Health Insurance Exchange

Final 2022 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

June 2022

Contents

List of Exhibits

1.0 Purpose of the 2022 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 2022 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (referred to hereafter as the Draft 2022 Call Letter) during the public comment period, held February 10, 2022 through March 9, 2022.

This document, the *Final 2022 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)* (referred to hereafter as the Final 2022 Call Letter), serves to communicate CMS' finalized refinements to the QRS and QHP Enrollee Survey programs. This document summarizes comments received on the Draft 2022 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 2023* (2023 QRS and QHP Enrollee Survey Technical Guidance) in the fall of 2022, reflecting the applicable finalized changes announced in this document.

For questions regarding QRS and QHP Enrollee Survey program refinements communicated in this document, please contact the CMS Marketplace Service Desk (MSD) at CMS_FEPS@cms.hhs.gov. Please include "MQI-QRS" in the subject line of your email.

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 *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 2022 ratings year (the 2022 QRS) generally represent calendar year 2021 data as the measurement year. Some measures require more than one year of continuous enrollment for data collection, so the measurement year for those measures will include years prior to 2021. ▪ For QRS survey measure data in the 2022 QRS, the QHP Enrollee Survey is fielded based on enrollees who are currently enrolled as of January 6, 2022, but the survey requests that enrollees report on their experience "from July through December 2021."

Term	Description
Ratings Year	The *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 "2022 QRS" refers to the 2022 ratings year. ▪ As part of the 2022 plan year certification process, which occurred during the spring and summer of 2021, QHP issuers attested that they will adhere to 2022 quality reporting requirements, which include requirements to report data for the 2022 QRS and QHP Enrollee Survey. ▪ Requirements for the 2022 QRS, and details as to the data collection, validation, and submission processes, are documented in the 2022 QRS and QHP Enrollee Survey Technical Guidance, which was published in October 2021. ▪ Ratings calculated for the 2022 QRS are displayed for QHPs offered during the 2023 plan year, in time for open enrollment, to assist consumers in selecting QHPs.

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 annual 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	**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	**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 the Draft Call Letter).
March – April	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS and QHP Enrollee Survey programs.
May/June	**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:** CMS provides technical guidance regarding the QRS and QHP Enrollee Survey and specifies requirements for QHP issuers offering coverage through the Health Insurance Exchanges (Exchanges). **Publication of Updated QRS Measure Technical Specifications**: CMS publishes an updated version of the QRS Measure Technical Specifications, as needed, that indicates final decisions regarding changes to the measures and/or measure rates (i.e., any measures finalized for addition or removal in the Final Call Letter).[1]

The *2023 Quality Rating System (QRS) Measure Technical Specifications,* published in March 2022, includes the specifications for measures and/or measure rates proposed for addition and

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

removal in the Draft 2022 Call Letter.[2] This Final Call Letter includes finalized changes proposed to the QRS measure set for 2023. In the fall of 2022, CMS intends to publish the 2023 QRS and QHP Enrollee Survey Technical Guidance, reflecting applicable finalized changes announced in the Final 2022 Call Letter.

2.0   QRS Revisions for the 2022 Ratings Year

For the 2022 ratings year, CMS proposed retaining the temporary rule to limit star rating declines in the QRS methodology.

Commenters supported this refinement for the 2022 ratings year. CMS will finalize this change as proposed for the 2022 ratings year.

2.1   Retention of the Temporary Rule to Limit Star Rating Declines

Commenters supported CMS' proposal to retain the temporary 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 global rating in 2021, the lowest overall global rating the plan would receive in ratings year 2022 would be three stars). Commenters expressed appreciation for CMS' efforts to continue monitoring and mitigating ongoing impacts of the COVID-19 public health emergency (PHE), as well as to stabilize ratings as CMS transitions to the Benchmark Ratio Approach. After consideration of comments, CMS will finalize the retention of the temporary rule to limit star ratings declines for the 2022 ratings year.

CMS will first apply the Benchmark Ratio Approach to calculate measure scores and then the clustering cut point methodology to assign star ratings at the global and summary indicator levels. CMS will 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.

3.0   QRS and QHP Enrollee Survey Revisions for the 2023 Ratings Year

CMS proposed a series of refinements to the QRS and QHP Enrollee Survey that would apply beginning with the 2023 ratings year. These refinements include:

- Addition of the *Kidney Health Evaluation for Patients With Diabetes* measure to the QRS measure set,
- Refinements to the *Colorectal Cancer Screening* measure,
- Temporary removal of the *Initiation and Engagement of Substance Use Disorder Treatment* measure from scoring,
- Incorporation of an optional Electronic Clinical Data System Reporting method,
- QRS cut point methodology refinements, and
- Stratification of race and ethnicity data to help advance health equity.

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[2] Please see the 2023 QRS Measure Technical Specifications available on the CMS Marketplace Quality Initiatives website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.

3.1 Adding the Kidney Health Evaluation for Patients With Diabetes Measure

Commenters supported the addition of the *Kidney Health Evaluation for Patients With Diabetes* measure to the QRS measure set to address the removal of the retired *Comprehensive Diabetes Care: Medical Attention for Nephropathy* measure and to better align with the kidney care and health clinical practice guidelines and recommendations. CMS will finalize the inclusion of the *Kidney Health Evaluation for Patients With Diabetes* measure in the QRS measure set, as proposed. Consistent with the previously finalized policies for incorporating refinements that involve significant changes[3], QHP issuers will be required to collect data for the *Kidney Health Evaluation for Patients With Diabetes* measure beginning with the 2023 ratings year, with scoring for the measure beginning with the 2024 ratings year.

Some commenters suggested updates to the *Kidney Health Evaluation for Patients With Diabetes* measure. Specifically, these commenters recommended: 1) removing the sodium glucose cotransporter 2 (SGLT2) inhibitor prescriptions as inclusion criterion in the measure population; 2) adding urine protein/creatinine testing, along with albumin/creatinine testing, for appropriate kidney evaluation; 3) removing the race-based modifier in the calculation of the estimated glomerular filtration rate (eGFR); and 4) adding the special use codes developed by the Logical Observation Identifiers Names and Codes (LOINC) (i.e., 98979-8 and 98980-6) to ensure alignment with current guidance from the National Kidney Foundation and American Society of Nephrology.

CMS appreciates these comments and acknowledges that some SGLT2 inhibitors are prescribed for non-diabetes indications, such as heart failure and chronic kidney disease. NCQA is reevaluating the diabetes denominator approach to mitigate this issue in a future measure update. Additionally, clinical practice guidelines recommend screening for albuminuria with urinary albumin-to-creatinine ratio (uACR), noting that alternative urine tests are not more burdensome and add little to prediction or accuracy. Additionally, NCQA incorporated the new LOINC codes for eGFR without the race-based modifier in the Healthcare Effectiveness Data and Information Set (HEDIS®[4]) Measurement Year 2022 Technical Update released March 31, 2022.[5] The Measurement Year 2022 QRS HEDIS® Value Set Directory also incorporates these codes.[6] To accommodate this shift in coding, NCQA will allow a transitional period before removing the LOINC codes for eGFR that include the race-based modifier. As outlined in the Draft 2022 Call Letter, the National Committee for Quality Assurance (NCQA) serves as the measure steward for the *Kidney Health Evaluation for Patients With Diabetes* measure. Consistent with other measures in the QRS measure set, QHP issuers will be required to follow the technical

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

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

[5] See the Measurement Year 2022 Technical Specifications Update for HEDIS® measures included in the QRS, available at: https://www.ncqa.org/wp-content/uploads/2022/03/MY-2022-HEDIS-for-QRS-Technical-Update-Memo.pdf.

[6] To access the Measurement Year 2022 QRS HEDIS® Value Set Directory, see NCQA > MY 2022 Quality Rating System (QRS) HEDIS Value Set Directory.

specifications adopted by the measure steward[7] (i.e., NCQA) for the *Kidney Health Evaluation for Patients With Diabetes* measure.[8]

3.2 Proposed Refinements to the Colorectal Cancer Screening Measure

Most commenters supported the proposed refinements to the *Colorectal Cancer Screening* measure, but recommended delaying the inclusion of the refined measure in the QRS until the 2024 ratings year. Commenters generally requested that CMS delay incorporation of the 45–49 age band for this measure in QRS scoring until measurement year 2023 (i.e., 2024 ratings year) to provide QHP issuers with more time to coordinate with providers on implementing these refinements and to educate and encourage members of the newly eligible population to seek colorectal cancer screenings.

CMS appreciates commenters' feedback on the proposed refinements to the *Colorectal Cancer Screening* measure. After consideration of comments, CMS will align with the measure steward's (i.e., NCQA's) timeline for refining the measure beginning with measurement year 2022 (i.e., 2023 ratings year).[9] In accordance with the measure steward's specifications for this measure, issuers will be required to collect and report data for both the 45-49 and 50-75 age bands beginning with measurement year 2022 (i.e., 2023 ratings year).[10] CMS will not include the new eligible population (i.e., 45-49 years of age) in scoring for this measure in the 2023 ratings year but will continue to include the *Colorectal Cancer Screening* measure in scoring for the 2023 ratings year using only the eligible population of ages 50-75. CMS anticipates introducing the refined measure that includes the revised age range from 45-75 in QRS scoring for the 2024 ratings year.

3.3 Temporary Removal of the Initiation and Engagement of Substance Use Disorder Treatment Measure from 2023 Scoring

CMS proposed to temporarily remove the *Initiation and Engagement of Substance Use Disorder Treatment* measure from scoring for the 2023 ratings year in alignment with updates made by the measure steward, NCQA, to the specifications for the measure.[11]

All commenters supported the temporary removal of the *Initiation and Engagement of Substance Use Disorder Treatment* measure from 2023 QRS scoring. After consideration of comments, CMS is finalizing the temporary removal of this measure from scoring for one year (i.e., 2023 ratings year). The temporary removal of this measure from scoring does not change or otherwise

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[7] 45 CFR §§ 156.200(b)(5) and (h); 156.1120; and 156.1125.

[8] Please see the 2023 QRS Measure Technical Specifications for the final *Kidney Health Evaluation for Patients with Diabetes* measure technical specifications, available at: https://www.cms.gov/files/document/2023-qrs-technical-specifications.pdf.

[9] See supra note 5.

[10] *Id.*

[11] As a result of these measure specification changes, NCQA modified the measure name of the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* to the *Initiation and Engagement of Substance Use Disorder Treatment.* See the 2023 QRS Measure Technical Specifications for information related to the modifications to the *Initiation and Engagement of Substance Use Disorder Treatment* measure, available at: https://www.cms.gov/files/document/2023-qrs-technical-specifications.pdf.

impact the QRS data collection requirements for this measure for measurement year 2022. As such, QHP issuers are still required to collect and report validated data for this measure following the measure steward's updated specifications. CMS anticipates reintroducing this measure in QRS scoring for the 2024 ratings year.

3.4   Incorporation of Optional Electronic Clinical Data System Reporting

Commenters supported the addition of optional Electronic Clinical Data Systems (ECDS) reporting for select HEDIS® measures in the QRS measure set. After consideration of comments, CMS will finalize, as proposed, the incorporation of optional ECDS reporting alongside hybrid or administrative reporting for the *Colorectal Cancer Screening*, *Breast Cancer Screening*, *Immunization for Adolescents (Combination 2)*, and *Childhood Immunization Status (Combination 10)* measures beginning with the 2023 ratings year in alignment with NCQA's timeline for incorporation of optional ECDS reporting for these measures.

To advance CMS' goals of digitizing measures and modernizing data collection and reporting, CMS is continuing to explore the incorporation of mandatory ECDS reporting for select HEDIS® measures in the QRS measure set. As part of this effort, the Draft 2022 Call Letter solicited feedback on further implementing ECDS reporting in the QRS by requiring ECDS reporting for select measures in future years. CMS appreciates respondents' feedback on the inclusion of mandatory ECDS reporting in the QRS and recognizes the concerns stakeholders identified, including the barriers associated with implementation and reporting. Several commenters noted a lack of infrastructure and resources needed to successfully report electronic data due to interoperability challenges. For example, there is limited information sharing between providers and health plans caused by gaps in Electronic Health Records (EHR) used by providers. Commenters also noted that required ECDS reporting may lead to missing data from key stakeholders with EHR adoption challenges, such as individual providers, smaller group practices, and providers in rural areas. CMS acknowledges ECDS reporting would require changes to the reporting method. However, ECDS reporting allows QHP issuers to use data source categories beyond EHR data, including health information exchanges/clinical registries, case management system, and administrative claims/enrollment data.[12]

CMS did not propose, and is not finalizing, mandatory ECDS reporting in the QRS at this time. CMS will continue to coordinate with the applicable measure stewards and other quality reporting programs (e.g., Medicare Part C and D Star Ratings Program) regarding a potential timeline for the incorporation of required ECDS reporting. CMS anticipates alignment of implementation of a mandatory ECDS reporting requirement across programs would mitigate burden and increase efficiencies and consistency in quality reporting.

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[12] For more information about ECDS reporting, please see ECDS Frequently Asked Questions, available at: https://www.ncqa.org/hedis/the-future-of-hedis/ecds-frequently-asked-questions/.

3.5   QRS Cut Point Methodology Refinements

CMS appreciates commenters' feedback on the proposed refinements to the QRS cut point methodology to align with the methodological transition to the Benchmark Ratio Approach.[13] Several commenters supported CMS' proposed replacement of the current cut point approach (i.e., clustering approach) with the static cut point approach using the 60, 70, 80, 90 threshold values, at both the summary indicator and global levels of the hierarchy. After consideration of comments, CMS will finalize use of the static cut point approach in the QRS methodology beginning with the 2023 ratings year.

CMS recognizes that stakeholders may have an interest in the methods for the cut point analyses, as well as the associated findings to assess the potential impact on QRS ratings.[14] CMS conducted the cut point analyses in tandem with the removal of the domain and composite levels of the QRS hierarchy[15] to determine the most optimal cut point methodology to use with the newly implemented Benchmark Ratio Approach. Evaluation criteria included the ability of the cut points to generate interpretable and consistent thresholds for stakeholders. Results suggested the static cut point approach (using the 60, 70, 80, 90 thresholds) was the most optimal cut point methodology.

Testing also highlighted the methodological differences between the static cut point and clustering methodologies. For example, in contrast to the clustering methodology, the static cut point approach does not require all star rating categories to be populated. As a result, all health plans can receive a high rating, if merited. The static cut point approach also defines set cut point thresholds (i.e., 60, 70, 80, 90), which offer health plans with a set of star rating performance targets that remain consistent across years and eliminate shifts in the cut point values year over year as values are now fixed. CMS acknowledges this benefit addresses stakeholders' interest in more stable, predictable performance targets. Additionally, the static cut point methodology varies from the clustering methodology in that star rating distributions better reflect underlying measure performance.

Stakeholders also expressed interest in understanding which scores corresponded to each star rating. Exhibit 3 provides the 2021 ratings distribution from testing after applying the static cut point approach with the 60, 70, 80, 90 thresholds to 2021 data, reflecting the streamlined QRS hierarchy and Benchmark Ratio Approach. Analyses found the 2021 global scores ranged from 64.028 to 97.010 (mean=83.088, standard deviation=6.235, median=83.235).

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[13] CMS finalized the transition to the Benchmark Ratio Approach in the Final 2021 Call Letter for the QRS and QHP Enrollee Survey beginning with the 2022 ratings year. The Final 2021 Call Letter is available at https://www.cms.gov/sites/default/files/2021-05/Final-2021-Call-Letter-for-the-QRS-and-QHP-Enrollee-Survey-508.pdf.

[14] See Section 3.5 in the Draft 2022 Call Letter for additional details on CMS testing of alternative cut point methodologies. The Draft 2022 Call Letter is available at https://www.cms.gov/files/document/2022-call-letter-qrs-qhp-enrollee-survey.pdf.

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

Exhibit 3. Global Rating Distribution Using Static Cut Points (60, 70, 80, 90)

Global Rating	2021 Rating Distribution
1 star	0 (0.00%)
2 stars	6 (2.87%)
3 stars	51 (24.40%)
4 stars	113 (54.07%)
5 stars	25 (11.96%)
NR	14 (6.70%)
Total	209 (100.00%)

After applying the cut point methodology, the static cut points align closely with the range of global scores from testing, reflecting the generally higher performances of reporting units under the Benchmark Ratio Approach. A benefit of the static cut point approach is that it defines star ratings without forcing a certain distribution of ratings, allowing the star ratings to better reflect underlying health plan performance. As a result, the star ratings distribution shown in Exhibit 3 reflects the ratings distribution only for the 2021 ratings year, based on performance in that specific year. As such, this distribution is not guaranteed year over year.

These highlighted benefits of the static cut point approach address stakeholders' priorities (e.g., improve stability of the QRS ratings, provide meaningful performance benchmarks, improve interpretability of star ratings) when refining the methodology. In addition, pairing the static cut point methodology with the Benchmark Ratio Approach will allow QHP issuers to more fully realize the benefits of the updated scoring methodology. For all of the above reasons, CMS will finalize inclusion of the static cut point approach for the 2023 ratings year.

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

CMS thanks commenters for their feedback on the proposed requirement for QHP issuers to submit race and ethnicity data for five measures in the QRS measure set. Commenters generally supported reporting of stratified race and ethnicity data in the QRS. After consideration of comments, CMS will finalize the proposal to update the form and manner in which QHP issuers must submit validated data for five measures in the QRS measure set. More specifically, QHP issuers will be required to collect and report stratified race and ethnicity data for the following measures: *Colorectal Cancer Screening, Controlling High Blood Pressure, Hemoglobin A1c (HbA1c) Control for Patient With Diabetes: HbA1c control (<8.0%), Prenatal and Postpartum Care,* and *Child and Adolescent Well-Care Visits* beginning with the 2023 ratings year in alignment with NCQA's refinements to these HEDIS® measures.[16] In the 2022 and 2023 measurement years, QHP issuers can report the stratification using their own directly collected member data for race and ethnicity, as outlined in the *2023 QRS Measure Technical Specifications*.[17] Additionally, QHP issuers can supplement directly collected data with indirect race and ethnicity data (i.e., assigned or imputed from secondary data sources such as assignment

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[16] For more information on NCQA's approach and timeline for stratification of select HEDIS® measures, see: https://www.ncqa.org/about-ncqa/health-equity/data-and-measurement/.

[17] For more information on QRS data collection guidelines for race and ethnicity stratification, please see the 2023 QRS Measure Technical Specifications, available at: https://www.cms.gov/files/document/2023-qrs-technical-specifications.pdf.

by geographic location, surname analysis, and geocoding). QHP issuers will not be required to use a specific method for imputation when reporting stratified race and ethnicity data using indirect data sources and will not be required to use direct data sources until the 2024 measurement year, at the earliest. [18]

CMS is committed to advancing health equity and adopting this requirement to report stratified race and ethnicity data for the identified measures is an initial step to permit further analysis of these issues for the Exchange population. For example, reporting of this stratified data will provide insight and awareness for QHP issuers into the quality of care among members of different demographics enrolled in each plan and thereby allow issuers to advance health equity.

CMS appreciates commenters' input on the reporting of stratified race and ethnicity in the QRS via direct data collection methods, including the potential barriers associated with accessing this data, concerns with data quality (e.g., concerns with potential lack of consistency in the data due to self-reporting, low consumer response rates, lack of interoperable data infrastructure, inconsistent data standards) and potential limitations to use of these data as a result of different factors, such as small sample sizes. CMS reminds QHP issuers that issuers may supplement direct data via indirect data sources during initial years of this requirement (i.e., 2022 measurement year and 2023 measurement year), providing an opportunity for QHP issuers to focus on enhancing data collection efforts and systems in preparation for use of direct data sources beginning in measurement year 2024. CMS is finalizing the phased-in approach for direct data collection as proposed and will continue to consider feedback related to direct data collection in future years.

Commenters also noted concerns with federal and state laws governing various aspects of race and ethnicity data collection and use, including states that prohibit the collection of race and ethnicity at the time of enrollment. Commenters also recommended CMS consider requiring the future collection and stratification of additional social risk factors, such as sexual orientation and gender identity (SOGI) data. CMS will continue to work with stakeholders and coordinate across the Agency including with other CMS quality reporting programs when determining the timeline for fully transitioning to direct data collection and the future collection and stratification of additional social risk factors, such as SOGI data.

At this time, CMS will not display stratified race and ethnicity data during the 2023 ratings year. Instead, CMS will use the data for internal analyses to examine and better understand the quality of care of the Exchange population across different demographics. CMS will also not use the additional data or any analysis results to pursue changes to program policies until CMS confirms the response rate is adequate to support any analytical conclusions. CMS may also consider confidentially providing this information to QHP issuers (e.g., via QRS Proof Sheets) and would encourage issuers to adopt similar safeguards when analyzing these new data.

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., modifying and removing questions from the QHP Enrollee Survey questionnaire, adding and modifying questions in the QHP

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[18] *Id.*

Enrollee Survey questionnaire to support analysis of health equity and disparities, and refining the QRS methodology half-scale rule) that would take effect in future years (i.e., beginning with the 2024 QRS at the earliest).

CMS thanks commenters for their important feedback on these potential refinements and will use the comments to inform the development of proposals for 2024 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). CMS thanks commenters who provided additional feedback on the QRS program. CMS also appreciates the feedback and recommendations on the QRS measure set and will continue exploring ways to refine the measure set in future years.

4.1 Revisions to the QHP Enrollee Survey Questionnaire

CMS thanks commenters for their feedback on potential survey questions to consider for removal from the QHP Enrollee Survey in future years. Commenters overwhelmingly supported CMS' proposal to remove questions from the QHP Enrollee Survey to reduce the length of the survey and recommended removing questions that do not provide actionable information for QHP issuers. CMS anticipates proposing to remove items from the QHP Enrollee Survey in future years.

Commenters generally supported CMS' proposal to add topics to the QHP Enrollee Survey that can be used to advance health equity in future years. CMS will continue to seek stakeholder input regarding additional potential topics to address through the QHP Enrollee Survey in future years and will consider feedback to add topics regarding access to mental health/behavioral health care, access to telemedicine, and reasons it was not easy to access specialty care.

Several commenters suggested CMS undertake a comprehensive review of the QHP Enrollee Survey and encouraged CMS to release information about testing conducted regarding potential refinements. In response, CMS notes that, in the next few years, the agency anticipates undertaking a comprehensive review of the concepts measured in the QHP Enrollee Survey. Throughout this upcoming assessment process, CMS will seek feedback through multiple venues, including addressing in future Call Letters, gathering input from a TEP, and conducting focus groups with QHP issuers.

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

CMS appreciates commenters' feedback on revisions to the QHP Enrollee Survey questions to support analysis of health equity and disparities within QHPs offered through Health Insurance Exchanges. Commenters generally supported CMS' proposed revisions to collect more granular information regarding race and ethnicity. Several commenters recommended that CMS consider adding additional race categories. Commenters specifically suggested adding categories for Middle Eastern or North African; Arab, Middle Eastern, North African; and LatinX. One commenter also suggested revising the American Indian or Alaskan Native to Native American, Alaska Native, or Indigenous.

CMS intends to move forward with finalizing the revisions to the race question and expanding the response for the ethnicity question, as proposed. The changes align with the 2011 HHS Data Collection Standard,[19] which were established based on a requirement in Section 4302 of the Patient Protection and Affordable Care Act (ACA).[20] Adding these expanded race categories and ethnicity response options will facilitate analysis of health equity and disparities amongst these subpopulations that would not be feasible without this level of granularity. These changes will also provide insight and awareness for QHP issuers into the quality of care and satisfaction among members of different demographics enrolled in each health plan, thereby, allowing issuers to advance health equity. As outlined in the Draft 2022 Call Letter, CMS intends to implement skip patterns for telephone survey instrument respondents to limit burden of administering the expanded question(s) over the phone. CMS will continue to monitor research findings from the Census Bureau and other federal statistical agencies to assess whether additional refinements to these questions are appropriate or otherwise needed in the future. CMS will seek further public comment on these new data categories through a Federal Register Notice published as part of the Paperwork Reduction Act clearance process in advance of the 2024 QHP Enrollee Survey.

Additionally, one commenter suggested CMS include a statement ahead of the race and ethnicity questions explaining how these data will be used in order to improve response rates to these questions. CMS appreciates this suggestion and will consider adding this type of statement in the future.

Several commenters noted that some of the newly added categories will apply to a small number of individuals, which would limit the usefulness of these data in helping plans to develop or refine their quality improvement strategies. CMS acknowledges that some of the new categories that will be added may only include a small number of enrollees and encourages issuers to conduct data quality checks, as well as ensure response rates are adequate to support any analytical conclusions. CMS appreciates the suggestions for additional new categories and may consider them for potential inclusion in future benefit years.

4.3   Potential Refinements to the QRS Methodology Half-Scale Rule

CMS thanks commenters who provided feedback on CMS' proposal to explore refinements to the current QRS half-scale rule under the streamlined QRS hierarchy. Some commenters supported CMS' proposal to investigate the percentage of measures that should be present in order for the associated summary indicator components to receive a score under the streamlined QRS hierarchy finalized in part 2 of the HHS Notice of Benefit and Payment Parameters for 2022 Final Rule.[21]

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[19] For more information on the 2011 HHS Data Standard, see http://aspe.hhs.gov/datacncl/standards/ACA/4302.

[20] See Section 4.2 of the Draft 2022 Call Letter for additional details on the revised question and response options for the race and ethnicity questions in the QHP Enrollee Survey. The Draft 2022 Call Letter is available at https://www.cms.gov/files/document/2022-call-letter-qrs-qhp-enrollee-survey.pdf.

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

CMS agrees and will continue to explore potential refinements to the QRS methodology for future years, including revisions to the half-scale rule. The feedback shared will inform the further exploration and testing of potential options. If CMS considers revising the half-scale rule and pursuing alternative percentages of measures to be present in order for a high-level component score to be calculated, CMS may seek feedback from the TEP and will also solicit public comments.

Appendix A. Revised 2023 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 summary indicator hierarchical components to form a single global rating.

Exhibit 4 illustrates the anticipated 2023 QRS hierarchy. Measures denoted with an asterisk (*) will be collected for the 2023 QRS, but not included in scoring.

Exhibit 4. Revised 2023 QRS Hierarchy

QRS Summary Indicator	Measure Title	NQF ID (¥ indicates not currently endorsed)
Clinical Quality Management	Asthma Medication Ratio	1800
	Antidepressant Medication Management	0105
	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30-Day Follow-Up)	0576
	Initiation and Engagement of Substance Use Disorder Treatment*	0004
	Controlling High Blood Pressure	0018
	Proportion of Days Covered (RAS Antagonists)	0541
	Proportion of Days Covered (Statins)	0541
	Eye Exam for Patient with Diabetes	0055
	Hemoglobin A1c (HbA1c) Control for Patient With Diabetes: HbA1c control (<8.0%)	0575
	Proportion of Days Covered (Diabetes All Class)	0541
	Kidney Health Evaluation for Patients With Diabetes*	N/A [22]
	International Normalized Ratio Monitoring for Individuals on Warfarin	0555
	Annual Monitoring for Persons on Long-term Opioid Therapy	3541
	Plan All-Cause Readmissions	1768 ¥
	Breast Cancer Screening	2372
	Cervical Cancer Screening	0032
	Colorectal Cancer Screening	0034
	Prenatal and Postpartum Care (Postpartum Care)	1517 ¥
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517 ¥
	Chlamydia Screening in Women	0033
	Flu Vaccinations for Adults Ages 18-64	0039 ¥
	Medical Assistance with Smoking and Tobacco Use Cessation	0027 ¥
	Annual Dental Visit	1388 ¥
	Childhood Immunization Status (Combination 10)	0038
	Immunizations for Adolescents (Combination 2)	1407
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024
	Well-Child Visits in the First 30 Months of Life	1392
	Child and Adolescent Well-Care Visits	N/A

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

QRS Summary Indicator	Measure Title	NQF ID (¥ indicates not currently endorsed)
Enrollee Experience	Access to Care	0006
	Care Coordination	0006
	Rating of All Health Care	0006
	Rating of Personal Doctor	0006
	Rating of Specialist	0006
Plan Efficiency, Affordability, & Management	Appropriate Testing for Pharyngitis	0002 ¥
	Appropriate Treatment for Upper Respiratory Infection	0069
	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis	0058
	Use of Imaging Studies for Low Back Pain	0052 ¥
	Access to Information	0007 ¥
	Plan Administration	0006
	Rating of Health Plan	0006