Health Insurance Marketplace℠

Final 2016 Call Letter for the Quality Rating System (QRS) and the Qualified Health Plan (QHP) Enrollee Experience Survey

Finalized QRS and QHP Enrollee Experience Survey Program Refinements

September 2016

Contents

List of Exhibits

1.0 Purpose of the 2016 QRS Call Letter

The Centers for Medicare & Medicaid Services (CMS) thanks all individuals and organizations who submitted comments on the draft 2016 QRS Call Letter during the public comment period, held July 13, 2016 through July 28, 2016.

This document, the final *2016 Call Letter for the Quality Rating System (QRS) and the Qualified Health Plan (QHP) Enrollee Experience Survey* (QHP Enrollee Survey) (2016 QRS Call Letter), serves to communicate CMS' finalized refinements to the QRS and QHP Enrollee Survey programs for QHPs for future data submissions (i.e., for the 2017 and 2018 ratings years).[1] No changes are being made at this time to CMS regulations; instead, the refinements relate to QRS and QHP Enrollee Survey program operations. This document references the themes of comments received on the draft 2016 QRS Call Letter during the public comment period within each relevant section.

The refinements in this document focus on stakeholder engagement, QRS and QHP Enrollee Survey participation requirements, and the QRS rating methodology.[2] Refinements to the participation requirements in Section 2.1 apply to both the QRS and the QHP Enrollee Survey programs.

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). In fall 2016, CMS intends to publish the *QRS and QHP Enrollee Survey: Technical Guidance for 2017* and the *QRS Measure Set Technical Specifications for 2017*, reflecting the applicable finalized changes announced in this document.

1.1 Key Terms

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

[1] The QRS and QHP Enrollee Survey requirements for the 2016 ratings year (the 2016 QRS) are detailed in Version 2.0 of the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2016* (2016 QRS Guidance), available on CMS' MQI website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html. The changes outlined in this document do not apply to or otherwise change the 2016 QRS Guidance or Measure Set Technical Specifications.

[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 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 calendar year 2016 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 2016. ▪ For QRS survey measure data in the 2017 QRS, the survey is fielded based on enrollees who are currently enrolled as of January 1, 2017, but the survey requests that enrollees report on their experience "in the last 6 months."
Ratings Year	The ratings year refers to the year the data are collected (including fielding of the QHP Enrollee Survey), validated, and submitted, and ratings are calculated. For example, "2017 QRS" refers to the 2017 ratings year. ▪ As part of the certification process for the 2017 plan year, which occurred during the spring and summer of 2016, QHP issuers attest that they will adhere to 2017 quality reporting requirements, which include requirements to report data for the 2017 QRS and QHP Enrollee Survey. ▪ Requirements for the 2017 QRS, and details as to the data collection, validation, and submission processes, are released in the *QRS and QHP Enrollee Survey: Technical Guidance for 2017* (anticipated release in September 2016). ▪ Ratings calculated for the 2017 QRS are displayed for QHPs offered during the 2018 plan year, in time for open enrollment, to assist consumers in selecting QHPs.

1.2 Establishment of an Annual Call Letter Process

CMS is establishing an annual cycle for soliciting stakeholder feedback on proposed refinements to the QRS program. Each year, CMS will use the QRS Call Letter to communicate proposed refinements to QRS program operations, including changes related to the QRS and QHP Enrollee Survey participation criteria, measure set, and/or methodology.

The majority of commenters expressed appreciation for the advance notice provided on potential changes and the establishment of a QRS Call Letter process.

CMS will communicate proposed QRS refinements via the release of a draft QRS Call Letter on CMS' Marketplace Quality Initiatives (MQI) website with a defined period of time for public comment. Once stakeholder feedback is received, CMS will review comments received, make final determinations regarding the proposed refinements, and communicate final changes via the final QRS Call Letter.

The final QRS Call Letter will also address themes in comments received on the draft QRS Call Letter. CMS anticipates annually issuing QRS and QHP Enrollee Survey Guidance and Measure Set Technical Specifications for each ratings year, reflecting finalized changes announced in the final QRS Letter.

1.2.1 Timeline for Call Letter Publication

Due to the timeframes for analyses during the 2015 beta test, CMS followed a different schedule for the 2016 QRS Call Letter than is anticipated for future years. The condensed schedule this year included an abbreviated public comment period and release of the final 2016 QRS Call Letter later in the calendar year than is anticipated for future years. CMS will not implement the

changes in this particular Call Letter (see Sections 2.0 and 3.0 for changes) until the 2017 ratings year at the earliest.

Going forward, the anticipated annual cycle for the QRS Call Letter will follow a winter-to-spring (approximately December through April) timeline as shown in Exhibit 2. The use of a QRS Call Letter, and the timeline for its release, is informed by the Medicare Advantage and prescription drug (Part D) star rating system's approach for soliciting feedback on proposed program changes.

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

Date	Description
December/January	**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 - March	**Analysis of Public Comment:** CMS reviews the stakeholder feedback received during the 30-day public comment period and finalizes changes to the QRS program.
March/April	**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:** CMS provides technical guidance regarding the QRS and QHP Enrollee Survey and specifies requirements for QHP issuers offering coverage through a Health Insurance Marketplace℠ (Marketplace).[3]

For example, CMS intends to release the draft 2017 Call Letter after the 2016 QRS preview period that occurred in mid-August 2016, and post-data scoring analyses. Upon release of the draft 2017 Call Letter, CMS anticipates holding a 30-day public comment period. In a given year, the time allowed for public comment may be extended based on the number and extent of refinements proposed in a draft Call Letter.

1.2.2 Timeline for Incorporation of Refinements into the QRS and QHP Enrollee Survey

CMS' timeline for incorporating refinements to the QRS and QHP Enrollee Survey programs in future years will depend on the type of refinement proposed. In the draft 2016 QRS Call Letter, CMS proposed a timeline for implementation of program refinements that would depend, in part, upon the significance of the change. Respondents during the public comment period requested additional detail regarding the criteria for determining significance.

Consistent with the proposal outlined in the draft 2016 QRS Call Letter, CMS will mirror the approach to determining significance used by other established quality reporting programs (e.g., the Medicare Advantage and Part D star rating system). Significance will be determined by a combination of factors, including, but not limited to, considerations of impact on the following: QRS implementation timeline and processes; burden on QHP issuers, CMS, and QHP Enrollee Survey vendors; data system needs; and scoring and results. In determining the timeline for implementation of a given change, CMS will also consider the QRS goals and principles, which

[3] Health Insurance Marketplace℠ and Marketplace℠ are service marks of the Department of Health & Human Services.

include that the QRS should produce sound, reliable, and meaningful results and that the evolution of the QRS should be public and transparent.[4]

For example, CMS anticipates methodological changes in the following topic areas could be significant enough to warrant more advanced notice: minimum denominator size for scoring, scoring approach for missing data, weighting, and risk or case-mix adjustment.

Beginning with the 2017 QRS Call Letter cycle (anticipated winter 2016 to spring 2017):

- Refinements to the QRS rating methodology proposed in the draft QRS Call Letter (and finalized in the final QRS Call Letter) could take effect in the *current* ratings year[5] at the earliest. However, the refinements could take effect later if the proposed changes are more significant.
- Refinements to the QRS and QHP Enrollee Survey participation requirements, measure set, or other significant program refinements proposed in the draft QRS Call Letter (and finalized in the final QRS Call Letter) could take effect in the *following* ratings year at the earliest. However, the refinements could take effect later if the proposed changes are more significant.

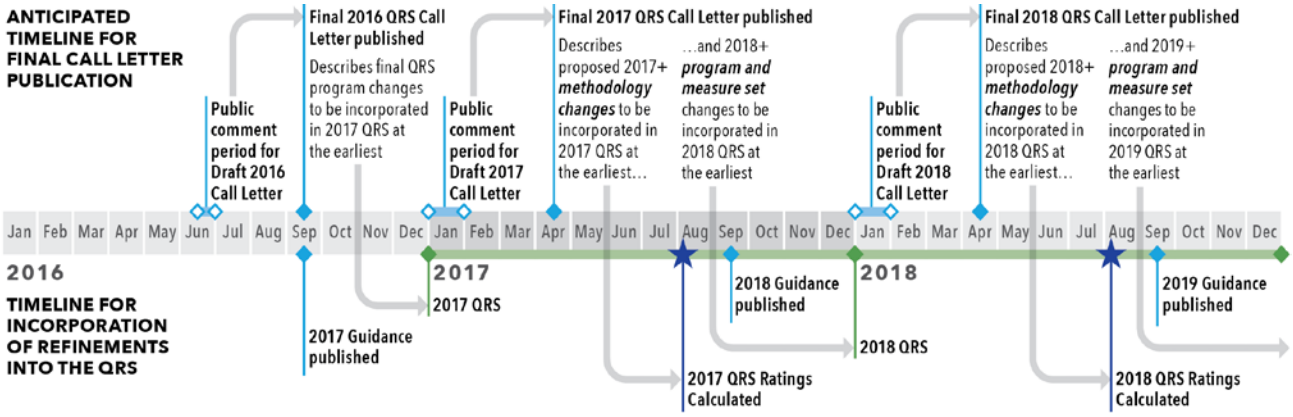
For example, the draft 2017 QRS Call Letter, anticipated to be released by January 2017, and final 2017 QRS Call Letter, anticipated to be released by April 2017, could include:

- Methodological changes that apply (at the earliest) to the 2017 QRS ratings year. This timing would allow CMS to use QRS clinical measure data from the 2015 measurement year (submitted in 2016) to inform methodological changes to be implemented in the 2017 QRS.
- Measure set or participation requirements changes that apply (at the earliest) to the 2018 QRS ratings year. This timing means these changes would appear in the QRS and QHP Enrollee Survey Technical Guidance for the following year (the QRS and QHP Enrollee Survey: Technical Guidance for 2018, as well as the QRS Measure Set Technical Specifications for 2018, published in fall 2017).
- Refinements to be implemented in future years (2019 QRS ratings year and beyond).

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

[4] Details regarding the QRS goals and principles can be found in the Federal Register Notice regarding the QRS methodology and measure set at https://www.gpo.gov/fdsys/pkg/FR-2013-11-19/pdf/2013-27649.pdf.
[5] However, the proposed changes communicated in the 2016 QRS Call Letter would not go into effect until the 2017 ratings year or 2018 ratings year at the earliest.

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



2.0 QRS and QHP Enrollee Survey Refinements for 2017 Ratings Year

During the 2015 beta test, CMS tested QRS and QHP Enrollee Survey implementation processes, including data collection, data validation, data submission, data scoring, and data preview. CMS analyzed 2015 beta test data to inform refinements to the QRS for future years. The changes communicated in this section of the final 2016 QRS Call Letter are based on the results and analysis of the beta test and will go into effect for the 2017 ratings year.[6] The majority of respondents during the QRS Call Letter public comment period supported the refinements proposed for the 2017 ratings year.

2.1 Changes to the QRS and QHP Enrollee Survey Participation Requirements for 2017 Ratings Year

CMS will implement the following refinements to the 2017 QRS and QHP Enrollee Survey requirements for QHP issuers offering coverage through the Marketplaces. Unless the context indicates otherwise, the term "Marketplaces" refers to the Federally-facilitated Marketplaces (FFMs), inclusive of FFMs where States performing plan management functions, State-based Marketplaces (SBMs), and SBMs on the Federal Platform (SBM-FPs). These requirements will take effect beginning in the 2017 ratings year and will be included in the QRS and QHP Enrollee Survey participation criteria section of the *QRS and QHP Enrollee Survey: Technical Guidance for 2017* document that CMS anticipates publishing in September 2016.

2.1.1 Clarification for QRS and QHP Enrollee Survey Reporting Unit Participation Criteria

CMS will include clarifying language to address QRS and QHP Enrollee Survey participation criteria for QHP issuers impacted by a change in control event (e.g., merger, acquisition). Reporting units impacted by a QHP issuer's change in control event will be subject to QRS and QHP Enrollee Survey requirements for a given ratings year under the gaining QHP issuer (i.e.,

[6] The changes outlined in this document do not apply to the 2016 ratings year. The requirements for the 2016 ratings year are detailed in Version 2.0 of the *QRS and QHP Enrollee Survey: Technical Guidance for 2016* and the *QRS Measure Technical Specifications for 2016*, which are available on CMS' MQI website.

the issuer that continues to operate the reporting units in the ratings year) if the change in control event is effective as of January 1 of the ratings year. In these instances of change-in-control events, the gaining QHP issuer should include these new enrollees in its applicable reporting unit (e.g., include enrollees previously aligned to the ceding QHP issuer) for purposes of determining whether the participation criteria for the reporting year have been met.

2.1.2 Additional Minimum Enrollment Threshold for Year of Data Submission

QHP issuers are currently required to collect and submit validated QRS clinical measure data and QHP Enrollee Survey response data for exclusive provider organization (EPO), health maintenance organization (HMO), point of service (POS), and preferred provider organization (PPO) product types offered through a Marketplace in the previous year. For the 2016 ratings year, QHP issuers were required to submit validated data for each of the above noted product types offered through a Marketplace in 2016 that had more than 500 enrollees as of July 1, 2015.

During 2016 QHP Enrollee Survey implementation, CMS identified reporting units that met the minimum enrollment threshold for the prior year (as of July 1, 2015), yet experienced a substantial decline in enrollment as of January 1, 2016 (i.e., the start of the ratings year).[7] This created a situation in which QHP issuers were required to field the QHP Enrollee Survey, even if they did not have sufficient enrollees to receive valid survey measure responses.

As a result, CMS is establishing an additional minimum enrollment threshold to QRS and QHP Enrollee Survey participation criteria. Beginning with the 2017 QRS, eligible reporting units must have more than 500 enrollees as of July 1 of the prior year and more than 500 enrollees as of January 1 of the ratings year to be required to participate in the QRS and the QHP Enrollee Survey.[8] This means that for the 2017 QRS, eligible reporting units must have more than 500 enrollees as of July 1, 2016 (the prior year) *and* more than 500 enrollees as of January 1, 2017 (the ratings year) to be required to participate in the QRS and the QHP Enrollee Survey.

This additional enrollment threshold also means that QHP issuers are not required to submit QRS measure data (including both the QRS clinical measure data and QHP Enrollee Survey response data) for reporting units that do not meet both minimum enrollment thresholds. Further, reporting units that do not meet the new participation criteria will be ineligible for QRS scoring (i.e., would not receive QRS scores and ratings).

Exhibit 4 below is an illustrative example showing a fictional QHP issuer certified to offer family medical coverage in two states: West Virginia (WV) and Maryland (MD). The exhibit shows the characteristics of the issuer's reporting units for the 2017 ratings year. In accordance with the refinements to the 2017 QRS and QHP Enrollee Survey participation criteria, this QHP issuer would be required to collect validated QRS clinical measure data and QHP Enrollee Survey response data and submit it to CMS for the 2017 QRS for only the WV PPO reporting

[7] QRS clinical measure data is collected based on events and services in the year prior to ratings calculation. However, for QRS survey measures, CMS obtains data from the QHP Enrollee Survey that is fielded to enrollees who are currently enrolled as of January 1 of the ratings year.

[8] CMS selected January 1 as the date for the additional minimum enrollment threshold, in part, because the QHP Enrollee Survey sampling frame is based on January 1 enrollment and the QHP Enrollee Survey response data collection begins in February to meet the deadline for calculating QRS ratings.

unit. The other reporting units either did not have a sufficient number of enrollees as of July 1, 2016; did not have a sufficient number of enrollees as of January 1, 2017; or were discontinued before June 15, 2017.

Exhibit 4. Example Reporting Units for a QHP Issuer Assessed Against 2017 QRS and QHP Enrollee Survey Participation Criteria

Reporting Unit	Enrollment as of July 1, 2016 (total and per individual market vs. SHOP)	Enrollment as of January 1, 2017 (total and per individual market vs. SHOP)	Offered in 2017 as of June 15, 2017	Meet participation criteria (i.e., required to submit QRS and QHP Enrollee Survey measure data)?
WV PPO	505 (505 individual, 0 SHOP)	505 (505 individual, 0 SHOP)	Yes	Yes
WV HMO	601 (501 individual, 100 SHOP)	N/A	No – discontinued as of December 31, 2016	No – not operating in ratings year
MD PPO	100 (55 individual, 45 SHOP)	100 (55 individual, 45 SHOP)	Yes	No – insufficient enrollment size in both years
MD HMO	700 (700 individual, 0 SHOP)	300 (300 individual, 0 SHOP)	Yes	No – insufficient enrollment size as of January 1, 2017

2.1.3 Handling of Voluntary Data Submissions

For the 2017 ratings year, CMS will not accept voluntary data submissions from QHP issuers for QHP Enrollee Survey response data and QRS clinical measure data.

CMS revised its policy about voluntary submissions, beginning with the 2017 ratings year, given the technical level of effort and dedicated resources required for issuers to submit and for CMS to accept such data submissions, combined with the low volume of voluntary submissions during the 2016 data collection process.

2.2 Refinements to the QRS Methodology and Measure Set for 2017

For the 2017 ratings year, CMS will include all measures in the QRS measure set in scoring (including, for the first time, those measures that require multiple years of continuous enrollment), except the Relative Resource Use (RRU) measure and the Immunizations for Adolescents (IMA) measure. Consistent with the 2015 and 2016 QRS Guidance, CMS will not include the RRU measure in scoring due to the additional testing CMS intends to conduct with this measure. The IMA measure will not be included in scoring due to significant technical specification changes by the applicable measure steward (described further below).

CMS will update QRS clinical measures in the QRS measure set for 2017 to align with the Healthcare Effectiveness Data and Information Set (HEDIS®)[9] 2017 measures. The HEDIS® specifications are the main source for the QRS Measure Set Technical Specifications, which are released alongside the QRS and QHP Enrollee Survey: Technical Guidance each fall. During its own, separate public comment process, the National Committee for Quality Assurance (NCQA)

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

considered updates to the HEDIS® 2017 measures for the next iteration of the HEDIS® 2017 measure set. The changes to the QRS measure set – to reflect NCQA updates to the HEDIS® 2017 measures – will go into effect for the 2017 ratings year (data submission in summer 2017). Incorporating these specification changes as recommended by the measure steward allows the QRS to align with the latest clinical standards.

The NCQA changes for HEDIS® 2017 will result in changes to three QRS clinical measures:

1. Use of Imaging Studies for Low Back Pain (LBP)
2. Immunizations for Adolescents (IMA)
3. Human Papillomavirus Vaccine for Female Adolescents (HPV)

NCQA combined the IMA and HPV measures to assess receipt of all recommended vaccines (meningococcal, Tdap, and HPV) for males and females in one IMA measure. NCQA retired the current HPV measure. For the LBP measure, NCQA revised the anchor date, value sets, and required exclusions. Details related to the HEDIS® 2017 updates are provided at http://www.ncqa.org/homepage/ncqa-public-comments/hedis-2017-public-comment.

As proposed in the draft 2016 QRS Call Letter and as most respondents during the public comment period concurred, CMS will align the QRS measure specifications with the final HEDIS® 2017 specifications: IMA measure (Combination 2).

Exhibit 5 shows an extract of the QRS hierarchy with the updates to the IMA and HPV measures within the Staying Healthy Child composite.

Exhibit 5. Extract from QRS Hierarchy Demonstrating Impact of HEDIS® Update to Immunizations for Adolescents (IMA) Measure

QRS Composite	Measure	National Quality Forum (NQF) Endorsement
Staying Healthy Child	Annual Dental Visit	Not Endorsed
	Childhood Immunization Status (Combination 3)	0038
	~~Human Papillomavirus Vaccination for Female Adolescents~~ - ***REMOVED***	~~1959~~
	~~Immunizations for Adolescents (Combination 1)~~ - ***REMOVED*** Immunizations for Adolescents (Combination 2) - ***NEW***	~~1407~~ 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

Additionally, CMS will not include the updated IMA measure in scoring for one year (i.e., it will not be included in scoring for the 2017 ratings year) as including this measure would represent a significant change to the technical specifications. CMS evaluates measure specification changes for their timing of incorporation with respect to the measurement period, as well as their impact to the measure denominator and QRS scoring. Since this specification change for the IMA measure occurred during the measurement period, impacts the population covered by the measure (i.e., impacts the measure denominator), and affects QRS scoring (as two previously

separate QRS measures are becoming one), CMS is proceeding as proposed to remove this measure from scoring for one year.

The specification changes to the LBP measure do not meet these guidelines for what constitutes a significant change as the changes are targeted adjustments based on clinical guidelines and should minimally impact the population covered by the measure; therefore, the LBP measure change is considered minor and CMS will continue to include the LBP measure (as updated) in scoring for the 2017 ratings year.

This approach allows CMS to align the QRS measure specifications with those of measure stewards, while also assessing the effect of this change on QRS scoring. This approach also aligns with the Medicare Stars policy for identifying and handling similar significant measure specification changes.[10]

3.0 Revisions for 2018 and Beyond

As noted in the draft 2016 QRS Call Letter, CMS has also begun to consider refinements for the 2018 ratings year and beyond. CMS received comments from respondents on the draft 2016 QRS Call Letter expressing support for the proposed change to the Access to Care QRS survey measure for the 2018 ratings year. Commenters also identified additional considerations and topic areas for future investigation (summarized in Section 3.2).

This section does not include all potential refinements to the QHP Enrollee Survey program. Those proposed refinements will be outlined in future draft Call Letters or through the information collection request process per PRA requirements (as appropriate).

3.1 Revision to Access to Care QRS Survey Measure

Commenters largely supported the proposed refinement to the Access to Care QRS survey measure. CMS will implement the following change to a QRS survey measure for the 2018 ratings year:

- CMS will alter which questions from the QHP Enrollee Survey are included in the Access to Care QRS survey measure. This change aligns the questions included in the Access to Care QRS survey measure with the questions included in other programs (i.e., it aligns with the questions included in other Consumer Assessment of Healthcare Providers and Systems [CAHPS®][11] surveys). This change does not necessarily impact which questions are fielded as part of the QHP Enrollee Survey.

The Access to Care measure currently consists of five questions, as shown in Exhibit 6 below. The Access to Care QRS survey measure, as it is derived from the QHP Enrollee Survey, is based on items from the CAHPS® surveys.

[10] In Medicare Stars, if the specification change is announced during the measurement period and impacts the denominator or population covered by the measure, the measure will be moved to the display page for at least one year (i.e., the measure is collected, but not included in scoring).

[11] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The CAHPS® surveys are available at https://cahps.ahrq.gov.

Exhibit 6. Updates to QRS Survey Measure Access to Care Questions

QRS Survey Measure	CAHPS Health Plan 5.0	Question
Access to Care	Getting Care Quickly	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
		In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
	Getting Needed Care	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
		In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
	~~Supplemental Item~~	~~In the last 6 months, how often were you able to get care you needed from a doctor's office or clinic after regular hours?~~

Beginning with the 2018 ratings year, CMS will remove the supplemental item from the Access to Care QRS survey measure, due to low item Inter-Unit Reliability (IUR), low item screen-in rate (8%), and low covariance coverage. CMS analyzed and confirmed, using 2015 beta test data, that there are no negative consequences at the measure level for dropping this item (i.e., measurement properties remained good). Additionally, the supplemental item is not included in other CAHPS® surveys.

The remaining four questions (those associated with the first two items in the second column of Exhibit 6) make up the two standard CAHPS® Health Plan 5.0 measures for reporting. CMS intends to further analyze Marketplace QHP Enrollee Survey data to determine if the Access to Care QRS survey measure should be made into two separate QRS survey measures for scoring: Getting Care Quickly and Getting Needed Care.

3.2 Additional Comments Received and Considerations for Future Years

In response to the solicitation of comments on potential refinements for future years, CMS received feedback from respondents during the public comment period addressing three topics for future evaluation or consideration: case-mix and risk adjustment, the use of an explicit weighting structure, and considerations for future measure set revisions.

While CMS describes the comments received and its responses on these topics below, CMS is not making refinements in these areas at this time. Instead, any such refinements would be proposed as part of the annual Call Letter process in future years and/or through the information collection request process per PRA requirements (as appropriate).

Case-mix and risk adjustment: Commenters recommended that CMS study the effects of subsidies when considering the use of risk adjustment based on socioeconomic status. Another commenter recommended that CMS consider additional variables (e.g., proportion of QHP members residing in a Health Professional Shortage Area) for case-mix adjustment of CAHPS measures.

In alignment with other quality ratings programs, CMS intends to monitor the latest research to inform discussions regarding potential risk adjustment of QRS measures based on

socioeconomic status. CMS generally relies on the measure steward's decisions about whether a measure should or should not be case-mix adjusted. CMS is continuing to do analyses in this area and will monitor potential methods.

Weighting: Commenters expressed that CMS should explicitly set weights at the measure level for the QRS or establish a weighting approach where clinical measures account for 75 percent of the overall global score.

CMS does not currently use an explicit weighting structure in the QRS methodology, meaning all measures and components are averaged together equally to calculate higher-level component scores. However, CMS recognizes use of a hierarchy creates implicit weighting. Each measure, composite, domain, and summary indicator has a different weight or influence on higher-level scores simply due to its position in the hierarchy. The amount of influence exercised by each measure is affected by the number of measures and components in each layer of the hierarchy.

Using existing QRS data, CMS intends to evaluate the impact of the current implicit weighting influence of the hierarchy structure, as well as potential explicit weighting options. CMS intends to assess weighting methodologies used by other programs and seek stakeholder feedback. CMS anticipates assessing weighting methodologies in consideration of the National Quality Strategy (NQS), and other CMS policy priorities for the QRS.

Measure changes: Respondents provided a variety of comments regarding the QRS measure set, including that all measures should be endorsed by the National Quality Forum, the Cultural Competence composite should be removed, and the size of the QRS measure set should remain relatively constant (e.g., if measures are added, others should be removed) in consideration of QHP issuer burden and the complexity of the ratings for consumers.

When first establishing the QRS measure set, CMS developed and utilized measure selection and measure set evaluation criteria.[12] The criteria were based on industry-tested standards and were informed by discussions with stakeholders. CMS will continue to use those criteria as part of future evaluations of the QRS measure set.

- The QRS measure selection criteria include the following: importance, performance gap, reliability and validity (NQF-endorsement status is considered), feasibility, and alignment.
- The QRS measure set evaluation criteria, used to evaluate the QRS measure set as a whole, include the following: alignment with NQS priorities, relevance to the consumer and QHPs, alignment with other priority measure sets, comprehensiveness, health care disparities, parsimony/efficient use of resources, and usability.

When CMS is considering any revision to any QRS measure, CMS intends to assess the impact of that revision on scoring, burden, and many other factors. CMS also plans to evaluate measures

[12] Details regarding the measure selection and measure set evaluation criteria can be found in the Federal Register Notice regarding the QRS methodology and measure set at https://www.gpo.gov/fdsys/pkg/FR-2013-11-19/pdf/2013-27649.pdf.

based on actual performance according to principles established in the *CMS Measures Management System Blueprint*.[13] The Blueprint is a standardized system for developing and maintaining quality measures used in CMS quality initiatives and programs.

[13] Details regarding the *CMS Measures Management System Blueprint* can be found on CMS' website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html.

Technical Assistance

Please see the instructions below for submitting questions regarding this document or any requirements related to the QRS or the QHP Enrollee Survey:

- **QHP issuers:** Please submit questions to the Exchange Operations Support Center (XOSC) Help Desk via email to CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Please reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.
- **Multi-State Plan (MSP) issuers:** Please submit questions via email to MSPPIssuer@OPM.gov and reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line. For MSP issuers that are also QHP issuers, please copy the QHP issuer contact (CMS_FEPS@cms.hhs.gov).
- **State-based Marketplaces:** Please submit questions to your respective State Officers.
- **Federally-facilitated Marketplaces:** Please submit questions via email to CMS_FEPS@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.
- **Other stakeholders:** Please submit questions via email to Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QRS" in the subject line.

For additional information and resources related to the QRS and QHP Enrollee Survey, please visit the CMS MQI website, available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.