Health Insurance Exchange

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

Finalized QRS and QHP Enrollee Survey Program Refinements

August 2020

Contents

List of Exhibits

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

The Centers for Medicare & Medicaid Services (CMS) appreciates all the individuals and organizations who submitted comments on 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 Call Letter) during the public comment period, held March 20, 2020 through May 20, 2020.[1]

This document, the *Final 2020 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)* (referred to hereafter as the Final 2020 Call Letter), serves to communicate CMS' finalized refinements to the QRS and QHP Enrollee Survey programs. This document summarizes comments received on the Draft 2020 Call Letter during the public comment period within each relevant section. No changes are being made at this time to CMS regulations; instead, the refinements apply to QRS and QHP Enrollee Survey program operations, to the QRS measure set and removal of items from the QHP Enrollee Survey questionnaire.

This document does not include all potential refinements to the QHP Enrollee Survey program (e.g., other types of survey revisions will be addressed through the information collection request process per Paperwork Reduction Act [PRA] requirements, as appropriate). CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2021* (2021 QRS and QHP Enrollee Survey Technical Guidance) in the fall of 2020, reflecting the applicable finalized changes announced in this document.

1.1 Key Terms

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

Exhibit 1. Key Terms for the Call Letter

Term	Description
Measurement Year	The term *measurement year* refers to the year reflected in the data submission. All measure data are retrospective. The exact period of time represented by each measure is dependent on the technical specifications of the measure. ▪ QRS clinical measure data submitted for the 2021 ratings year (the 2021 QRS) generally represent data for enrollees from the previous calendar year(s) (i.e., CY 2020). The calendar year representing data for enrollees is referred to as the measurement year. Some measures require more than one year of continuous enrollment for data collection so the data for those measures for the 2021 QRS may also include years prior to CY 2020. ▪ For QRS survey measure data in the 2021 QRS, the survey is fielded based on enrollees who are enrolled as of January 1, 2021, but the survey requests that enrollees report on their experience "in the last 6 months."
Ratings Year	The term *ratings year* refers to the year the data are collected (including fielding of the QHP Enrollee Survey), validated, and submitted, and QRS ratings are calculated. For example, the "2021 QRS" refers to the 2021 ratings year. ▪ Ratings calculated for the 2021 QRS are displayed for QHPs offered during the 2022 plan year, in time for the individual market open enrollment period, to assist consumers in selecting QHPs offered through Health Insurance Exchanges (Exchanges).

[1] CMS extended the public comment period for the Draft 2020 Call Letter by 30 days to allow additional time for interested parties to review proposed refinements for the QRS and QHP Enrollee Survey.

1.2 Timeline for Call Letter Publication

The anticipated annual cycle for the QRS Call Letter follows a four-to-six-month (approximately February/March through May/August) timeline as shown in Exhibit 2, followed by the publication of the QRS and QHP Enrollee Survey Technical Guidance in September/October.

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

Anticipated Timeframe	Description
February/March	**Publication of Draft QRS Call Letter:** CMS proposes changes to the QRS and QHP Enrollee Survey programs and provides stakeholders with the opportunity to submit feedback via a 30-day public comment period.
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 programs.
May/August	**Publication of Final QRS Call Letter:** CMS communicates final changes to the QRS and QHP Enrollee Survey programs and addresses the themes of the public comments.
September/October	**Publication of QRS and QHP Enrollee Survey Technical Guidance and Measure Technical Specifications for upcoming ratings year:** CMS provides technical guidance regarding the QRS and the QHP Enrollee Survey, and specifies requirements for QHP issuers offering coverage through the Exchanges.

2.0 QRS Revisions for the 2020 Ratings Year and Beyond

2.1 Explicit Weighting for Patient Safety

Commenters supported the proposed explicit weighting structure for the Clinical Quality Management summary indicator as an interim measure for the 2020 ratings year and supported CMS using the proposed temporary weighting structure for the domains in this summary indicator to increase stability. Based on the suspension of QRS clinical data and QHP Enrollee Survey data collection for the 2020 ratings year,[2] CMS will not finalize the proposed interim measure to adopt explicit weighting for the Patient Safety composite and domain as proposed at this time. CMS will consider whether a similar temporary approach is necessary for the 2021 QRS ratings to balance the influence of individual measures on the global score and would propose its adoption as part of the 2021 Call Letter process, as appropriate.

CMS previously finalized the addition of the *International Normalized Ratio Monitoring for Individual on Warfarin* (INR) measure beginning in 2020.[3] However, due to the suspension of data collection and reporting activities for the 2020 QRS, the 2021 ratings year will be the first

[2] 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.

[3] See the Final 2019 Call Letter, 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

year of data collection for the INR measure and that the 2022 ratings year will be the first year for scoring the measure.

Additionally, CMS recognizes that the removal of the *Medication Management for Patients with Asthma* (MMA) measure, as noted in Section 3.1.2, will leave the Asthma Care composite without any scored measures during the 2021 ratings year. Therefore, CMS may need to determine an appropriate temporary weighting adjustment that both reduces the implicit weight of the Patient Safety composite and domain, and mitigates the absence of measure data in the Asthma Care composite during the 2021 ratings year. [4] Additionally, as noted in Section 4.3, CMS is investigating removing levels of the QRS hierarchy for future ratings years to balance the influence of individual survey and clinical measures on the global score. CMS would solicit comments on any specific proposed interim measures to mitigate the absence of measure data in the Asthma Care composite for the 2021 ratings year, as well as any proposed changes to the QRS hierarchy, in future Draft Call Letters or through the rule-making process, as appropriate.

2.2 Other Suggestions for COVID-19 Relief and QRS Revisions for Future Years

Commenters provided additional suggestions and feedback about potential approaches for handling QRS measure data that may be impacted by the public health emergency caused by COVID-19.[5] CMS appreciated these comments and continues to assess the potential impact of the COVID-19 pandemic on requirements for the 2021 QRS and QHP Enrollee Survey and will consider these suggestions as part of the agency's analysis. In addition, CMS is working to align federal quality reporting programs to the extent possible. CMS anticipates issuing guidance regarding the data collection and reporting requirements in the 2021 QRS and QHP Enrollee Survey Technical Guidance in fall of 2020.

CMS will also issue further guidance on the display of quality rating information beginning during the 2021 Open Enrollment (OE) period for the individual market prior to the start of the 2021 OE period.[6]

[4] CMS may propose a temporary weighting adjustment for the 2021 ratings year in the *Draft 2021 Call Letter for the QRS and QHP Enrollee Survey*.

[5] On January 31, 2020, HHS Secretary Alex M. Azar II declared that as of January 27, 2020, a public health emergency exists nationwide as the result of the 2019 novel coronavirus. *See* Determination of the HHS Secretary that a Public Health Emergency Exists, https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx. On April 21, 2020, the HHS Secretary renewed the COVID-19 public health emergency declaration, effective April 26, 2020. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-21apr2020.aspx. On March 13, 2020, the President declared that the outbreak of COVID-19 in the United States constitutes a national emergency beginning March 1, 2020. *See* Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, issued March 13, 2020, https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novelcoronavirus-disease-covid-19-outbreak/.

[6] See 45 C.F.R. § 155.410(e)(3).

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

Commenters generally supported the proposed removal of the *Adult Body Mass Index (BMI) Assessment* (ABA) and *Medication Management for People with Asthma (75% of Treatment Period)* (MMA) measures to align with the proposed retirements by the measure steward. Commenters also agreed with the proposed inclusion of the *Asthma Medication Ratio* (AMR) measure. A number of commenters disagreed with CMS' proposal to incorporate the *Annual Monitoring for Persons on Long-term Opioid Therapy* (AMO) measure into the QRS measure set, noting concern that the measure is not endorsed by the National Quality Forum (NQF) and with the proposed measure specifications.

CMS appreciates commenters for providing their important feedback on these refinements. CMS is finalizing these refinements for the 2021 ratings year; however, the timeline for incorporating refinements is subject to change as CMS continues to assess the impact of the COVID-19 pandemic on requirements for the 2021 QRS and QHP Enrollee Survey. These proposed revisions, the comments received, and the final policies adopted with respect to these changes are discussed in additional detail below.

3.1 Removal of Measures

In the Draft 2020 QRS Call Letter, CMS proposed the removal of 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). CMS proposed to remove these measures from the QRS measure set beginning with the 2021 ratings year due to the recommended retirement of the measures by the measure steward, National Committee for Quality Assurance (NCQA).

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

All commenters supported the proposed removal of the ABA measure. CMS will finalize removal of the ABA measure beginning with the 2021 ratings year.[7]

CMS also appreciates commenters' suggestions for alternative measures for the QRS measure set that could replace the ABA measure. CMS will continue to investigate potential replacement measures and may propose other BMI-related preventive care measures or metabolic syndrome-related measures in a future Call Letter. When investigating measures for potential inclusion in the QRS measure set, CMS supports alignment with other CMS federal quality reporting programs, as well as ensuring the measures address high-priority areas in the Meaningful Measures Framework and important topics for the Exchange population. These criteria will guide CMS' consideration of other BMI-related preventive care measure or metabolic syndrome-related measures for potential inclusion in the QRS measure set.

[7] As noted above, the timeline for incorporation of this refinement is subject to change as CMS continues to assess the potential impact of the COVID-19 pandemic on 2021 QRS and QHP Enrollee Survey requirements.

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

All commenters supported the proposed removal of the MMA measure. CMS will finalize removal of this measure beginning with the 2021 ratings year.[8]

3.2 Addition of New Measures

In the Draft 2020 Call Letter, CMS proposed the addition of two new measures to the QRS measure set beginning with the 2021 ratings year: *Annual Monitoring for Persons on Long-term Opioid Therapy* (AMO) and *Asthma Medication Ratio* (AMR). CMS proposed these measures for 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. While proposed for inclusion beginning with the 2021 ratings year, CMS explained that an initial year of data collection would occur for these new measures before they would be included in the calculation of QRS scores and ratings; i.e., 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.

3.2.1 *Annual Monitoring for Persons on Long-term Opioid Therapy* (AMO)

CMS received comments in support of the AMO measure, but requesting adjustment to the measure specifications, raising concerns around increased administrative burden, or calling for CMS to delay scoring the measure. Some commenters expressed concerns with CMS' proposal to include the AMO measure in the QRS measure set prior to the measure receiving NQF endorsement and recommended alternative opioid measures. Others recommended CMS adopt a measure that is NQF-endorsed and used in other CMS quality reporting programs. Several commenters also recommended modifications to the AMO measure technical specifications. CMS appreciates the comments submitted by stakeholders, but is finalizing the inclusion of this measure beginning with the 2021 ratings year.[9] As such, data collection will begin with the 2021 QRS. The AMO measure will not be included in scoring until the 2022 ratings year, at the earliest.

As noted in the Draft 2020 Call Letter, CMS proposed the AMO measure for inclusion in the QRS measure set to align with the policy priorities of combating the opioid crisis, reducing adverse drug events, and promoting safe and responsible pain management. The AMO measure is based on evidence-based guidelines from the Centers for Disease Control and Prevention (CDC)[10] and fills a substantial quality gap that was identified during testing of the measure. CMS collaborated with the CDC on review of this measure and concluded the AMO measure is consistent with the CDC guidelines regarding management of chronic opioid use.[11] In addition,

[8] Ibid.
[9] As noted above, the timeline for incorporation of this refinement is subject to change as CMS continues to assess the potential impact of the COVID-19 pandemic on 2021 QRS and QHP Enrollee Survey requirements.
[10] Dowell D, Haegerich T, Chou R. CDC guideline for prescribing opioids for chronic pain — United States, 2016. Atlanta, GA: Centers for Disease Control and Prevention; 2016. http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. Accessed August 27, 2018.
[11] Ibid.

the measure was recommended by a multi-stakeholder technical expert panel (TEP) that was composed of stakeholders for the QRS. Further, in the winter of 2020, the NQF Behavioral Health and Substance Use Standing Committee (Standing Committee) voted in favor of recommending endorsement for the AMO measure, agreeing that the measure was sound, useful, and warranted endorsement. The Standing 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, and that the AMO measure will receive NQF endorsement in August 2020.

CMS also remains committed to improving alignment across federal quality reporting programs and minimizing provider burden. CMS is communicating and coordinating across federal reporting programs to promote alignment regarding the adoption of the AMO measure.

The AMO measure promotes early intervention that may prevent harm and encourages safe and responsible pain management. As the AMO measure addresses important policy priorities, CMS is finalizing the inclusion of the AMO measure beginning with the 2021 QRS. As noted in the Draft 2020 Call Letter, and in consideration of the comments received, CMS reaffirms the agency's commitment to monitor and review the AMO measure data collected during the first year to examine data quality, confirm the placement of the measure in the QRS hierarchy is statistically appropriate, and conduct other analysis related to the inclusion of this new measure to determine whether further adjustment in measure specifications or rating methodology would be appropriate. The results from these analyses will inform CMS' decision on the timing for including the AMO measure in QRS scoring, which would not occur until the 2022 ratings year at the earliest.

CMS thanks commenters for recommending potential alternative opioid measures for inclusion in the QRS measure set. CMS reviewed and considered many existing opioid measures for potential inclusion in the QRS measure set when considering the AMO measure. In particular, our literature review found that other existing opioid measures (e.g., *Risk of Continued Opioid Use*, *Use of Pharmacotherapy for Opioid Use Disorder*) have not been tested in the Exchange population and/or were intended for different populations than the AMO measure. For example, the target population of the *Use of Pharmacotherapy for Opioid Use Disorder* measure is patients that have already been diagnosed with opioid use disorder (OUD), whereas the AMO measure targets all patients with chronic opioid use to ensure they are monitored in accordance with CDC guidelines. CMS intends to continue to investigate additional measures for potential inclusion in the QRS measure set and may propose other pain management-related measures in future Call Letters.

One commenter also suggested that CMS adopt a more holistic measure and include an opioid measure that is focused on safety. CMS appreciates the suggestion and, as noted above, may propose additional opioid measures for future years. However, we are finalizing the inclusion of the AMO measure beginning with the 2021 ratings years, as proposed. CDC guidelines recommend annual monitoring of opioid use at a minimum and monitoring is further supported by four other evidence-based clinical practice guidelines that recommend drug testing at the

initiation of therapy and periodically thereafter.[12, 13, 14, 15, 16] In addition, the initial testing for the AMO measure found a substantial quality gap for annual monitoring by Exchange health plans. Furthermore, a study published evaluating a system-wide intervention of urine drug screening suggests that there is up to a 1 percent reduction in patient risk of an opioid-related suicide or overdose event for every additional 1 percent of patients that receive drug tests.[17]

One commenter who opposed the inclusion of the AMO measure cited a recent article in the *American Journal of Public Health* that prescription drug monitoring programs risk increasing deaths from street drugs measured as projected loss in both Life Years and Quality Adjusted Life Years.[18] CMS notes that the AMO measure is not based on prescription drug monitoring programs as evaluated in the *American Journal of Public Health* article; rather, the measure is based on drug testing performed by the physician monitoring the patient's drug therapy. Unlike prescription drug monitoring programs, these tests can be administered to identify both prescription and street drug use among patients taking opioids and can enable the physician to identify potentially dangerous drug-drug interactions. 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. CMS is therefore finalizing the inclusion of the AMO measure as proposed.

Some commenters also suggested updates for the AMO measure technical specifications. Specifically, these commenters recommended: 1) revising the monitoring threshold to 90 consecutive days, instead of 90 cumulative days; and 2) requiring an average daily dose of ≥ 90 morphine milligram equivalents (MME)/day. These commenters noted that these revisions would align the AMO measure with other Healthcare Effectiveness Data and Information Set (HEDIS®) and Pharmacy Quality Alliance (PQA) measures focused on patients at high risk of OUD and aligns with thresholds in CDC guidance.

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[12] Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *The Journal of Pain: Official Journal of the American Pain Society*. 2009;10(2):113-130. doi: 10.1016/j.jpain.2008.10.008.

[13] Dowell D, Haegerich T, Chou R. CDC guideline for prescribing opioids for chronic pain — United States, 2016. Atlanta, GA: Centers for Disease Control and Prevention; 2016.

[14] U.S. Department of Veterans Affairs, U.S. Department of Defense. *Management of Opioid Therapy for Chronic Pain. VA/DoD clinical practice guideline for opioid therapy for chronic pain*. Washington, DC: U.S. Department of Veterans Affairs and U.S. Department of Defense; 2017.

[15] Manchikanti L, Kaye AM, Knezevic NN, et al. Responsible, Safe, and Effective Prescription of Opioids for Chronic Non-Cancer Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines. *Pain Physician*. 2017;20(2S):S3-S92. (1. page S61; 2. page S62)

[16] Langman L, Jannetto P. Laboratory Medicine Practice Guidelines: Using Clinical Laboratory Tests to Monitor Drug Therapy in Pain Management Patients. The American Association for Clinical Chemistry Academy; 2017.

[17] Brennan PL, Del Re AC, Henderson PT, Trafton JA. Healthcare system-wide implementation of opioid-safety guideline recommendations: The case of urine drug screening and opioid-patient suicide- and overdose-related events in the Veterans Health Administration. *Translational Behavioral Medicine*. 2016;6(4):605-612. doi: 10.1007/s13142-016-0423-7.

[18] Pitt A, Humphreys K, Brandeau M. Modeling health benefits and harms of public policy responses to the US opioid epidemic. *American Journal of Public Health*. 2018;108(10):1394-1400. doi: 10.2105/AJPH.2018.304590.

As explained in the Draft 2020 Call Letter, the PQA serves as the measure steward for the AMO measure. Consistent with other measures in the QRS measure set, QHP issuers will be required to follow the technical specifications adopted by measure steward (the PQA) for the AMO measure.[19] In addition, regarding the first recommendation, the AMO measure was recommended by the NQF Behavioral Health and Substance Use Standing Committee as currently specified with 90 cumulative days rather than 90 consecutive days. Regarding the second recommendation, CMS appreciates this suggestion; however, the guidelines regarding annual monitoring are applicable to all patients using opioids chronically and not just for those with daily doses above 90 MME. For these reasons, we decline to adopt these suggested modifications to the AMO measure technical specifications.

Some commenters noted concerns about potential unintended consequences on patients who need pain management, including those with cancer or sickle cell disease, or on palliative care. CMS appreciates these comments and clarifies that the current specifications for the AMO measure exclude members with: 1) a diagnosis of cancer (except non-melanoma skin cancer) at any time during the measurement year, and/or 2) hospice care at any time during the year. Therefore, these seriously ill patients would not be impacted by the measure. Patients with sickle cell disease are not excluded from the measure population; however, this exclusion could be considered by the measure steward in a future maintenance update and CMS encourages commenters to also share this concern with the PQA and NQF.

CMS is finalizing the inclusion of the AMO measure beginning with the 2021 ratings year.[20] Data collection will therefore begin with the 2021 QRS but the measure will not be included in scoring until the 2022 ratings year, at the earliest. As shown in Appendix A, CMS anticipates including the AMO measure in the Patient Safety composite and domain, pending reliability testing after the initial year of data submission. CMS will release further information on measure scoring and hierarchy placement in the 2021 QRS and QHP Enrollee Survey Technical Guidance. The current technical specifications for the AMO measure are included in Appendix B.[21] To access the PQA Value Sets for the AMO measure, please navigate to the NQF website and download the AMO specifications.[22] The PQA Value Sets for the AMO measure are in the AMO Complete Coding file.

3.2.2 *Asthma Medication Ratio* (AMR)

Commenters generally supported the addition of the AMR measure to the QRS measure set. After consideration of comments, since the change from the MMA measure to the AMR measure imposes minimal burden on QHP issuers, and the AMR measure addresses an important policy

[19] The final technical specifications for the AMO measure will be incorporated in the 2021 QRS Measure Technical Specifications.
[20] As noted above, the timeline for incorporation of this refinement is subject to change as CMS continues to assess the potential impact of the COVID-19 pandemic on 2021 QRS and QHP Enrollee Survey requirements.
[21] The AMO measure technical specifications included in Appendix B are subject to change from those published in the 2021 QRS Measure Technical Specifications.
[22] See the AMO measure technical specifications available on the NQF Behavioral Health and Substance Use webpage: http://www.qualityforum.org/ProjectMeasures.aspx?projectID=86054&cycleNo=2&cycleYear=2019

priority,[23] CMS is finalizing the inclusion of AMR into the QRS, as proposed. CMS anticipates collecting data for the AMR measure beginning with the 2021 QRS, with scoring for the measure beginning with 2022 ratings year.[24]

As shown in Appendix A, CMS anticipates including the AMR measure in the Asthma Care composite and Clinical Effectiveness domain, pending reliability testing after the initial year of data submission. CMS will release further information on measure scoring and hierarchy placement in the 2021 QRS and QHP Enrollee Survey Technical Guidance.

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

Stakeholders who submitted comments on the QHP Enrollee Survey sample frame were supportive of CMS including any proposed changes to the variables included in the sample frame file layout as part of the Call Letter process and removing the completeness thresholds for the enrollee education and enrollee education variables. Moving forward, CMS intends to use the Call Letter process to propose changes to the QHP Enrollee Survey sample frame, such as adding or removing variables.

For the 2021 QHP Enrollee Survey, after consideration of comments received, CMS will remove the completeness thresholds for the enrollee education and enrollee employment variables, as proposed, such that it is optional for QHP issuers to report employment and education data.

CMS appreciates the suggestions regarding enrollee demographic data that issuers currently collect and could be used as case mix adjusters in future survey years. CMS will continue to explore options for refining the case mix adjustment methodology for the QHP Enrollee Survey measures for future survey administration years.

4.0 QRS and QHP Enrollee Survey Revisions for Future Years

Commenters generally supported the potential modifications for future consideration and evaluation regarding the QRS and QHP Enrollee Survey (i.e., removing items from the QHP Enrollee Survey questionnaire, modifying the QRS clustering and cut point methodologies, revising the QRS hierarchy, and incorporating risk adjustment based on sociodemographic status) that would take effect in future years (i.e., beginning with the 2022 QRS at the earliest).

[23] For further details, see section 3.2.2 of the Draft 2020 Call Letter, available at: https://www.cms.gov/files/document/draft-2020-call-letter-quality-rating-system-qrs-and-qualified-health-plan-enrollee-experience.pdf

[24] As noted above, the timeline for incorporation of this refinement is subject to change as CMS continues to assess the potential impact of the COVID-19 pandemic on 2021 QRS and QHP Enrollee Survey requirements.

CMS thanks commenters for their important feedback on these potential refinements and will use the comments submitted to inform the development of proposals for 2022 and beyond.

CMS anticipates including these types of 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).

4.1 Removing Items from the QHP Enrollee Survey Questionnaire

Commenters overwhelmingly supported CMS' proposal to remove questions from the QHP Enrollee Survey that do not provide actionable information for QHP issuers. CMS will consider the feedback regarding the specific QHP Enrollee Survey questions commenters recommended removing and retaining for potential refinements for future survey administration years.

CMS is conducting focus groups with issuers and consumers, followed by cognitive testing, to identify potential survey refinements and questions for possible removal. CMS may consider other factors when identifying potential changes to the QHP Enrollee Survey questionnaire, including but not limited to whether the question captures data not otherwise collected and whether questions are used in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan surveys.

CMS anticipates proposing to remove items from the QHP Enrollee Survey beginning with the 2022 QHP Enrollee Survey. CMS will comply with the PRA, as applicable, in implementing any such changes.

At this time, CMS is not considering removing survey questions that feed into the survey measures in the QRS measure set. However, when proposing refinements to the questions included in the QRS survey measures, CMS will provide additional information, including the anticipated impact to the QRS.

4.2 Future Modification of the QRS Clustering and Cut Point Methodologies

Stakeholders who submitted comments on the QRS clustering and cut point methodologies supported the proposal to investigate alternative methods for clustering and assigning cut points. Commenters also expressed interest in reviewing the proposed methodologies and findings from CMS analyses that demonstrate the impact of these potential refinements on the QRS program.

CMS will continue to consider different ways to incorporate refinements to the QRS clustering and cut point methodologies that increase the stability and predictability of cut points between years and reduce sensitivity to changes in the underlying data and intends to solicit feedback on such approaches in future Call Letters. CMS will consider a number of factors when identifying proposals to incorporate refinements to the QRS clustering and cut point methodologies, including input from the QRS TEP, public comments submitted in response to the Call Letters, testing results, and other CMS quality reporting programs. In response to comments, CMS will consider sharing details regarding the testing of the modified clustering and/or cut point approaches in the QRS scoring process.

4.3 Revisions to the QRS Hierarchy

Commenters who submitted feedback about CMS' proposal to revise the QRS hierarchy expressed support for the removal of one or more levels of the QRS hierarchy that are not displayed to consumers (e.g., the composite and/or domain components). Additionally, commenters recommended that CMS consider incorporating explicit weights at the measure level. This included comments recommending CMS explore adopting permanent explicit weights at the measure level to increase stability in QRS scores and ratings.

CMS believes that removing levels of the QRS hierarchy will eliminate the need for CMS to introduce temporary explicit weighting structures; however, CMS may explore assigning explicit weights to the QRS measures or other component levels in the future. CMS will also continue efforts to align the Exchange quality programs with the Meaningful Measures Initiative and will continue to consider potential refinements for the QRS measure set and rating methodology, including commenter's suggestions, for future years to streamline quality measures, reduce regulatory burden, and foster operational efficiencies.[25]

CMS continues to explore removing levels of the QRS hierarchy and assigning permanent explicit weights to the QRS measures or other component levels. CMS will include specific proposed methods for changes to the QRS hierarchy and/or assignment of explicit weights in future Draft Call Letters or through the rule-making process for public comment, as appropriate.

4.4 Risk Adjustment Based on Sociodemographic Status

Some commenters supported CMS' proposal to investigate a strategy to risk adjust QRS measures based on sociodemographic status. CMS appreciates commenters' suggestions regarding types of sociodemographic data issuers currently collect that CMS could use in an analytical adjustment of this nature.

CMS continues to explore the possibility of risk adjusting QRS measure for sociodemographic status and the availability of data needed for this purpose. As noted in the Draft 2002 Call Letter, in alignment with other federal quality ratings programs (e.g., the Medicare Part C & D Star Ratings Program), CMS intends to monitor the latest research to inform potential risk adjustment of QRS measures based on sociodemographic status for future years.

[25] For more information on the Meaningful Measure Initiative, please visit: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.

Appendix A. Revised 2021 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 3 illustrates the finalized 2021 QRS hierarchy.[26] Measures denoted with a strikethrough (–) will no longer be collected beginning with the 2021 ratings year. Measures denoted with an asterisk (*) will be collected for the 2021 QRS, but not included in scoring.

Exhibit 3. Revised 2020 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~~
		Behavioral Health	Asthma Medication Ratio*[27]	50
			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	Annual Monitoring for Persons on Long-term Opioid Therapy*[28]	49
			Plan All-Cause Readmissions	15
			INR Monitoring for Individuals on Warfarin (INR)*[29]	48
	Prevention	Checking for Cancer	Breast Cancer Screening	16
			Cervical Cancer Screening	17
			Colorectal Cancer Screening	18
		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

[26] For information on the 2019 QRS hierarchy, see Appendix E in the 2019 QRS and QHP Enrollee Survey Technical Guidance, available on CMS' MQI website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

[27] CMS anticipates including the AMO measure in the Asthma Care composite and Clinical Effectiveness domain, pending reliability testing after the initial year of data submission.

[28] CMS anticipates including the AMO measure in the Patient Safety composite and domain, pending reliability testing after the initial year of data submission.

[29] CMS anticipates including the INR measure in the Patient Safety composite and domain, pending reliability testing after initial data submission. Because CMS did not collect data for *the International Normalized Ratio Monitoring for Individual on Warfarin* (INR) measure in 2020, the 2021 QRS will be the first year of data collection for the INR measure and CMS intends to begin scoring the measure beginning with the 2022 ratings year.

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	M#
Clinical Quality Management (Weight 2/3) (continued)	Prevention (continued)	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
			Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	32
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 Children With Pharyngitis	39
			Appropriate Treatment for Children With Upper Respiratory Infection	40
			Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	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 4. 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.

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.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Drug Test	Any drug screens/tests (presumptive or definitive) for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids. • ≥1 claim with specified Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes, or Logical Observation Identifiers Names and Codes (LOINC). See Value Set, Drug Test Value.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
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 first 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 (Medication Table AMO: Opioid Analgesics) during the measurement year. The cumulative days' supply does not have to be consecutive.

NOTE:
- The prescriptions can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Step 4 Exclude individuals who met ≥1 of the following during the measurement year:
- Hospice- Refer to General Guideline: XXX. Members in Hospice.
- Cancer- Any individual with non-melanoma skin cancer during the measurement year.
- ≥1 claim with during the measurement year. See Value Set, Cancer.

Administrative Specification

Denominator	The eligible population.
Numerator	Individuals in the denominator who have not received a drug test during the measurement year. See Value Set, Drug Test.
Measure Rate	Divide the numerator by the denominator and multiply by 100.

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).