS is soliciting public comment on three potential approaches for calculating QRS cut points:

1. **Current Clustering Methodology:** Under this option, CMS would retain the current methodology for generating cut points, which applies a data-driven clustering algorithm to assign star ratings at the global, summary indicator, domain, and composite levels of the QRS hierarchy. Under this approach, CMS calculates cut points after calculating measure and component scores. The QRS clustering methodology is similar to the clustering methodology used for the Medicare Part C & D Star Rating program, though the structure of the two programs results in slight changes to the clustering application (e.g., QRS does not have star ratings at the measure level).
2. **Static Cut Points:** Under this option, CMS would set policy-based, static cut points to determine the assignment of star ratings for each component of the QRS hierarchy. Static cut points would allow for the potential for all reporting units to receive high ratings and offer issuers a set of performance targets that remain consistent across years. For example, CMS tested setting points at 25, 50, 75, and 90 in combination with the proposed Benchmark Ratio Approach and observed stability across years and data sensitivity scenarios. CMS solicits feedback on the concept of static cut points.
3. **Percentile Aggregations:** Using a modified version of the Equal Ranges approach used for the Physician Compare program,²⁸ CMS would identify measure-level cut points that are extrapolated up the hierarchy to determine component cut points. First, CMS would set a value of 100 (i.e., the score associated with satisfying the measure benchmark) as the 4th cut point for a given measure. Then, CMS would use the Percentile Aggregation approach to calculate the three remaining measure-level cut points. It would do so by subtracting the lowest, non-outlier score from 100 and dividing the range of scores into quarters.²⁹ The following calculations would be used to identify each measure-level cut point:
 - Cut point 1: $100 - (3 * ((100 - \text{lowest non outlier score}) / 4))$
 - Cut point 2: $100 - (2 * ((100 - \text{lowest non outlier score}) / 4))$
 - Cut point 3: $100 - ((100 - \text{lowest non outlier score}) / 4)$
 - Cut point 4: 100

After identifying the scores associated with each measure-level cut point, the scores would be converted to the percentile equivalent using the score distribution of the given measure. CMS would use the following formula to convert the four measure cut points into measure percentiles:

$$\text{Measure Percentile}_i = \text{Normal Probability Distribution} \left(\left(\frac{\text{Measure Cut Point}_i - \mu_{\text{Measure Scores}}}{\hat{\sigma}_{\text{Measure Scores}}} \right) \right)$$

where $i = 1, 2, 3, 4$

Once the percentile equivalents for each measure cut point are calculated, CMS would average the measure percentile equivalents up the hierarchy, similar to the method CMS

²⁸ The equal ranges method is based on the difference between the ABC™ benchmark and the lowest performance score for a given measure. The method uses that range to assign 1 to 4 stars. Groups that meet or exceed the established ABC™ benchmark for a measure will be assigned 5 stars. See the *Physician Compare Benchmark and Star Rating Fact Sheet*, available here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Downloads/Benchmark-Star-Ratings.pdf>.

²⁹ CMS will use the following formula to identify low performing outliers to remove from the calculation of cut points: 25^{th} percentile – $(1.5 * \text{Interquartile Range})$. Removing low performing outliers from the cut point calculation will minimize outlier impact on the ratings.

currently uses to calculate component level scores (e.g., measure percentile equivalents would be averaged to determine the composite percentile equivalents). To create the final cut points for each component, CMS would convert the percentile equivalents back into scores using that specific component's score distribution.

CMS previously tested the Percentile Aggregation methodology in combination with the proposed Benchmark Ratio Approach and observed stability across years and data sensitivity scenarios.

4.3 Strategy for Refining the QRS Measure Set

In alignment with other CMS quality ratings programs and the Meaningful Measures 2.0 initiative, CMS anticipates proposing refinements to the QRS measure set (e.g., adopting digital quality measures, adding outcome measures, introducing patient-reported outcome measures).

CMS is interested in adopting digital quality measures (dQMs) in the QRS measure set to align with CMS' efforts to keep pace with the rapidly changing health care environment by promoting innovation and modernization while continuing to decrease reporting burden for providers, clinicians, and issuers reporting quality measures.

CMS defines dQMs as measures that originate from sources of health information that are captured and can be transmitted electronically and via interoperable systems.³⁰ Examples of digital sources include electronic health records (EHRs), health information exchanges (HIEs), clinical registries, case management systems, electronic administrative claims systems, electronically submitted assessment data, and wearable devices. Electronic clinical quality measures (eCQMs) are data derived from electronic medical records, and are a subset of dQMs. CMS is interested in feedback regarding barriers or challenges to adopting dQMs in the QRS measure set.

CMS is also exploring the potential incorporation of additional outcome measures and the introduction of patient-reported outcome measures (PROs) in the QRS measure set.^{31, 32} These measures could replace existing measures in the QRS measure set or address high-priority or emerging conditions for the Exchange population. CMS is interested in feedback regarding priority outcome measures, measure concepts, or conditions to incorporate into the QRS measure set. CMS is also interested in feedback related to approaches for collecting PROs.

4.4 Measure Level Weights

CMS continues to investigate ways to reduce the impact of implicit weighting in the QRS hierarchy, such as the potential incorporation of measure level weights into the QRS methodology. The use of a hierarchy creates implicit weighting. Each level of the QRS hierarchy, or component (i.e., measure, composite, domain, and summary indicator), has a

³⁰ See the Meaningful Measure Initiative 2.0 website for more information: <https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization>.

³¹ In the [CMS Measures Management System Blueprint](#), CMS defines an outcome measure as “a measure that focuses on the health status of a patient (or change in health status) resulting from healthcare – desirable or adverse.”

³² PROs are defined by the National Quality Forum (NQF) in [PROs in Performance Measurement](#) as an “instrument, scale, or single item measure used to assess the PRO concept as perceived by the patient, obtained by directly asking the patient to self-report.”

variable weight and influence due to its position in the hierarchy. The amount of influence each QRS measure has on the QRS global result is affected by the number of measures, the components within each layer of the hierarchy, as well as the amount of missing data.

In the Final 2017 Call Letter for the QRS and QHP Enrollee Survey, CMS finalized the application of explicit weights in the calculation of QRS scores and ratings. Specifically, CMS assigned a weight of 2/3 (66.67%) to the Clinical Quality Management summary indicator, and a weight of 1/6 (16.67%) to the Enrollee Experience and Plan Efficiency, Affordability, & Management summary indicators.³³

To support alignment with other CMS quality reporting programs, CMS is continuing to explore the potential removal of one or more levels of the QRS hierarchy (e.g., the composite and/or domain levels).³⁴ CMS believes that with the removal of the composite and/or domain level of the QRS hierarchy, there may be opportunity to incorporate measure level weights because there would be fewer levels of aggregation to dilute the impact of measure level weights.

CMS is interested in receiving feedback in response to this Call Letter on potential approaches for applying explicit weights to the QRS measures.

For example, as of 2021, the Medicare Part C & Part D Star Rating Program generally assigns weights based on measure type:

- Improvement measure: Weight of 5
- Outcome or intermediate outcome: Weight of 3
- Access or patient experience measure: Weight of 2³⁵
- Process measure: Weight of 1

³³ The Final 2017 QRS and QHP Enrollee Survey Call Letter is available at:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Final-2017-Call-Letter-for-QRS-and-QHPES.pdf>.

³⁴ See supra note 8.

³⁵ Beginning with the 2023 Medicare Star Ratings, CMS will increase the weight of patient experience/complaints and access measures from 2 to 4. See the Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Final Rule, available at: <https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program>.

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 hierarchy components (composites, domains, summary indicators) to form a single global rating.³⁶

Exhibit 8 illustrates the proposed ratings year 2022 QRS hierarchy, which is the organization of measures into composites, domains, and summary indicators, and ultimately, a single global rating. Measures denoted with a strikethrough (–), if removed as proposed, would not be collected for the 2022 ratings year. Measures denoted with an asterisk (*), if finalized as proposed, would be collected, but not included in 2022 QRS scoring. Measures not currently endorsed by the National Quality Forum (NQF) are noted as †.

Exhibit 8. Proposed 2022 QRS Hierarchy

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	NQF ID († indicates not currently endorsed)
Clinical Quality Management	Clinical Effectiveness	Asthma Care	Asthma Medication Ratio	1800
		Behavioral Health	Antidepressant Medication Management	0105
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	0576
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)*	0576
			Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004
		Cardiovascular Care	Controlling High Blood Pressure	0018
			Proportion of Days Covered (RAS Antagonists)	0541
			Proportion of Days Covered (Statins)	0541
		Diabetes Care	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) – POTENTIAL REMOVAL	0575
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*	0059
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062
			Proportion of Days Covered (Diabetes All Class)	0541

³⁶ 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*.

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	NQF ID (* indicates not currently endorsed)
Clinical Quality Management (continued)	Patient Safety	Patient Safety	International Normalized Ratio Monitoring for Individuals on Warfarin	0555
			Annual Monitoring for Persons on Long-term Opioid Therapy	3541
			Plan All-Cause Readmissions	1768 *
	Prevention	Checking for Cancer	Breast Cancer Screening	2372
			Cervical Cancer Screening	0032
			Colorectal Cancer Screening	0034
	Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	Prenatal and Postpartum Care (Postpartum Care)	1517 *
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517 *
	Staying Healthy Adult	Chlamydia Screening in Women	Chlamydia Screening in Women	0033
			Flu Vaccinations for Adults Ages 18-64	0039
			Medical Assistance with Smoking and Tobacco Use Cessation	0027
	Staying Healthy Child	Annual Dental Visit	Annual Dental Visit	1388 *
			Childhood Immunization Status (Combination 3)	0038
			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 and Care Coordination	Access and Care Coordination	Access to Care	0006
			Care Coordination	0006
	Doctor and Care	Doctor and Care	Rating of All Health Care	0006
			Rating of Personal Doctor	0006
		Rating of Specialist	0006	
Plan Efficiency, Affordability, & Management	Efficiency & Affordability	Efficient Care	Appropriate Testing for 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 *
	Plan Service	Enrollee Experience with Health Plan	Access to Information	0007 *
			Plan Administration	0006
			Rating of Health Plan	0006

Appendix B. Expanded Benchmark Calculation

Clinical Measure Benchmark Calculation

- The process to create a clinical non-Plan All-Cause Readmission (PCR) measure-specific benchmark in a given ratings year is as follows:
 1. Rank all scoring eligible RUs—within a measure—satisfying denominator criteria ($N \geq 30$) from highest to lowest based on the reported measure rate.
 2. Sum the eligible population across RUs to calculate the total number of eligible enrollees; calculate 10% of the total number of enrollees.
 3. Select the subset of the highest performing scoring eligible RUs until $\geq 10\%$ of total number of enrollees is captured in the subset.
 4. Sum the number of enrollees associated with the RUs selected in Step 3 by combining the numerators for the measures (i.e., calculate the numerator).
 - a. For measure data captured using the hybrid method, the reported rate was extrapolated to the eligible population, creating an estimated numerator relative to the eligible population, instead of the selected sample of cases.
 5. Sum the eligible populations associated with the RUs selected in Step 3 (i.e., calculate the eligible population).
 6. Divide the numerator from Step 4 by the eligible population in Step 5 to generate the measure benchmark.

$$ABC_{Measure X} = \frac{\sum_{i=1}^n (rate_{X, RUi} * den_{X, RUi})}{\sum_{i=1}^n den_{X, RUi}}$$

Where n = the highest performing scoring – eligible RUs post
– denominator criteria until $\geq 10\%$ of the total denominator is represented

PCR Measure Benchmark Calculation

- The process to create the Plan All-Cause Readmission measure-specific benchmarks in a given ratings year is as follows:
 1. Rank all scoring-eligible RUs satisfying the PCR denominator criteria ($N \geq 150$) from highest-performing to lowest-performing (i.e., lowest values to highest values) based on the reported PCR measure rate.
 2. Calculate the count of Observed Readmissions by multiplying the measure denominator (count of index hospital stays) by the measure indicator for Observed Readmissions rate.
 3. Calculate the count of Expected Readmissions by multiplying the measure denominator by the measure indicator for Expected Readmissions rate.
 4. Sum the count of index hospital stays (IHS) to identify the total number of IHS across all scoring-eligible RUs satisfying denominator criteria.
 5. Calculate 10% of the total number of IHS identified in Step 4.
 6. Select RUs starting from highest performing (i.e., lowest reported PCR rate) until $\geq 10\%$ of total IHS is represented.
 7. Sum the count of Observed Readmissions from subset of RUs selected in Step 6.
 8. Sum the count of Expected Readmissions from subset of RUs selected in Step 6.

9. Divide count of observed readmissions from Step 7 (i.e., numerator) by the count of expected readmissions from Step 8 (i.e., denominator) to determine the benchmark for PCR.
- To calculate the measure score, PCR has a slightly modified calculation than non-PCR clinical measures and survey measures due to the inverse nature of the PCR measure (i.e., a lower rate indicates better performance).
 1. The score is calculated as $100 + (1 - RU/ABC) * 100$, where RU/ABC is the ratio of the reported measure rate and respective measure ABC benchmark.

Survey Measure Benchmark Calculation

- The process to create the QHP Survey measure-specific benchmark in a given ratings year is as follows:
 1. Rank all scoring eligible RUs—within each measure—satisfying denominator criteria ($N \geq 100$) from highest to lowest based on the reported measure rate.
 2. Calculate the eligible population across scoring-eligible RU meeting the denominator criteria per measure using the sampled enrollees selected to receive the survey as a proxy for eligible population.
 - a. Eligible population for survey measures was approximated as the sample of enrollees minus those deemed ineligible via codes X20 and X40.
 3. Select the subset of the highest performing scoring eligible RUs until ≥ 10 percent of the total sampled enrollee population (defined in Step 2) is captured.
 4. Calculate the weighted mean of the reported measure rate for the top-performing subset selected in Step 3, weighted using the sample size per RU, to generate the modified benchmark.

Appendix C. SARS-CoV-2 Vaccination by Clinicians Draft Measure Technical Specification

Quality ID #X: SARS-CoV-2 Vaccination by Eligible Clinicians
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Preventive Care

2022 COLLECTION TYPE:

MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:

Process

DESCRIPTION:

Percentage of patients aged 18 years and older seen for a visit during the measurement period who have ever received or reported having ever received a SARS-CoV-2 vaccination dose OR who have ever received or reported having ever received a full SARS-CoV-2 vaccination course.

INSTRUCTIONS:

This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. This measure is intended to measure the percentage of patients aged 18 years and older who have ever received a SARS-CoV-2 vaccination dose or full SARS-CoV-2 vaccination course during the year, either from the submitting Merit-based Incentive Payment System (MIPS) eligible clinician or from an alternate provider. There is no diagnosis associated with this measure. This measure may be submitted by MIPS eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

***NOTE:** Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

MEASURE SUBMISSION TYPE:

Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:

All patients aged 18 years and older seen for a visit during the measurement period

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the year (CPT or HCPCS): Codes to be determined

AND NOT

DENOMINATOR EXCLUSIONS:

Patient received hospice services any time during the measurement period: Codes to be determined

NUMERATOR:

Patients who have ever received or reported having ever received a SARS-CoV-2 vaccination dose OR who have ever received or reported having ever received a full SARS-CoV-2 vaccination course

Numerator Instruction:

The numerator for this measure can be met by submitting either administration of a SARS-CoV-2 vaccination dose or full SARS-CoV-2 vaccination course or that the patient reported having ever received a SARS-CoV-2 vaccination dose or full SARS-CoV-2 vaccination course. If the performance of the numerator is not met, a MIPS eligible clinician can submit a valid denominator exception for having not administered a SARS-CoV-2 vaccination dose or full SARS-CoV-2 vaccination course. For MIPS eligible clinicians submitting a denominator exception for this measure, there should be a clear rationale and documented reason for not administering a SARS-CoV-2 vaccination dose or full SARS-CoV-2 vaccination course if the patient did not indicate previous receipt or completion. These exceptions are patient contraindication, patient refusal, or vaccine not available.

NUMERATOR NOTE: Denominator Exception(s) are determined at the time of the denominator eligible encounter.

Numerator Options:

Performance Met:

SARS-CoV-2 vaccine dose administered or previously received
(X)

OR

Performance Met:

Full SARS-CoV-2 vaccine course administered or previously received
(X)

OR

Denominator Exceptions:

SARS-CoV-2 vaccine dose or full SARS-CoV-2 vaccination course was not administered for reasons documented by clinician (i.e., patient contraindication **(X)**, patient refusal **(X)**, or vaccine not available **(X)**)

OR

Performance Not Met:

SARS-CoV-2 vaccine dose or full SARS-CoV-2 vaccination course was not administered, reason not given **(X)**

RATIONALE:

As of December 6, 2020, the Centers for Disease Control and Prevention (CDC) reported 14,462,527 cases of Coronavirus Disease 2019 (COVID-19) and 280,135 deaths.³⁷ A vaccine for SARS-CoV-2, the virus that causes COVID-19, will be critically important to stemming the morbidity and mortality caused by this disease.

CLINICAL RECOMMENDATION STATEMENTS:

None. Clinical guidelines to be published upon final development of SARS-CoV-2 vaccine. Measure specification to be updated upon guideline release.

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³⁷ https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

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