Health Insurance Exchange

Final 2018 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 2018

Contents

List of Exhibits

1.0 Purpose of the 2018 QRS Call Letter

The Centers for Medicare & Medicaid Services (CMS) appreciates all the individuals and organizations who submitted comments on the *Draft 2018 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)* (referred to hereafter as the Draft 2018 QRS Call Letter) during the public comment period, held March 7, 2018 through April 9, 2018.

This document, the *Final 2018 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)* (referred to hereafter as the Final 2018 QRS Call Letter), serves to communicate CMS' finalized refinements to the QRS and QHP Enrollee Survey programs.[1] This document summarizes comments received on the Draft 2018 QRS 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.

The refinements described in this document focus on refinements to the QRS rating methodology,[2] removal of QRS measures, aggregation of QRS measures, 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 will be publishing an updated version of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2018* (version 2.0 of the 2018 QRS Guidance), reflecting the applicable finalized changes announced in this document.

1.1 Key Terms

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

[1] The QRS and QHP Enrollee Survey requirements for the 2018 ratings year (the 2018 QRS) will be detailed in Version 2.0 of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2018*, which will be available on CMS' Marketplace Quality Initiatives (MQI) website in summer 2018 at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

[2] CMS applies the QRS rating methodology to validated QRS clinical measure data and a subset of the QHP Enrollee Survey response data (QRS survey measures) to produce quality ratings on a 5-star rating scale.

Exhibit 1. Key Terms for the QRS 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 2018 ratings year (the 2018 QRS) generally represent data for enrollees from the previous calendar year(s) (i.e., CY 2017). 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 2018 QRS may also include years prior to CY 2017. ▪ For QRS survey measure data in the 2018 QRS, the survey is fielded based on enrollees who are enrolled as of January 1, 2018, 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 "2018 QRS" refers to the 2018 ratings year. ▪ Ratings calculated for the 2018 QRS are displayed for QHPs offered during the 2019 plan year, in time for the individual market open enrollment period, to assist consumers in selecting QHPs offered through Health Insurance Exchanges.

1.2 Timeline for Call Letter Publication

The anticipated annual cycle for the QRS Call Letter follows a three-to-four-month (approximately March/April through May/June) timeline as shown in Exhibit 2, followed by the publication of the 2019 QRS Guidance in September.

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

Date	Description
March/April	**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.
April/May	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS and QHP Enrollee Survey 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.
August	**Publication of QRS and QHP Enrollee Survey 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 Health Insurance Exchanges (Exchanges).

2.0 Revisions Proposed for the 2018 Ratings Year

A number of respondents disagreed with CMS' proposed updates to the timeline for incorporating refinements into the QRS, citing particular concerns around expediting the timeline for removing measures from the QRS measure set. In consideration of these concerns, CMS will not finalize this refinement with respect to the removal of measures, and will continue to provide at least one year's notice before implementing such changes. However, CMS will retain flexibility to allow for implementation of methodology refinements that are determined to not be considered significant on a more expedited timeline. Given these initial years of implementation

of the QRS program, CMS believes there is an overriding interest in allowing for expedited and streamlined improvement of the QRS methodology in response to critical stakeholder feedback, as appropriate.

Commenters generally supported the changes proposed to the QRS scoring methodology, including consolidation of the *Access to Care* and the *Care Coordination* measures into a single composite and domain, replacement of the PROC RANK standardization procedure with the Z-score approach, incorporation of a jackknife procedure, and increasing the denominator criterion for the *Plan All-Cause Readmission* measure.

CMS thanks commenters for their important feedback on these refinements.

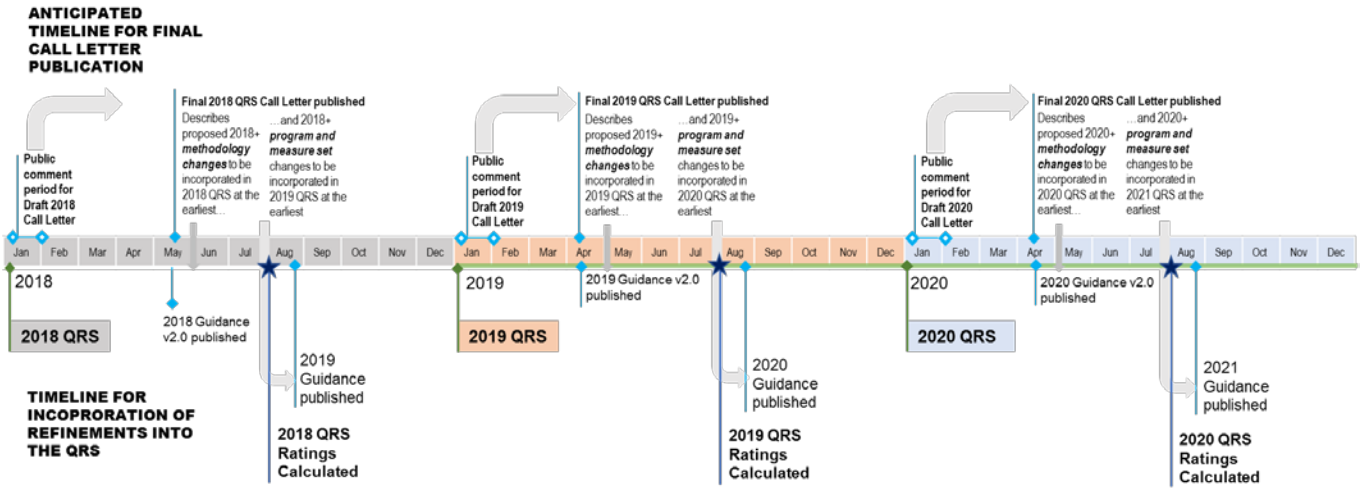
2.1 Timeline for Incorporating Refinements into the QRS Program

A number of commenters cited concerns with the proposed updated timeline as it relates to the removal of measures. CMS appreciates this feedback and will continue to provide one year's notice before removing measures from the QRS measure set.

After consideration of comments received, CMS is generally maintaining the timeline for incorporating ratings methodology refinements and other non-significant changes to allow such changes to occur within the same ratings year they are announced. CMS believes there is an important interest in allowing for flexibility with respect to implementing refinements to the QRS rating methodology and other program operations that are determined to not be significant in a more expedited manner. CMS' intention with proposing a more flexible timeline to incorporate certain refinements (e.g., revisions to the QRS hierarchy) was to facilitate expedited and streamlined improvement of the QRS methodology in response to critical stakeholder feedback.

Exhibit 3 illustrates the QRS Call Letter cycle and incorporation of refinements into the QRS.

Exhibit 3. Sample Timeline for Proposing and Incorporating Refinements to the QRS



Please note this approach does not mean that all ratings methodology refinements will take effect in an expedited manner. CMS will continue to provide advance notice to stakeholders of

refinements to the QRS program that are determined to be significant (e.g., refinements to the QRS and QHP Enrollee Survey participation requirements, additions and/or reductions to the measure set) and will continue to mirror the approach to determine significance used by other established CMS quality reporting programs. This approach determines significance based on a combination of factors, including whether there is increased burden on QRS stakeholders and/or an impact on data system needs, such as changes to the QRS and QHP Enrollee Survey participation requirements, significant modifications to measure technical specifications, and additions and/or reductions to the measure set. Based on the above criteria, CMS determined that the rating methodology refinements finalized in this Call Letter are not significant and, thus, may be implemented in the 2018 ratings year.

2.2 Revise the QRS Hierarchy

Commenters generally supported the proposed QRS hierarchy refinement, and expressed appreciation for CMS' efforts to address weighting issues in the QRS hierarchy. In an effort to balance the influence of individual measures on the global score, CMS will consolidate two of the four single-measure components in the QRS hierarchy beginning with the 2018 ratings year. Under the current hierarchy, each single-measure component contributes a considerable amount of influence on the global score due to the aggregation of measure and component scores up the hierarchy.

To reduce the disproportionate influence of these individual measures, CMS will consolidate the single-measure Access to Care and Care Coordination composites and domains. This refinement will reduce the overall contribution of the *Access to Care* and *Care Coordination* measures on the global score (from a combined weight of ~22% to a combined weight of ~16%). Additionally, based on testing using historical data, CMS believes the change may allow a larger percentage of reporting units to achieve a global rating due to an increased ability to meet the half-scale rules.

CMS proposed this refinement in response to consistent requests by stakeholders to reduce the influence of individual survey measures on the global score. Consistent with the proposal in the Draft 2018 QRS Call Letter, this refinement will take effect in the 2018 QRS. Additionally, CMS expects this hierarchy revision will supplement the addition of explicit weights announced in the Final 2017 QRS Call Letter (published in May 2017) and included in the 2018 QRS Guidance.[3] CMS believes that incorporating both weighting refinements in the same ratings year will more quickly establish a new baseline for trending results than implementing these changes sequentially over two years.

2.3 Refine Standardization and Cut Point Methodology

Commenters generally supported the Z-score and jackknifing proposed refinements to the QRS rating methodology. To mitigate sensitivity in the current QRS methodology, CMS will replace

[3] CMS reminds commenters that, beginning with the 2018 ratings year, CMS will apply explicit weights at the summary indicator level when calculating QRS scores and ratings. CMS will assign 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 the Plan Efficiency, Affordability, & Management summary indicators. For more details, please see the 2018 QRS Guidance, available on the MQI website.

the PROC RANK SAS® procedure with a Z-score standardization approach beginning with the 2018 ratings year. The Z-score approach transforms all raw measure rates, independently, by normalizing the reported rates using the respective mean and standard deviation of the measure across all scorable reporting units. CMS then converts the Z-score to a 0-100 scale using the normal curve equivalent (NCE), and uses this value to calculate the global score. CMS' testing of historical measure data confirmed that the Z-score approach stabilizes scores and ratings (via global cut points), making them less susceptible to minor data set changes.

As an additional measure for reducing sensitivity, CMS will incorporate a jackknife procedure into the calculation of global cut points. The jackknife procedure calculates QRS global cut points using sub-samples of data, with one observation systematically removed from each sub-sample (i.e., first data set has the 1st observation removed, second data set has the 2nd observation removed). The addition of the jackknife procedure will allow CMS to generate more robust global cut points for the QRS.

CMS became aware of the highly sensitive nature of PROC RANK during past QRS ratings preview periods from stakeholders who increasingly expressed concerns over this vulnerability in the rating methodology. Thus, CMS concluded that these refinements to the standardization and cut point methodology will bring critical improvements to the QRS program, such that CMS will implement these refinements beginning with the 2018 ratings year.

2.4 Revise Denominator Criterion for the *Plan All-Cause Readmission* Measure

Commenters supported CMS' proposal to revise the denominator criterion for the *Plan All-Cause Readmission* (PCR) measure. In the Draft 2018 QRS Call Letter, CMS proposed applying the denominator criterion of 150 to the PCR measure beginning with the 2018 ratings year based on CMS testing of historical PCR measure data submitted to identify the appropriate denominator criterion for improving reliability of the PCR measure.

Per commenters' request for advance notice of measure changes, CMS will delay incorporation of this refinement until the 2019 ratings year.[4] As such, beginning in 2019, CMS will apply the denominator criterion of 150 to the PCR measure. To clarify, the 150-denominator criterion will be applied during the QRS scoring process for the 2019 ratings year and will not impact data submission for the PCR measure. The current minimum denominator size of 30 will continue to apply to all QRS clinical measures (including the PCR measure) for the 2018 QRS.

3.0 Proposed QHP Enrollee Survey Revisions for Future Years

Commenters generally supported the proposed updates regarding the QRS measure set and QHP Enrollee Survey questionnaire that would take effect in future years (i.e., beginning with the 2019 QRS at the earliest). CMS thanks commenters for their important feedback on these refinements.

[4] As detailed in the Draft 2018 QRS Call Letter, CMS continues to believe this refinement would not be considered significant (as described in Section 2.1) and reserves the right to implement this type of non-significant change in the future in the current ratings year.

3.1 Removing Measures from the QRS Measure Set

CMS recently announced a new Meaningful Measures Initiative, aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess core quality of care issues that are most vital to advancing the agency's work to improve patient outcomes. This initiative focuses on assessing the highest priority areas for quality measurement to ensure high-quality care and improve patient outcomes. In alignment with CMS' Meaningful Measures Initiative, and to reduce burden on QHP issuers, CMS proposed to remove six measures from the QRS measure set. The majority of commenters supported removal of the following two measures:

- *Comprehensive Diabetes Care: Hemoglobin A1c Testing* (NQF #0057)
- *Cultural Competence* (Not Endorsed)

CMS will finalize the removal of these two measures beginning with the 2019 QRS. At this time, based on comments received and the interest in continued evaluation of important quality metrics, CMS will retain the *Adult Body Mass Index (BMI) Assessment* (Not Endorsed), *Comprehensive Diabetes Care: Eye Exam (Retinal) Performed* (NQF #0055), *Comprehensive Diabetes Care: Medical Attention for Nephropathy* (NQF #0062), and *Flu Vaccinations for Adults Ages 18-64* (NQF #0039) measures in the QRS measure set. CMS will continue to evaluate the timeline for potential removal and/or replacement of these measures.

3.1.1 Combining QRS Measures

A significant number of commenters opposed CMS' proposal to aggregate the *Childhood Immunization Status* and *Immunization for Adolescent* measures and the *Well-Child Visit* measures, citing differences in measure technical specifications and misalignment with other quality reporting programs. Following consideration of these comments, CMS will continue to calculate separate measure rates for the following clinical measures, and will not aggregate measure rates to create combined measure scores:

- *Childhood Immunization Status (Combination 3)* (NQF #0038)
- *Immunizations for Adolescents (Combination 2)* (NQF #1407)
- *Well-Child Visits in the First 15 Months of Life* (NQF #1392)
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (NQF #1516)

3.1.2 Removing Items from the QHP Enrollee Survey Questionnaire

Commenters overwhelmingly supported CMS proposal to shorten the QHP Enrollee Survey questionnaire, and offered feedback on specific questions for removal. CMS thanks commenters for their feedback and anticipates implementing reductions to the survey beginning with the 2020 ratings year. CMS will comply with the Paperwork Reduction Act (PRA), as applicable, in implementing any changes.

Appendix A. Revised 2018 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 hierarchy components (composites, domains, summary indicators) to form a single global rating. Exhibit 4 illustrates the updated QRS hierarchy, incorporating the proposed revisions outlined in Section 2.2. Please note, the hierarchy exhibit included in the Draft 2018 QRS Call Letter included the *Aspirin Use and Discussion* (ASP) measure in error. CMS officially removed the ASP measure from the QRS measure set for the 2018 ratings year via the Call Letter process.[5] QHP issuers are no longer required to submit data for this measure.

Exhibit 4. Revised 2018 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	Antidepressant Medication Management	2
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	3
			Follow-Up Care for Children Prescribed ADHD Medication	4
			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: Hemoglobin A1c (HbA1c) Testing	11
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	12
			Proportion of Days Covered (Diabetes All Class)	13
	Patient Safety	Patient Safety	Annual Monitoring for Patients on Persistent Medications	14
			Plan All-Cause Readmissions	15
	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
		Staying Healthy Child	Annual Dental Visit	26
			Childhood Immunization Status (Combination 3)	27
			Immunizations for Adolescents (Combination 2)	47

[5] See the Final 2017 QRS Call Letter, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Final-2017-Call-Letter-for-QRS-and-QHPES.pdf.

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title	M#
			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	Cultural Competence	35
			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