Health Insurance Exchange℠

Final 2017 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)

Finalized QRS and QHP Enrollee Experience Survey Program Refinements

May 2017

Contents

List of Exhibits

1.0 Purpose of the 2017 QRS Call Letter

The Centers for Medicare & Medicaid Services (CMS) appreciates all the individuals and organizations who submitted comments on the Draft 2017 QRS Call Letter during the public comment period, held February 22, 2017 through March 22, 2017.

This document, the *Final 2017 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey)* for Qualified Health Plans (QHPs) (referred to hereafter as the Final 2017 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 2017 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 in this document focus on the removal of QRS measures; removal of items from the QHP Enrollee Survey questionnaire; and topics for future evaluation regarding the QRS measure set, hierarchy, and rating methodology.[2]

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 requirements, as appropriate). CMS will be publishing an updated version of the *QRS and QHP Enrollee Survey: Technical Guidance for 2017* (2017 QRS Guidance), version 2.0, 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 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 the measure is dependent on the technical specifications of the measure. ▪ QRS clinical measure data submitted for the 2017 ratings year (the 2017 QRS) generally represent data for enrollees from the previous calendar year(s) (CY 2016). 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 2017 QRS may also include years prior to 2016. ▪ For QRS survey measure data in the 2017 QRS, the survey is fielded based on enrollees who are enrolled as of January 1, 2017, but the survey requests that enrollees report on their experience "in the last 6 months."

[1] The QRS and QHP Enrollee Survey requirements for the 2017 ratings year (the 2017 QRS) will be detailed in Version 2.0 of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017*, which will be available on CMS' Marketplace Quality Initiatives (MQI) website in June: 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.

Term	Description
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: ▪ "2017 QRS" refers to the 2017 ratings year. ▪ Ratings calculated for the 2017 QRS are applied to QHPs offered during the 2018 plan year, to assist consumers in selecting QHPs offered through Exchanges.

1.2 Timeline for Call Letter Publication

The anticipated annual cycle for the QRS Call Letter follows a three-to-four-month (approximately January/February through April/May) timeline as shown in Exhibit 2, followed by the publication of the 2017 QRS Guidance in September.

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

Date	Description
January/February	**Publication of Draft QRS Call Letter:** CMS proposes changes to the QRS and provides stakeholders with the opportunity to submit feedback via a 30-day public comment period.
January - April	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS program.
April/May	**Publication of final QRS Call Letter:** CMS communicates final changes to the QRS program and addresses the themes of the public comments.
September	**Publication of QRS and QHP Enrollee Survey Guidance and Measure Technical Specifications for upcoming ratings year:** 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).[3]

2.0 Revisions to the QRS for 2017 and 2018 Ratings Years

Based on public comments received on the Draft 2017 QRS Call Letter supporting these refinements, CMS will update the QRS measure set for 2018 to align with the Healthcare Effectiveness Data and Information Set (HEDIS®) 2017 measure recommendations.[4] The HEDIS specifications are the main source for the QRS Measure Technical Specifications, which CMS will publish along with the *QRS and QHP Enrollee Survey: Technical Guidance for 2018*.

These changes to the QRS measure set will go into effect for the 2018 ratings year (data submission in summer 2018), and allow the QRS to align with the latest clinical standards. Additionally, for the 2017 ratings year, neither the *Aspirin Use and Discussion* measure (ASP measure) nor the *Relative Resource Use for People with Diabetes (Inpatient Facility)* measure (RRU measure) will be included in scoring and QHP issuers are not required to submit data for either measure as part of the 2017 QRS data submission.[5]

[3] Health Insurance Exchange℠ and Exchange℠ are service marks of the U.S. Department of Health & Human Services.
[4] HEDIS is a registered trademark of the National Committee for Quality Assurance.
[5] In a frequently asked questions (FAQ) document released on January 6, 2017, CMS announced that it would take steps to align the 2017 QRS with these changes made by the measure steward. Specifically, neither the *Aspirin Use and Discussion* (ASP) nor the *Relative Resource Use for People with Diabetes (Inpatient Facility)* (RRU) measure will be used for scoring in the 2017 ratings year; and QHP issuers are not required to submit data for the RRU measure in 2017. The FAQ is available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

Furthermore, for the 2017 ratings year and beyond, CMS will apply the QRS clinical measure denominator criterion of 30 to all QRS clinical measures that are included in scoring, including those captured in the QHP Enrollee Survey. Measures that do not meet the minimum denominator size will be excluded from QRS scoring.

Commenters overwhelmingly supported application of an explicit weighting structure to reduce the impact of survey measures on the QRS global rating. For the 2018 ratings year and beyond, CMS will incorporate an explicit weighting structure into the QRS scoring methodology.

2.1 Removing the Aspirin Use and Discussion Measure from the QRS

In December 2016, the National Committee for Quality Assurance (NCQA) announced the retirement of the ASP measure due to misalignment with updated recommendations from the United States Preventive Services Task Force (USPSTF). CMS then announced through a FAQ that it would take steps to align the 2017 QRS with these changes made by the measure steward. Specifically, the ASP measure will not be used for scoring in the 2017 ratings year, and QHP issuers are not required to submit data for the ASP measure in 2017. The FAQ is available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

CMS will also remove the ASP measure from the 2018 QRS measure set to align with the measure steward's recommendation. Stakeholders who commented on this refinement supported incorporating this change to align the QRS with the latest clinical standards.

2.2 Removing the Relative Resource Use Measure from the QRS

In December 2016, NCQA suspended collection of the RRU measure due to decreased usefulness and costs that exceed value. CMS then announced through an FAQ that it would take steps to align the 2017 QRS with these changes made by the measure steward. Specifically, the RRU measure will not be used for scoring in the 2017 ratings year, and QHP issuers are not required to submit data for the RRU measure in 2017. The FAQ is available at: https://www.regtap.info/uploads/library/QHP_QRSDisclaimerFAQ_010617_v1_5CR_010617.pdf.

CMS will remove this measure from the 2018 QRS measure set to align with the measure steward's recommendation. Stakeholders who commented on this refinement supported the removal of the RRU measure.

2.3 Proposed Revision to Denominator Criterion for QRS Clinical Measures Captured in QHP Enrollee Survey

For the 2017 ratings year and beyond, CMS will apply the QRS clinical measure denominator criterion of 30 to all QRS clinical measures that are including in scoring, including those captured in the QHP Enrollee Survey, such as the *Flu Vaccinations for Adults Ages 18-64* (Flu Shot) and the *Medical Assistance with Smoking and Tobacco Use Cessation* (Tobacco) measures. CMS believes the clinical denominator criterion is appropriate for these measures given their clinical nature, and expects the refinement will allow a greater number of reporting units to report these measures. There is also precedent for this decision, as the denominator criterion of 30 is applied to the Tobacco measure for Medicare accreditation purposes.

Although a number of commenters expressed concerns related to the reliability of these survey measures if the denominator criterion was reduced, CMS found that reliability decreased by a single percentage point for the Flu Shot measure and improved by two percentage points for the Tobacco measure using the 30 denominator criterion. Detailed findings from CMS' reliability testing are provided in Appendix A. CMS will continue to monitor reliability and the impact of the reduced denominator criterion for these measures, as more data become available.

2.4 QRS Weighting Structure and Potential Changes to the QRS Hierarchy

Commenters supported application of an explicit weighting structure to reduce the impact of implicit weighting in the QRS hierarchy. Commenters also expressed support for the removal of levels of the QRS hierarchy that are not displayed to consumers (e.g., the composite and/or domain levels), and provided recommendations for strengthening various components of the QRS hierarchy by removing and adding measures.

For the 2018 ratings year and beyond, CMS will apply explicit weights in the calculation of QRS scores and ratings. CMS intends to 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 Plan Efficiency, Affordability, & Management summary indicators. As requested by commenters, this weighting structure will place a greater emphasis on the clinical measures and reduce the impact of the implicit weighting in the QRS hierarchy. Additionally, this weighting structure reflects the approximate percentage of measures in each summary indicator.

In response to the request for feedback on the QRS weighting structure, several commenters provided options for applying explicit weights at the measure level, similar to the Medicare Part C & D Star Rating program. CMS appreciates these comments, but considers weighting at the summary indicator level to be more appropriate for the QRS program. CMS believes the average of averages approach used to calculate QRS scores and ratings will diminish the impact of weights assigned at the measure level.[6] Therefore, CMS anticipates incorporating a weighting approach for the 2018 ratings year and beyond that assigns weights at the summary indicator level, as outlined above.

Additionally, CMS will investigate methods for simplifying the QRS hierarchy, and anticipates including proposed changes in future Draft Call Letters for public comment. CMS will also continue to coordinate with stakeholders and the Technical Expert Panel (TEP) on revisions to the QRS measure set.

3.0 Proposed QHP Enrollee Survey Revisions for 2018 Ratings Year

3.1 Removing Items from the QHP Enrollee Survey Questionnaire

Through a variety of channels, CMS has received stakeholder feedback that the QHP Enrollee Survey questionnaire (survey questionnaire) should be shortened to reduce respondent burden. While CMS continues to review additional possibilities for shortening the survey questionnaire,

[6] Additional details regarding the 2017 QRS scoring methodology will be available in Version 2.0 of the *Quality Rating System and Quality Health Plan Enrollee Experience Survey: Technical Guidance for 2017*, available at: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/health-insurance-marketplace-quality-initiatives.html.

CMS identified some initial revisions to the survey questionnaire that are discussed below. Specifically, there are several questions CMS anticipates removing from the 2018 QHP Enrollee Survey as proposed in the Draft 2017 QRS Call Letter, after completion of the Paperwork Reduction Act clearance process (as applicable) to implement these changes.

3.1.1 Removing Access to After Hours Care Questions

*7. In the last 6 months, did you need to visit a doctor's office or clinic **after** regular office hours?*

*8. In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic **after** regular office hours?*

In the Draft 2016 QRS Call Letter, CMS proposed removing the Access to After Hours Care assessment question from the *Access to Care* QRS survey measure beginning with the 2018 QRS due to low screen-in rates, which lead to small denominators for this survey question. Commenters agreed with this proposal and this change was adopted in the Final 2016 Call Letter.[7]

Given that this question (#7 above) will no longer be used for the QRS and has a low screen-in rate of less than 9%, CMS will also remove this survey question from the 2018 QHP Enrollee Survey. The accompanying screener question (#8 above) used to determine if the enrollee needed to visit a doctor after regular office hours will also be removed from the 2018 QHP Enrollee Survey.

3.1.2 Removing Question about Recommending Health Plan to Friends and Family

53. Using any number from 0 to 10, where 0 is not at all likely and 10 is extremely likely, how likely is it that you would recommend this health plan to a friend or family member?

Based on stakeholder feedback, CMS added a question about the respondents' likelihood of recommending their current health plan to friends or family (i.e., "recommend question") to the 2016 QHP Enrollee Survey. The recommend question had previously been included in the questionnaire for the 2014 psychometric test, but CMS removed it from the questionnaire used for the 2015 Beta Test to limit respondent burden.

During analysis of the 2016 QHP Enrollee Survey, CMS found a strong, positive correlation (0.96) between the recommend question and the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Health Plan Survey global rating question at the reporting unit level. Given that the recommend question is not used by the QRS, and based on public comment received on the Draft 2017 QRS Call Letter, CMS will eliminate this question (#53 above) from the 2018 QHP Enrollee Survey.

3.1.3 Removing Survey Questions for Aspirin Use and Discussion Measure

65. Do you take aspirin daily or every other day?

[7] The *Final 2016 Call Letter for the QRS and QHP Enrollee Survey* is available on CMS' MQI website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

66. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

67. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

68. Are you aware that you have any of the following conditions? Mark one or more.
- *a. High cholesterol*
- *b. High blood pressure*
- *c. Parent or sibling with heart attack before the age of 60*

69. Has a doctor ever told you that you have any of the following conditions? Mark one or more.
- *a. A heart attack*
- *b. Angina or coronary heart disease*
- *c. A stroke*
- *d. Any kind of diabetes or high blood sugar*

As discussed in Section 2.1, CMS will retire the ASP measure for the 2018 QRS measure set. Accordingly, CMS will remove the survey questions associated with this measure (#65 through #69 above) beginning with the 2018 QHP Enrollee Survey.

4.0 Potential Revisions for Future Years

CMS is considering additional refinements for potential incorporation in future years. Topics for future consideration and evaluation may include, but are not limited to: refinements to the QRS measure set and/or hierarchy; adding an alternative efficiency, cost, and resource use measure; and/or use of an alternative geographic reference group. This section does not include all potential future refinements to the QRS or QHP Enrollee Survey. CMS anticipates including proposed future refinements in future Draft Call Letters or through the information collection request process per the Paperwork Reduction Act requirements (as appropriate).

CMS solicited general comments through the Draft 2017 QRS Call Letter to help inform the development of these future proposals. For more information regarding the current QRS rating methodology, QRS measure set, or the QRS hierarchy, see the 2017 QRS Guidance.[8]

4.1 Future Evaluation of Measures with High Levels of Missing Data

Commenters supported CMS' proposal to investigate the effect of missing measure data and how missing data should be handled in future years of the QRS. Missing measure data refers to data that are missing for any of the QRS measures that QHP issuers are required to report for the QRS or as part of the QHP Enrollee Survey.

CMS currently uses a half-scale rule when calculating QRS ratings to mitigate the impact of measures with high levels of missing data. CMS will continue to investigate alternative methods for handling missing data in the future. CMS will also continue to monitor missing data patterns

[8] Version 2.0 of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017* and the *2017 Quality Rating System Measure Technical Specifications* are available on CMS' MQI website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

to determine drivers of missing QRS measure data (e.g., Exchange demographics), and develop criteria for management of measures with consistently high levels of missing data.

4.2 Alternative Efficiency, Cost, and Resource Use Measures for the QRS

Commenters agreed with the removal of the RRU measure from the QRS measure set and many respondents agreed that CMS should explore alternative measures to address efficiency, cost, and resource use. Specifically, several respondents recommended CMS consider the Total Care Relative Resource Value™ measure as an alternative for the RRU measure. CMS will consider these recommendations in coordination with TEP and Measures Application Partnership (MAP) feedback.

4.3 Geographic Reference Group

CMS received varying feedback related to the investigation of alternative geographic reference groups; some commenters recommended regional reference groups, while others noted that a national, all-product reference group is more appropriate for comparing clinical quality for the QRS program. CMS will continue to explore alternative geographic reference groups for use in calculating QRS ratings.

4.4 Measure Areas of Interest

CMS continues to evaluate measure gaps. It has sought MAP review of the QRS and conducted several environmental scans. Specific areas of interest identified through these processes include plan level measures for both clinical concerns, such as addressing drug safety and/or addressing care coordination in follow-up care after emergency room visits, as well as non-clinical concerns, such as health care cost and access. CMS will continue to investigate additional measures for potential incorporation into the QRS. Appendix B shows all QRS measures within the 2017 QRS hierarchy.

Appendix A. Reliability Testing

In response to comments regarding the reliability of the Tobacco and Flu measures using the clinical denominator criteria, Exhibit 3 provides the results of CMS' reliability testing on these two measures. This table shows the median and mean reliability results for both the Tobacco and Flu measures using the denominator criterion of 30 and 100. As these results indicate, reliability was not significantly impacted by the change in denominator.

Exhibit 3. Results of Reliability Testing

Measure Description	N	Median Reliability	Mean Reliability
Tobacco, DC = 30, n = 260	198	0.419	0.448
Tobacco, DC = 100, n = 260	27	0.413	0.427
Flu Shot, DC = 30, n = 260	250	0.821	0.816
Flu Shot, DC = 100, n = 260	236	0.827	0.827

Appendix B. QRS Hierarchy

The QRS measures are organized into the QRS hierarchy. The measures are grouped into hierarchy components (composites, domains, summary indicators) to form a single global rating.

Exhibit 4 illustrates the 2017 QRS hierarchy. The survey measures in the QRS measure set are noted with an asterisk (*). Shown in grey are the measures that will not be included in QRS scoring for 2017.

Exhibit 4. 2017 QRS Hierarchy

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
Clinical Quality Management	Clinical Effectiveness	Asthma Care	Medication Management for People With Asthma (75% of Treatment Period)	1799
		Behavioral Health	Antidepressant Medication Management	0105
			Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	0576
			Follow-Up Care for Children Prescribed ADHD Medication	0108
			Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004
		Cardiovascular Care	Controlling High Blood Pressure	0018
			Proportion of Days Covered (RAS Antagonists)	0541
			Proportion of Days Covered (Statins)	0541
		Diabetes Care	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575
			Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	0057
			Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062
			Proportion of Days Covered (Diabetes All Class)	0541
	Patient Safety	Patient Safety	Annual Monitoring for Patients on Persistent Medications	2371
			Plan All-Cause Readmissions	1768
	Prevention	Checking for Cancer	Breast Cancer Screening	2372
			Cervical Cancer Screening	0032
			Colorectal Cancer Screening	0034
		Maternal Health	Prenatal and Postpartum Care (Postpartum Care)	1517
			Prenatal and Postpartum Care (Timeliness of Prenatal Care)	1517
		Staying Healthy Adult	Adult BMI Assessment	Not Endorsed
			Chlamydia Screening in Women	0033
			Aspirin Use and Discussion*	Not Endorsed
			Flu Vaccinations for Adults Ages 18-64*	0039
			Medical Assistance With Smoking and Tobacco Use Cessation*	0027

QRS Summary Indicator	QRS Domain	QRS Composite	Measure Title (* indicates survey measure)	NQF ID
		Staying Healthy Child	Annual Dental Visit	Not Endorsed
			Childhood Immunization Status (Combination 3)	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 15 Months of Life (Six or More Visits)	1392
			Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516
Enrollee Experience	Access	Access to Care	Access to Care*	Not Endorsed
	Care Coordination	Care Coordination	Care Coordination*	Not Endorsed
	Doctor and Care	Doctor and Care	Cultural Competence*	Not Endorsed
			Rating of All Health Care*	0006
			Rating of Personal Doctor*	0006
			Rating of Specialist*	0006
Plan Efficiency, Affordability, & Management	Efficiency & Affordability	Efficient Care	Appropriate Testing for Children With Pharyngitis	0002
			Appropriate Treatment for Children With Upper Respiratory Infection	0069
			Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0058
			Use of Imaging Studies for Low Back Pain	0052
	Plan Service	Enrollee Experience with Health Plan	Access to Information*	Not Endorsed
			Plan Administration*	Not Endorsed
			Rating of Health Plan*	0006
Not included in QRS hierarchy for purposes of QRS scores or ratings				
N/A	N/A	N/A	Relative Resource Use for People with Diabetes (Inpatient Facility)	1557