An overview of the CMS Quality Rating System for QHPs

Dustin Grzeskowiak, FSA, MAAA
Darin Muse, ASA, MAAA
Daniel Perlman, FSA, MAAA

The Centers for Medicare and Medicaid Services (CMS) issued a Quality Rating Information Bulletin[1] on August 15, 2019, announcing that public display of 2019 quality rating information by all exchanges will begin during the individual market open enrollment period (OEP) for the 2020 plan year (which runs November 1 to December 15, 2019). This should not be news to health plans offering coverage via federally facilitated exchanges (FFEs) or state-based exchanges (SBEs), collectively, the "exchanges." The initial guidance around this program was released in October 2018,[2] and there have been several deadlines for health plans to meet throughout 2019. However, there may be some uncertainty for plans and consumers alike around what the quality scores represent, how they are developed, and/or how they may be used now or in the future. This paper provides clarity on these topics, some general background on the program, and a summary of the 2019 quality information published by CMS in the public use file (PUF).[3] This latest related CMS bulletin marks the beginning of the annual preview period, during which the quality data and survey results are made available online in the PUFs for qualified health plans (QHPs) to review in advance of public display.

What star ratings?

The Secretary of the U.S. Department of Health and Human Services (HHS) is required under 42 U.S. Code § 18031(c) (March 23, 2010)[4] to "develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price." Hence, the birth of the Quality Rating System (QRS). The QRS is a reporting program that allows consumers, regulators, and health plans alike to compare QHPs on the basis of their quality of healthcare services and health plan administration. The stated purpose of the QRS[5] is to:

1. **Help** consumers make informed healthcare decisions.
2. **Facilitate** oversight of health plans.
3. **Provide** actionable information to health plans to improve the quality of services they provide.

The QRS was initially rolled out in a two-phase pilot, beginning with Virginia and Wisconsin during the OEP for plan years 2017 and 2018, and then added Michigan, Montana, and New Hampshire for the OEP for plan year 2019. During the OEP for plan year 2020 all Exchanges across the country will be required to comply, allowing consumers that are shopping for individual, family or small group coverage on Exchanges to base their purchasing decisions in part on quality ratings. These ratings will be on a 5-star scale (with a 5 being the highest, and 1 the lowest). As shown in Figure 1, ratings will be provided for three summary level indicators, as well as a weighted average global score. Each summary indicator level is made up of clinical and/or survey measures that fall within certain domains.

CMS has aligned the quality metrics in the QRS with other federal and state quality reporting program standards and the six quality priority areas from the CMS Meaningful Measures Initiative, with the ultimate goal of these standards being used to improve patient outcomes. These six areas are:

1. **Making care safer** and reducing harm.
2. **Improving patient engagement** so they are partners in their care.
3. **Promoting effective communication** and coordination of care.
4. **Promoting effective prevention** and treatment of chronic disease.
5. **Working with communities** to promote best practices of healthy living.
6. **Improving affordability** of care.

1   CMS (August 15, 2019). CMS Bulletin on Display of Quality Rating System (QRS) Star Ratings and Qualified Health Plan (QHP) Enrollee Survey Results for QHPs Offered Through Exchanges (often called the health insurance marketplace). Retrieved October 22, 2019, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QualityRatingInformationBulletinforPlanYear2020.pdf.

2   CMS (October 2018). Health Insurance Exchange: Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019. Retrieved October 22, 2019, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2019-QRS-and-QHP-Enrollee-Survey-Technical-Guidance_FINAL_20181016_508.pdf.

3   CMS. Plan Year 2020 Nationwide Quality Rating System PUF. Retrieved October 31, 2019, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Downloads/2020-Quality-PUF.zip (Zip file download).

4   The full text is available at https://www.law.cornell.edu/uscode/text/42/18031.

5   CMS (August 15, 2019). Health insurance exchange Quality Rating System 101. Fact Sheet. Retrieved October 22, 2019, from https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchange-quality-ratings-system-101.

States may implement additional quality reporting standards for QHP issuers in order to align with their state priorities and the needs of their unique populations. The current system uses two data sets in the derivation of the quality scores: the QRS clinical measure data set and the QHP Enrollee Survey results. Overall, the system includes 28 clinical measures focused on quality of care and plan administration, and 10 survey measures that gauge members' satisfaction with their experience.

The final star ratings that are seen by consumers represent relative scores, and are therefore easily compared from one QHP to another within their state and product lines. The criteria for determining which QHPs are eligible to be scored and the process for developing the relative star ratings from the clinical and survey measures are described later in this report.

How well did QHPs perform in the 2020 ratings?

On October 25, 2019, CMS published star rating and quality measure level data for the 2020 plan year via a Public Use File (PUF).[6] We combined this star rating data with issuer level enrollment data[7] and other plan information[8] to determine enrollment-weighted market average ratings, and to analyze rating differences among different issuer characteristics. Our analysis included the 39 states using FFEs and included in

---

6   CMS, Plan Year 2020 Nationwide Quality Rating System PUF, op cit.

7   CMS. 2017 Enrollment Disenrollment PUF. Retrieved October 22, 2019, from **https://www.cms.gov/CCIIO/Resources/Data-Resources/ Downloads/2017-Enrollment-Disenrollment-PUF.xlsx (Excel spreadsheet download)**.

8   Healthcare.gov (August 9, 2019). QHP PY19 Medical Individual Landscape Zip File. Retrieved October 22, 2019, from **https://data.healthcare.gov/ dataset/QHP-PY19-Medical-Individual-Landscape-Zip-File/m2uk-wyvh/**.

the CMS PUFs. The most recent issuer level enrollment data available from CMS is from the 2017 plan year; if the enrollment mix by issuer has changed materially since plan year 2017 as it relates to QRS performance then our summaries below would not reflect this (i.e., if enrollment has since shifted to higher or lower rated plans on average this would not be reflected below).

Here are some observations about the data:

- The national average Global Rating was 3.0 and nearly one-fifth (18%) of enrollees were in plans with less than a 3 Star rating.
- Issuers scored the lowest in the Clinical Quality Summary Indicator with a national average rating of just 2.7.
- Issuers located in the Midwest had the highest Global Rating (average of 3.2) while issuers located in the Southwest had the lowest Global Rating (average of 2.6).
- EPO products had the highest Global Rating (average of 3.2) while HMO products had the lowest Global Rating (average of 2.9).
- Issuers from states that had QRS pilots (MI, MT, NH, and VT) had higher average Global Ratings for 2020 (3.4) than issuers from states without QRS pilots (2.9).
- Issuers with less than 110,000 total enrollees across all products (about 1/3 of issuers) had slightly higher average Global Ratings (3.1) than issuers with at least 110,000 total enrollees (average of 3.0).
- Issuers with at least 9 total QHP plan IDs (about two-thirds of issuers) had higher average Global Ratings (3.1) than issuers with fewer than 9 total QHP plan IDs (average of 2.6).

FIGURE 1: DERIVING QUALITY SCORES

SUMMARY INDICATOR (% WEIGHT)	DESCRIPTION	DOMAINS	CLINICAL MEASURES	SURVEY MEASURES
Clinical Quality Management (66.67%)	Measures the level of clinical quality of a plan's network providers based on how they manage care (regular screenings, vaccines, etc.) and monitors specific conditions.	Clinical Effectiveness, Patient Safety, Prevention	24	2
Enrollee Experience (16.665%)	Based on feedback gathered through enrollee surveys gauging satisfaction with care received, physicians, and ease of access.	Access and Care Coordination	0	5
Plan Efficiency, Affordability, and Management (16.665%)	Measures a plan's efficiency, affordability, access to customer service and plan information, and the appropriateness of tests that have been ordered by network providers.	Efficiency and Affordability, Plan Service	4	3
Global (100%)	Represents the weighted average quality star rating for the categories above.	All	28	10

FIGURE 2: NATIONAL AVERAGE RATINGS, DISTRIBUTION OF ENROLLEES AND SELECTED GLOBAL RATING CATEGORIES

NATIONAL AVERAGE RATINGS - DISTRIBUTION OF ENROLLEES				
STAR RATING	GLOBAL RATING	CLINICAL QUALITY	ENROLLEE EXPERIENCE	PLAN EFFICIENCY
1	0%	1%	6%	0%
2	18%	32%	14%	9%
3	65%	60%	67%	76%
4	16%	7%	11%	13%
5	1%	1%	1%	2%
Average	**3.0**	**2.7**	**2.9**	**3.1**

REGION	AVERAGE GLOBAL RATING
Northeast	3.1
Southeast	3.1
Midwest	3.2
Southwest	2.6
West	3.0

PLAN TYPE	AVERAGE GLOBAL RATING
HMO	2.9
PPO	3.1
POS	3.0
EPO	3.2

PILOT STATES	AVERAGE GLOBAL RATING
Pilot	3.4
No Pilot	2.9

ISSUER QHP ENROLLMENT	AVERAGE GLOBAL RATING
< 110,000 Enrollees	3.1
110,000+ Enrollees	3.0

ISSUER # OF QHP PLAN IDs	AVERAGE GLOBAL RATING
< 9 Plan IDs	2.6
9+ Plan IDs	3.1

How will the ratings be used?

QHP plan sponsors may reference quality ratings in consumer marketing materials, so long as they do so in a way that is compliant with published CMS guidance.[9] If marketing campaigns highlighting high star ratings resonate with consumers, brokers, and agents, leading to higher enrollment and member satisfaction, then this may motivate plan sponsors with low star ratings to improve their performances with quality measures. At least initially, quality ratings may only have marginal impact on consumer enrollment decisions as consumers familiarize themselves with this new information. It is possible, in comparing plans of similar actuarial value, price, and provider network, that consumers may turn to quality rating differences to make final enrollment decisions.

The Medicare Advantage program may illustrate potential future uses of the quality ratings for QHPs, however. Section 722[10] of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated the collection, analysis, and reporting of health outcomes-related information for the purpose of improving the quality of care provided to enrollees and facilitating consumer choice and administration of Medicare Advantage plans. These intended uses of quality ratings for Medicare Advantage plans are not materially dissimilar from the intended use of the quality ratings for QHPs mandated under 42 U.S. Code § 18031(c). However, in 2010, Section 3202(B)[11] of the Patient Protection and Affordable Care Act (ACA) introduced significant financial incentives for Medicare Advantage plans to achieve high star ratings, directly tying a plan's payment from CMS to its star rating. As a result of these financial incentives, initially low-rated Medicare Advantage plans will generally increase their quality ratings over time or exit the market.[12] Few Medicare Advantage plans are able to remain in the market with low star ratings for many years. The QHP quality-rating metrics do not have the same direct financial impact as the Medicare Advantage quality ratings do. The focus of QHP issuers on quality ratings would likely be different in the presence of such incentives, but it remains to be seen whether Congress will seek to tie federal payments to quality ratings for QHP issuers as they have for Medicare Advantage plans.

9   CMS Bulletin (August 15, 2019), op cit.

10   The full text of the law is available at **https://www.congress.gov/bill/108th-congress/house-bill/1/text**.

11   The full text of the ACA is available at **http://housedocs.house.gov/energycommerce/ppacacon.pdf**.

12   Backes, K.S., Friedman, J.M., Grzeskowiak, D.J. et al. (February 2018). Medicare Advantage Star Ratings: Expectations for New Organizations. Milliman Research Report. Retrieved October 22, 2019, from **http://us.milliman.com/uploadedFiles/insight/2018/medicare-advantage-star-ratings.pdf**.

Who reports?

QHP issuers are responsible for coordinating the collection, validation, and submission of this data to CMS for each eligible "reporting unit." A reporting unit is defined as a unique issuer, state, and product type—exclusive provider network (EPO), HMO, POS, preferred provider organization (PPO)—and is the level at which eligibility determination and quality scoring is performed. In other words, QHP issuers are required to submit data to CMS for each unique combination of product type and state that meets the following three eligibility criteria:

1. The reporting unit must have been in the exchange in the prior year (2018 calendar year).
2. The reporting unit must have been in the exchange in the ratings or current year (2019 calendar year).
3. The reporting unit must meet the QRS minimum enrollment requirements of having more than 500 enrollees as of the midpoint of the prior year (July 1, 2018) and the beginning of the ratings year (January 1, 2019).

Reporting units may not be combined, and any reporting unit that fails to meet the above eligibility criteria is exempt from submitting data. It is important to note that CMS has defined reporting units in a way that requires experience from individual exchanges and the Small Business Health Options Program (SHOP) to be combined if they are the same product type within the same state.

QHP issuers are required to begin submitting data for eligible reporting units in the second year of operations even though QRS scores and ratings will not be calculated until the third consecutive year of operations. So, for example, to receive QRS scores and ratings for the 2019 calendar year, a reporting unit must have been in operation during calendar years 2017, 2018, and 2019.

What data is collected?

For non-exempt reporting units the non-survey-based clinical measures can be collected by an administrative method (using administrative claims data) and/or by a hybrid method, which also uses medical records and electronic health records (EHRs). CMS specifies in its technical guidance which method is appropriate for each measure. Once the data has been collected and validated by a third-party HEDIS® Compliance Auditor (Certified Auditor), only then can it be submitted to CMS for processing. CMS has developed online portals and standardized data feeds to assist health plans with this process.

The QHP Enrollee Survey is based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and principles, which are the national standard for assessing patient and consumer experience.[13] The QRS has

very specific rules around survey sampling, timing, validation, and administration. At a high level the process requires QHPs to submit accurate survey sample frames containing specific contact information for each eligible enrollee tied to their reporting units to a Certified Auditor. Once the auditor has established that a sample frame meets CMS requirements, the QHP then submits the sample frame to an HHS-approved QHP Enrollee Survey vendor who then draws the survey sample, administers the survey, and securely submits validated results straight to CMS in the specified format.

The survey covers the following topics, and is used in conjunction with the clinical measures to determine the quality ratings:

- Access to care
- Access to information
- Care coordination
- Cultural competence
- Doctor communication
- Enrollee experience with cost
- Plan administration
- Prevention

How are ratings calculated?

Once the data has been received, CMS then uses a 10-step process[14] to calculate the QRS scores and ratings. The technical guidance provides a great deal of detail around this process, but we will only offer a brief summary of each step:

1. Calculate measure rates: A measure rate is calculated for each QRS clinical measure and QRS survey measure based on the score for that measure.
2. Determine whether measure denominator size is sufficient for scoring: Each measure must meet a minimum denominator size requirement in order for it to be included in scoring. The minimum size is 30 observations for clinical measures,[15] and 100 for nonclinical survey measures.
3. Calculate standardized measure scores: Transform all raw measure rates into standardized scores using z-standardization. This step compares each measure rate to the mean rate of a national reference group.
4. Calculate composite scores: Average the standardized measure scores, as long as at least half of the associated measures have a score ("half-scale rule"). Otherwise, no score is calculated.

---

13   Backes, K.S., Friedman, J.M., Grzeskowiak, D.J. et al. (February 2018). CMS Bulletin (August 15, 2019), op cit.

14   CMS (October 2018), Health Insurance Exchange: Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019, op cit.

15   Except for the Plan All Cause Readmissions (PCR) measure, which has the minimum denominator criteria of 150 observations.

5. Calculate domain scores: Apply the same half-scale rule at the composite level, and average the composite scores when appropriate.

6. Calculate summary indicator scores: Apply the half-scale rule again at the domain level, and average the domain scores when appropriate to achieve the scores for the categories described in Figure 1 above.

7. Apply explicit weights to summary indicator scores: Apply the weights shown in Figure 1 above to the three summary indicator scores.

8. Calculate global score: A global score can be developed as long as the medical care summary indicator received a score and at least one of the other two summary indicators received a score.

9. Convert scores to ratings: CMS uses cluster analysis and a jackknife procedure to develop cut point values at the global level, and then measures each of the composite, domain, summary indicator, and global scores against those cut points to convert the scores into a five-star scale.

10. Produce QRS results for preview and finalization: CMS then produces a Ratings Output File (ROF), QRS preview reports, and proof sheets to be used in the preview period.

CMS expects to refine the QRS and QHP Enrollee Survey over time, and will communicate refinements using an annual Call Letter process or the information collection request process per the Paperwork Reduction Act.

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Dustin Grzeskowiak
dustin.grzeskowiak@milliman.com

Darin Muse
darin.muse@milliman.com

Daniel Perlman
daniel.perlman@milliman.com