Quality Improvement Strategy: Technical Guidance and User Guide for the 2017 Coverage Year

July 1, 2015

DRAFT FOR PUBLIC COMMENT

CMS is accepting comments on the proposed QIS Technical Guidance and User Guide until July 30, 2015. Please email all comments to Marketplace_Quality@cms.hhs.gov with subject line "QIS Technical Guidance and User Guide Comments."

Table of Contents

List of Exhibits

Technical Assistance

Technical assistance is available for issuers, Marketplaces, and other entities who may have questions related to the quality improvement strategy (QIS) requirements. For additional information or assistance, please see the following:

Help Desk

To submit questions regarding this document or any QIS implementation and reporting requirements, please contact the Exchange Operations Support Center (XOSC) Help Desk via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Please reference "Marketplace Quality Initiatives (MQI)-QIS" or "MQI-QIS" in all requests or questions.

Website Links

Website	Description	Link
Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives (MQI) website	This website provides resources related to CMS MQI activities including the QRS, Consumer Experience Surveys, QIS requirements, and Patient Safety Standards. As the central site for QIS resources, this site contains instructional documents regarding QIS implementation and reporting, including this document.	http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html
CMS Qualified Health Plans (QHP) Application website	This website provides issuers with detailed application instructions, forms—including the QIS Implementation Plan and Progress Report form—as well as justifications, supporting documents, and tools to complete the annual QHP certification process.	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html
Registration for Technical Assistance Portal (REGTAP)	This website serves as an information hub for CMS technical assistance related to Marketplace and Premium Stabilization programs. Registered users can access the library, frequently asked questions, training resources, and the inquiry tracking and management system. Use keyword search "QIS" to identify any resources related to the QIS.	https://REGTAP.info

Other Resources

- State-based Marketplaces (SBMs) should contact their respective Center for Consumer Information and Insurance Oversight (CCIIO) State Officers for resolutions of their inquiries.

- Stakeholders other than issuers and Marketplaces may submit inquiries via email to Marketplace_Quality@cms.hhs.gov, and should reference "MQI-QIS" in the subject line.

- The **2017 Letter to Issuers in the Federally-facilitated Marketplaces** (Letter to Issuers) provides issuers seeking to offer QHPs, including stand-alone dental plans (SADPs), in the FFM or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs) with operational and technical guidance to help them successfully participate in those Marketplaces in 2017. The draft 2017 Letter to Issuers is expected to be released in late 2015.

- The **Patient Protection and Affordable Care Act; U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016** (Payment Notice) includes implementation requirements for QHP quality improvement strategies for Coverage Year 2016. The Notice of Benefit and Payment Parameters for 2017 will be published in early 2016, for the Coverage Year 2017.

Document Purpose and Scope

The *Quality Improvement Strategy (QIS) Technical Guidance and User Guide for Coverage Year 2017* provides (1) Technical Guidance, including comprehensive background information about the QIS requirements; and (2) a User Guide with step-by-step instructions for how to comply with the QIS requirements for the 2017 Qualified Health Plan (QHP) Application Submission and Review Period (QHP Application Period, which applies to the coverage year beginning in 2017).[1] This document is organized into two volumes:

- Volume I: QIS Technical Guidance for the 2017 Coverage Year; and
- Volume II: QIS User Guide for the 2017 Coverage Year.

VOLUME I: QIS TECHNICAL GUIDANCE FOR THE 2017 COVERAGE YEAR

The QIS Technical Guidance (Technical Guidance) for the 2017 coverage year provides information on the QIS participation and reporting requirements for all issuers offering or seeking to offer QHP coverage through a Marketplace, and the evaluation methodology for the Federally-facilitated Marketplace (FFM), including states performing plan management functions in the FFM. Throughout this document, unless otherwise noted, references to the FFM includes states performing plan management functions in the FFM.

The requirements outlined in this document are based on statute and Centers for Medicare & Medicaid Services (CMS) regulation, including the "Patient Protection and Affordable Care Act and the HHS Notice of Benefit and Payment Parameters for 2016" Final Rule.[2] The Technical Guidance provides:

- Background on the QIS;
- An overview of the QIS Technical Guidance;
- The QIS implementation schedule for the 2017 coverage year;
- Marketplace oversight responsibilities;
- The QIS requirements;
- An overview of the QIS evaluation process and methodology; and
- An overview of the QIS for the 2018 coverage year.

VOLUME II: QIS USER GUIDE FOR THE 2017 COVERAGE YEAR

The User Guide for the 2017 Coverage Year (User Guide) provides issuers offering coverage in the FFM with directions to meet the QIS requirements for the 2017 QHP Application Period.[3] The User Guide is a procedural, step-by-step instruction for issuers on how to access, complete, and submit a QIS Implementation Plan to the FFM.

[1] The 2017 QHP Application Period occurs in the 2016 calendar year; please see Appendix A for illustrative dates.

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 FR 10750 at 10876 (Feb. 27, 2015) (45 CFR § 156.1130).

[3] These sections will be updated annually to reflect changes in the QHP Application from year to year.

The User Guide covers each aspect of the QIS application and submission process and includes the following sections, which provide:

- An introduction to the User Guide;
- Information on how to access the QIS materials;
- Instructions for completing the QIS Implementation Plan sections;
- Information on how and when to submit the Implementation Plan sections;
- Instructions on what steps issuers may need to take after their QIS submissions have been evaluated; and
- An introduction to completing the subsequent QIS Progress Report sections.

Volume I. QIS Technical Guidance for the 2017 Coverage Year

1. Background

A QHP issuer participating in a Marketplace for two or more consecutive years must implement and report on a QIS, in accordance with section 1311(g) of the Affordable Care Act, to cover all of its QHPs that meet the eligibility criteria described in Section 5.1 and/or Multi-state Plans (MSPs).[4] The QIS requirements apply to all issuers offering QHPs and MSPs, whether through the individual market or through the Small Business Health Options Program (SHOP). Throughout this document, references to "issuers" refer to issuers offering or applying to offer QHPs in a Marketplace.

All issuers must comply with the following requirements:

(1) Implement a QIS, defined as a payment structure that provides increased reimbursement or other incentives.
(2) Implement at least one of the following:
   i. Activities for improving health outcomes;
   ii. Activities to prevent hospital readmissions;
   iii. Activities to improve patient safety and reduce medical errors;
   iv. Wellness and health promotion activities; and/or
   v. Activities to reduce health and health care disparities.
(3) Comply with guidelines established by the Secretary of Health and Human Services (HHS) in consultation with experts in health care quality and stakeholders.
(4) Report on progress implementing the QIS to the applicable Marketplace on a periodic basis.

How Can an Issuer Address Health and Health Care Disparities in Its QIS?

Issuers are required to address health and health care disparities in their QIS. This may be done in one of two ways:

(1) by choosing "Implementation of activities to reduce health and health care disparities" as a topic area addressed by the QIS; *or*
(2) by addressing the reduction of health and health care disparities as part of the activities implemented within any other chosen topic area(s).

All Marketplaces are required[5] to evaluate an issuer's QIS and issuers must submit separate QIS submissions by state.

- CMS will evaluate the QIS submissions for issuers applying to offer QHPs in the FFM states.
- In states performing plan management functions in the FFM, issuers applying to offer QHPs will undergo a joint review of their QIS submissions by the state and the FFM. These states must evaluate the QIS submissions from issuers offering coverage through their states using the federal QIS evaluation methodology.
- State-based Marketplaces (SBMs) will evaluate the strategies of the issuers applying to offer QHPs in their respective Marketplaces. SBMs must comply with the federal minimum reporting requirements. They may establish their own reporting forms and

[4] Section 1311(c)(1)(E) of the Affordable Care Act, 45 C.F.R. § 156.200(b) and 45 C.F.R. § 156.1130.
[5] 45 CFR § 155.200(d).

evaluation methodologies, as well as their own reporting manner and frequency requirements, or they may choose to use those established by the FFM.

- The Office of Personnel Management (OPM) will evaluate MSP QIS submissions. Issuers seeking to offer both a QHP and an MSP option in the same Marketplace must submit two QIS submissions—one for the QHP option to the Marketplace and one for the MSP option to OPM. The QIS submission can be the same or different. Issuers offering MSPs should contact OPM to confirm the requirements and timing associated with QIS implementation.

Issuers applying to offer QHPs in SBM states and in states performing plan management functions in the FFM should contact the states to confirm timing and whether there are any state-mandated QIS requirements beyond the federal minimum requirements.

2. Technical Guidance Overview

The goal of QIS implementation is to improve the quality and value of care delivered to Marketplace enrollees through strategies that provide for increased reimbursement or other market-based incentives to improve the quality of patient care. Through their implementation, QIS activities will help to strengthen system-wide efforts to improve health care quality and health outcomes. To achieve this goal, CMS will:

- Operationalize the requirements in the statute;
- Align the statutory requirements with other quality improvement programs;
- Offer flexibility to encourage issuer innovation and to promote a culture of continuous quality improvement;
- Allow for flexibility for state implementation; and
- Develop requirements in a public and transparent manner.

Issuers will have two years of experience offering coverage through a Marketplace to understand and build quality performance data on their Marketplace enrollees before being required to submit a QIS. Issuers must define the health outcome needs of their enrollees (e.g., if an issuer has a large proportion of diabetic enrollees, it may elect to incentivize enrollees to maintain regular doctor visits for diabetes care, and/or incentivize physicians to focus on improving diabetic patient outcomes). Issuers must set goals for quality improvement, use market-based incentives to promote those goals, and use performance measures to track progress against these goals. Quality improvement strategies that do not include the use of market-based incentives and are not aimed at improving health outcomes should not be included in a QIS submission. Issuers can leverage existing quality improvement strategies used for other programs, as long as the strategies meet the QIS requirements.

Issuers may choose to either implement one QIS that applies to all of their eligible QHPs in a given Marketplace, or implement more than one QIS to cover all of their eligible QHPs. An issuer offering a QHP through the Marketplace in the 2014 and 2015 coverage years must submit all required QIS information to the applicable Marketplace in 2016 for the 2017 coverage year.

(In subsequent years, the issuer must submit an annual update on its implementation progress). See Exhibit 1 for examples of the timespan for QIS submissions.

Exhibit 1: QIS Initial Implementation Plan Submission Timespan

Issuer's Initial QHP Certification Application Year	Initial Year of Providing Coverage	Calendar Year of Initial QIS Implementation Plan Submission	Initial QIS Implementation Plan Coverage Year
2013	2014	2016	2017
2014	2015	2017	2018
2015	2016	2018	2019
2016	2017	2019	2020
2017	2018	2020	2021

In the event coverage is not continuous, the two-year window restarts each time the issuer begins offering coverage again. For example, if an issuer offered QHPs through a Marketplace in 2014, does not offer any QHPs through a Marketplace in 2015, and offers QHPs again in 2016 and 2017, the issuer will only be required to submit a QIS Implementation Plan and Progress Report form in 2018 for the 2019 coverage year.

The QIS Implementation Plan and Progress Report form is a consolidated form, which can be accessed on the MQI website for use by all issuers in the FFM, requiring them to provide information on their proposed quality improvement strategies (see Appendix C). The QIS elements and criteria in the QIS Implementation Plan and Progress Report form are described in detail in Section 2 of the User Guide. Each element has associated criteria that describe the type of information issuers must provide. A more detailed explanation of the organization of the QIS Implementation Plan and Progress Report form is provided in Section 5.2 of the Technical Guidance.

3. QIS Implementation Schedule for the 2017 Coverage Year

Issuers applying for QHP certification in the FFM will submit QIS information during the annual QHP Application Period, and should refer to the 2017 Letter to Issuers[6] for finalized dates for that period. Exhibit 2 highlights the major stages of the QIS process for the 2017 coverage year in the FFM, assuming an October 1, 2016, open enrollment date. Issuers operating in other Marketplace types should refer to their Marketplaces regarding the specific timeframes, and MSPs should refer to OPM.

[6] The Draft 2017 Letter to Issuers is expected to be released in late 2016.

Exhibit 2: Stages of the QIS Process

Stages	Approximate Timeframe
Issuers develop QIS for the 2017 coverage year	Fall 2015 – April 2016
QIS submission window for the 2017 coverage year	April – May 2016
QIS evaluation window for the 2017 coverage year	May – September 2016
Final QHP certification for the 2017 coverage year	September 2016

4. Marketplace Oversight Responsibilities

Marketplaces are responsible for QHP certification as well as oversight of QHP issuer compliance with certification standards. All Marketplaces are responsible for evaluating an issuer's QIS as a condition of certification for the 2017 coverage year.

4.1 Federally-Facilitated Marketplace

The FFM will follow the QHP Application and Certification process outlined in the 2017 Letter to Issuers, as it pertains to the QIS requirements.

States performing plan management functions in the FFM will receive QIS Implementation Plan and Progress Report forms directly from issuers offering coverage through their state, as part of the issuers' QHP applications, via the System for Electronic Rate and Form Filing (SERFF). States performing plan management functions in the FFM must evaluate the QIS submissions of the issuers offering coverage through their states using the federal QIS evaluation methodology, but issuers should contact the states for additional details.

4.2 State-Based Marketplaces

SBMs are responsible for Marketplace functions, such as QHP certification and oversight of issuer compliance with certification standards. This responsibility includes overseeing issuer compliance with the QIS requirements.[7]

SBMs must comply with the federal minimum reporting requirements. They may establish their own reporting forms and evaluation methodologies, as well as their own reporting manner and frequency requirements, or they may choose to use those established by the FFM. Issuers operating in SBMs should consult their states for information about how to comply with the states' QIS requirements.

[7] 45 CFR § 155.1010(a)(2) and § 155.200(d).

5. QIS Requirements

This section outlines the criteria for determining which issuers must submit a QIS to the applicable Marketplace. This section also describes the QIS requirements, specifically the QIS Implementation Plan and Progress Report form.

5.1 Eligibility Criteria for Issuers

Issuers must submit a QIS to the Marketplace for the 2017 coverage year if:

An issuer offered coverage through the Marketplace in 2014 and 2015. If an issuer offered coverage in 2015 and 2016 (but not in 2014), the issuer would not need to submit a QIS until 2017 for the 2018 coverage year.

How Many QIS Implementation Plans Should an Issuer Submit?

If an issuer uses the same QIS across multiple Marketplaces, it will still need to submit a separate Implementation Plan to each Marketplace in which it offers eligible QHPs.

- Issuers **must** implement at least one QIS per Marketplace in which they offer eligible QHPs.
- Issuers **may** implement multiple quality improvement strategies within the same Marketplace if they have different strategies for different eligible QHPs within the same Marketplace.
- Each eligible QHP must be included in a QIS.

An issuer provides family and/or adult-only medical coverage. All levels of coverage (bronze, silver, gold, platinum, and catastrophic) should be included. At this time, QIS requirements do not apply to child-only plans, stand-alone dental plans (SADPs), or QHPs that are compatible with health savings accounts (HSAs).

An issuer meets the QIS minimum enrollment threshold. Each eligible QHP that aligns to a product type (e.g., HMO, PPO) that has more than 500 enrollees as of July 1, 2015, must be covered by a QIS. This means that an issuer has to submit a QIS if any of its product types meet the minimum threshold requirement. However, only QHPs that fall under the eligible product type must be covered.

To determine whether a product type meets the threshold, issuers must include all enrollees in eligible QHPs Issuers should note:

- If an issuer offers the same product type in the individual Marketplace as well as in the SHOP within a state, the issuer must combine the enrollee totals from both the individual Marketplace and SHOP.
- If an issuer offers both a QHP and an MSP option of the same product type in the same state, the issuer must combine the enrollee totals from both QHP and MSP plan types.
- Issuers should include enrollees in QHPs that are offered through the Marketplace. Enrollees in QHPs that are offered outside the Marketplace (off-Marketplace) and non-QHPs are not included in the calculation of the minimum enrollment.[8]

[8] CMS anticipates providing this direction in the final QIS Technical Guidance published in the fall 2015, but may adjust the requirement following public comment.

- Issuers should use QHP enrollment numbers from the year prior (2015) to the QIS submission (2016) to determine whether the product type meets the threshold.

5.2 QIS Implementation Plan and Progress Report Form

Issuers applying for QHP certification in the FFM for the 2017 coverage year are expected to submit a QIS Implementation Plan and Progress Report form in 2016 and then implement the QIS beginning no later than January 2017.[9] This section provides details about the specific elements and criteria that an issuer will need to address when submitting information about its QIS.

The QIS Implementation Plan and Progress Report form provides a structure for an issuer to show that its QIS includes all the necessary components and adequately addresses the QIS criteria. By submitting information in response to all the elements and meeting the criteria, an issuer will demonstrate that it has examined its enrollee population and designed a QIS that provides market-based incentives to drive quality improvement and improved health outcomes.

Commonly Used QIS Terms

- **QIS requirements:** The information that issuers are required to submit for evaluation by the Marketplace
- **Elements:** Identifying and descriptive information that issuers will use to complete the QIS Implementation Plan and Progress Report form
- **Criteria:** The specifics of how issuers are developing and implementing their quality improvement strategies

Issuers will use the QIS Implementation Plan and Progress Report form to submit a QIS Implementation Plan to the Marketplace.[10] During the 2017 QHP Application Period,[11] when QIS implementation is in its initial year, every issuer will indicate in the Implementation Plan and Progress Report form that it is submitting a new QIS. In subsequent application periods, issuers will indicate in the form which of the following types of information they are submitting:

- New QIS;
- New QIS After Discontinuing a QIS Submitted During the Most Recent QHP Application Period;
- Continuing a QIS with No Modifications; or
- Continuing a QIS with Modifications.

The sections of the form and their parts are listed in Exhibit 3.

[9] Issuers are permitted to use a strategy they are already implementing for the Marketplace or another product line as long as it meets the QIS elements and criteria.

[10] Part F: Progress Report Summary (QIS Progress Report Section) will be covered in full detail in the QIS Technical Guidance & User Guide for the 2018 Coverage Year.

[11] The 2017 QHP Application Period occurs in the 2016 calendar year; please see Appendix A for more information.

Exhibit 3: QIS Implementation Plan and Progress Report Form – Sections and Parts

QIS Implementation Plan and Progress Report Form
QIS Submission Type Section
o Part A: New or Continuing QIS Submission
Background Information Section
o Part B: Issuer Information
o Part C: Data Sources Used for Problem Identification and Monitoring Progress
QIS Implementation Plan Section
o Part D: QIS Summary
o Part E: QIS Requirements
QIS Progress Report Section
o Part F: Progress Report Summary

Parts A-E of the form make up the "Implementation Plan" that is referred to throughout the Technical Guidance & User Guide. References to the "Implementation Plan Section" of the overall form relate specifically to Parts D and E. Part F of the form is the Progress Report section, which issuers will need to complete in future years for the annual updates, but which should not be completed during the QHP Application Period for the 2017 coverage year. The annual reporting elements are further detailed in the User Guide, and will be scored as part of the QIS evaluation. See Section 5 of the User Guide for more information about Part F in particular.

Issuers ***must*** complete all elements within all parts that are being submitted. If an issuer fails to provide responses to any criteria within any of the elements, CMS will ask the issuer to complete the missing information and resubmit the form. The information submitted in Parts A, B, C, and D will be reviewed for completeness, while the information submitted in Parts E (and F, when applicable) will be both reviewed for completeness **and** scored (refer to Section 6.2, QIS Evaluation Methodology, for an explanation of QIS scoring).

Each element in Part E of the Implementation Plan is associated with criteria that will be assessed. CMS will assess the criteria to evaluate whether issuers' submitted information meets each element in Part E.

The User Guide lists and describes the elements found in the QIS Implementation Plan and Progress Report form. The list includes the element number, an explanation of each element, and the criteria upon which it will be evaluated. It also indicates whether issuers' responses are subject to character limits.

6. QIS Evaluation

On an annual basis, issuers must meet the QIS requirements as part of QHP certification. In 2016, issuers will be required to provide information on the following parts of the form:

- Part A: QIS Submission Type;
- Part B: Issuer Information;
- Part C: Data Sources Used for Problem Identification and Monitoring Progress;
- Part D: QIS Summary Description; and
- Part E: QIS Requirements.

6.1 QIS Evaluation Process

The QIS evaluation process for the FFM will take place annually as part of the QHP Application Period, as outlined in the 2017 Letter to Issuers.

To determine whether an issuer's QIS meets the applicable requirements, the FFM[12] will review and evaluate an issuer's QIS information submitted via the Implementation Plan and Progress Report form. There are three stages of review to assess an issuer's QIS submission: first review, second review, and final review. These stages correspond to the three stages of the QHP application and certification process. All issuers will go through first review. Only issuers whose submissions are incomplete or deficient will go through subsequent reviews. If an issuer is still missing any information or does not receive a score that is at or above the predetermined minimum evaluation threshold for the Part E elements after the final review, CMS may require the issuer to develop a Work Plan.

The QIS evaluation process in the FFM will incorporate knowledge related to health plans, qualitative measurement, and market-based incentive programs.

6.2 QIS Evaluation Methodology

The QIS Evaluation Methodology reflects how the FFM reviews and evaluates an issuer's responses to the elements and criteria of the QIS Implementation Plan and Progress Report form. The fields in elements 1-18 of the QIS Implementation Plan and Progress Report form are required and will be reviewed for completeness, but will not be scored. For Part E, CMS uses a "Partial-Credit plus Must-Pass" scoring approach. This approach includes the following three characteristics: (1) issuers will be given partial credit for responses and do not have to score 100 percent to demonstrate compliance with the QIS certification standard; (2) each element included in Part E will be worth 1.00 point toward the final evaluation score, regardless of how many criteria are included in an element; and (3) certain elements are considered "must-pass," and therefore issuers must pass all of the criteria included within those elements.

Further detail on must-pass and other scored elements is provided below in Section 6.3.

6.3 Scoring

Scoring is done at the element level and only for those elements included in Part E. All elements included in Part E are worth 1.00 point, regardless of designation as "must-pass." An issuer will receive a passing score for Part E if it: (1) meets the criteria for the predetermined must-pass elements (i.e., receives 1.00 point for each must-pass element), **and** (2) meets minimum score thresholds of 0.50 point (i.e., 50 percent) for each other scored element (see Section 6.3.1).

Elements 19-24 are "must-pass," and there is no partial credit offered for these six elements. For must-pass elements, an issuer either receives 1.00 point (i.e., 100 percent) for meeting all criteria, or receives zero credit if any criteria are not met. Elements 25 and 26 are also scored, but issuers

[12] 45 C.F.R. § 155.200(d) directs the Marketplace to evaluate QIS submissions. For FFM states, CMS will perform the evaluations; for SBM states, the SBM will perform evaluations.

may receive partial credit for these two elements. See Exhibit 4 for details on the scored elements that issuers will be required to address, by type.

Exhibit 4: Part E Scored Elements by Type

Element Type	Definition	Individual Elements
Must-Pass Elements	▪ Issuer must meet all criteria within an element to receive 1.00 point. ▪ There is no partial credit; meeting less than all criteria results in receipt of 0.00 point. ▪ Receiving 0.00 point on any must-pass element will result in issuer receiving a correction notification.	▪ Element 19: Market-based Incentive Type ▪ Element 20: Topic Area Selection ▪ Element 21: Targets All Health Plans Offered through the Marketplace ▪ Element 22: Rationale for QIS ▪ Element 23: Activities that Will be Conducted to Implement the QIS ▪ Element 24: Goals, Measures, and Performance Targets to Monitor QIS Progress
Other Scored Elements	▪ Issuer may receive partial credit based on how many criteria are met. ▪ An issuer must receive at least 50 percent on these elements.	▪ Element 25: Timeline for Implementing the QIS ▪ Element 26: Risk Assessment

During the initial years of the QIS requirements, an issuer will not be required to demonstrate that its QIS has resulted in improvement over time. In other words, issuers will not be penalized if they do not achieve the performance targets set out in their QIS Implementation Plans.[13]

6.3.1 Other Scored Elements

Element 25 (Timeline for Implementing the QIS) and Element 26 (Risk Assessment) are not must-pass. Each of these elements have two criteria, meaning issuers receive 50 percent credit for meeting one criterion, and 100 percent credit for meeting both criteria. See Exhibit 5 for details.

Exhibit 5: Scoring Scale for Elements 25 and 26

		100%	80%	50%	20%	0%
Element 25, Timeline for Implementing the QIS (2 criteria)	*# of Criteria Met*	Issuer meets 2 criteria	No scoring available	Issuer meets 1 criterion	No scoring available	Issuer meets no criteria
	Points Awarded	1.00 point awarded	N/A	0.50 point awarded	N/A	0.00 point awarded

Element 26, Risk Assessment (2 criteria)	*# of Criteria Met*	Issuer meets 2 criteria	No scoring available	Issuer meets 1 criterion	No scoring available	Issuer meets no criteria
	Points Awarded	1.00 point awarded	N/A	0.50 point awarded	N/A	0.00 point awarded

[13] 80 Fed. Reg. 10848 (Feb. 27, 2015).

6.3.2 Evaluation Outcomes

An issuer will achieve a compliance designation of "Meets" for its QIS submission if it: (1) successfully completes all fields in elements 1-18; (2) successfully completes Part E (see Section 6.3.1).

Based on the results captured in the QIS evaluation, an overall outcome of "Meets" or "Does Not Meet" will be assigned to each issuer's QIS submission(s) and will be reflected in the Correction Notices that are sent to issuers after each round of review during the application process. Issuers will not receive actual scores, but, if applicable, they will be notified of how their QIS submissions were found deficient, including whether their QIS submission was incomplete. Issuers receiving Correction Notices notifying them that no corrections are required will not have to go through additional review.

6.3.3 Data Submission Validation

CMS will review QIS submissions upon receipt for completeness, and will proceed to review and score submissions even if they are incomplete. As noted above, in the case of incomplete data, when issuers receive the Correction Notice from the first review, it will inform them that corrections are required for the parts of the QIS submission that were incomplete or missing.

7. Overview of the 2018 Coverage Year

An issuer must submit a completed Progress Report to the FFM during the QHP Application Period in the following year after the issuer submitted its QIS Implementation Plan. For example, an issuer that offers coverage through the FFM during the 2014 and 2015 coverage years will submit an Implementation Plan to the Marketplace during the 2017 QHP Application Period, which takes place in 2016. That issuer will then submit a QIS Implementation Plan and Progress Report form providing an update on its QIS during the 2018 QHP Application Period, which takes place in 2017. The table below provides additional examples to demonstrate these reporting requirements.

Exhibit 6: QIS Implementation Plan and Progress Report Submission Timespan

QHP Issuer's Initial QHP Certification Application Year	Initial Year of Providing Coverage	Initial Submission of QIS Implementation Plan	Initial Submission of QIS Annual Progress Report
2013	2014	2016	2017
2014	2015	2017	2018
2015	2016	2018	2019
2016	2017	2019	2020
2017	2018	2020	2021

An issuer is encouraged to allow at least two QHP Application Periods for monitoring and assessment of their current QIS prior to implementation of a new QIS. This means that an issuer that submits a QIS Implementation Plan during the 2017 QHP Application Period will submit a Progress Report during the 2018 QHP Application Period, and may submit a new Implementation Plan (i.e., discontinue) its QIS during the 2019 QHP Application Period.

An issuer may change its QIS when:

- The market-based incentive type or sub-type (Element 19) is changed;
- The topic area (Element 20) is changed;
- One or more of the QIS performance targets are reached;
- The QIS impact is not realized as expected; or
- The QIS results in negative outcomes or unintended consequences.

Issuers may make some adjustments (i.e., modifications) in their quality improvement strategies, such as redefining QIS activities, measures, or performance targets, throughout the course of implementation without having to submit a new QIS Implementation Plan.

When issuers complete the QIS Submission Type section (Part A) of the QIS Implementation Plan and Progress Report form, they will be asked to identify the type of QIS submission (e.g., new or continuing QIS). Beginning with the 2018 QHP Application Period, a QHP issuer may indicate that it is changing its existing QIS (i.e., the QIS for which it previously submitted an Implementation Plan) for any of the reasons specified above. If a QHP issuer changes its existing QIS, it must submit a QIS Implementation Plan for its new QIS ***and*** a Progress Report for its existing QIS. For example, assume an issuer submits an Implementation Plan in the 2017 QHP Application Period and submits a subsequent Progress Report, but decides mid-year that it would like to change its QIS during the next QHP Application Period. In this instance, the issuer would need to submit both a Progress Report (for its existing QIS) and an Implementation Plan (for its new QIS) during the 2019 QHP Application Period. This scenario, and other common QIS submission scenarios, are discussed in greater detail in Appendix D.

Volume II. QIS User Guide for the 2017 Coverage Year

1. User Guide Introduction

This User Guide provides instructions for issuers about compliance with QIS requirements, and also describes differences in the submission process for issuers that operate in the FFM versus those that operate in states performing plan management functions in the FFM. An issuer operating in the latter will work directly with its state to submit its QIS in alignment with existing CMS electronic form filing processes for states.

Issuers seeking to comply with the QIS requirements in the FFM should review the QIS materials, including the entirety of this QIS Technical Guidance & User Guide for the 2017 Coverage Year, and the QIS Implementation Plan and Progress Report form, prior to beginning their 2017 QHP Applications.[14] Issuers should also review the 2017 Letter to Issuers and the Final HHS Notice of Benefit and Payment Parameters for 2017 (Payment Notice). The QIS materials can be accessed on the CMS Marketplace Quality Initiatives (MQI) website or via the the CMS QHP Application website.

1.1 Accessing the QIS Materials on the MQI Webpage

The QIS materials will be accessible via the MQI website prior to the start of the QHP Application Period. The MQI website is an online resource for issuers that houses information about ongoing Marketplace quality initiatives such as the Quality Rating System (QRS)[15] and QHP Enrollee Survey.

Follow these step-by-step instructions to access and review the QIS materials online via the MQI website:

Step 1: Click on this link to open the MQI website.

If the website does not automatically open, copy and paste the link below into an Internet browser (e.g., Internet Explorer, Google Chrome, Mozilla Firefox): http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ Health-Insurance-Marketplace-Quality-Initiatives.html

Step 2: Scroll to the section titled "Downloads" at the bottom of the page.

Step 3: Select each QIS-related document and click on the file name to view it.

Step 4: Under the File tab, select "Print" or "Save" as desired.

The QIS materials will also be accessible via the CMS QHP Application website prior to the start of the QHP Application Period. The QHP Application website houses instructions and forms for issuers to complete the annual QHP Application to be certified in the FFM.

[14] The 2017 QHP Application Period occurs in calendar year 2016; please see Appendix A for more information.

[15] While QRS and QIS materials are housed in proximity to one another, it is important to note that these are two separate initiatives with distinct reporting requirements for issuers. QRS develops public-facing health plan ratings based on relative quality and price, whereas according to the QIS requirements, issuers must have quality improvement strategies that rely on market-based incentives in place to cover all of their health plans as a condition of QHP certification in the Marketplace.

1.2 Preparing to Complete the Implementation Plan and Progress Report Form

After reviewing the Technical Guidance & User Guide, prepare to complete the three sections of the QIS Implementation Plan and Progress Report form that comprise the Implementation Plan by following these instructions:

Step 1: Click on the PDF file titled, "QIS Implementation Plan and Progress Report."

Step 2: Download the file by selecting "Save As" on the File tab.

Step 3: Save a local copy to an easily accessible folder.

Step 4: Begin populating the QIS Submission Type, Background Information, and QIS Implementation Plan Sections by following the instructions provided in Volume II, Section 2 below.

TIP: The QIS Implementation Plan and Progress Report is a fillable PDF form that is only available electronically; issuers may not request hard copies by mail.

TIP: To view and save the form, issuers need to download and install Adobe Acrobat Reader, a free electronic file reader that is available online. To complete the form, issuers must follow the prompts to enable JavaScript. This will allow the form to indicate whether you have failed to provide a response to required fields.

TIP: For assistance accessing the QIS Implementation Plan and Progress Report online, please contact the Exchange Operations Support Center (XOSC) Help Desk at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

TIP: Print a copy of this User Guide so you can view it side-by-side with the form and refer to it as often as necessary. Be sure to save the form regularly as you enter your responses.

2. Completing the QIS Implementation Plan

An issuer must fill out one Implementation Plan for each QIS it intends to implement and submit the Implementation Plan to each Marketplace in which the health plan associated with the QIS is offered. An Implementation Plan consists of the following three sections of the Implementation Plan and Progress Report form:

- **QIS Submission Type** (consisting of Part A: New or Continuing QIS Submission)
- **Background Information** (consisting of Part B: Issuer Information, and Part C: Data Sources Used for Problem Identification and Monitoring Progress)
- **QIS Implementation Plan Section** (consisting of Part D: QIS Summary, and Part E: QIS Requirements)

TIP: You must fill out all three of the above sections of the form and their corresponding parts (Parts A through E) to submit a complete Implementation Plan. **If any element is left blank, it will be returned to the issuer for completion.**

The subsections below provide instructions on how to complete each part of the three sections of the form that, taken together, make up an issuer's Implementation Plan. They also provide information about the elements and criteria, the level of detail expected in issuers' responses, and applicable character limits. Issuers must use the space provided in the QIS Implementation Plan and Progress Report form to provide their responses; inclusion of additional attachments and/or supporting documentation is discouraged. The form allows issuers to copy and paste language from other documents (e.g., Microsoft Word documents) into the response fields, as long as the pasted text does not exceed the field's character limits. Appendix C contains the QIS Implementation Plan and Progress Report form in its entirety.

TIP: The character limits for certain elements include spaces and punctuation. The fillable PDF form includes a character counter for each field that will indicate the number of characters (i.e., written letters, numbers, spaces, and punctuation) used in relation to the character limit (e.g., 155/160 indicates that there are 5 characters remaining for use). When drafting your responses, be mindful of the character counter so your responses fit within the limits.

TIP: Prior to submitting your Implementation Plan to the FFM, use the QIS Implementation Plan Pre-Submission Checklist provided in Appendix F to confirm that you have provided responses to all elements—including must-pass elements—and criteria, and to guide you through the submission process.

2.1 Part A. New or Continuing QIS Submission

Part A of the QIS Implementation Plan and Progress Report asks issuers to identify what type of QIS submission they are making. During the 2017 QHP Application Period, when QIS implementation is just beginning, all issuers will indicate that they are submitting new quality improvement strategies. In future years, however, an issuer may use the QIS Implementation Plan and Progress Report form not only to submit a new QIS, but also to continue a QIS without making any modifications, continue a QIS with some modifications, or implement a new QIS while discontinuing an existing QIS.[16] Part A is designed to guide issuers to complete the correct parts of the QIS Implementation Plan and Progress Report form, depending on the type of QIS submission they are making.

Exhibit 7 depicts the element that issuers must populate in Part A. Issuers are required to provide a response to this element, but responses will not be scored. There are no associated criteria requested in Part A.

[16] Appendix D defines these QIS submission types and indicates which sections of the QIS Implementation Plan and Progress Report form issuers must complete depending on the applicable scenario. As a reminder, most of these scenarios will not apply until the 2017 QHP Application Period and beyond; all issuers will submit a new QIS during the 2017 QHP Application Period.

Exhibit 7: Part A. New or Continuing QIS Submission

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
1	Type of QIS Submission Check the box that describes the type of QIS submission. Follow the directions provided to complete the remainder of the form.	None	This element is required, but will not be scored.	None

After the QIS Implementation Plan and Progress Report form has been downloaded and saved, follow the steps below to complete Part A:

Step 1: Indicate what type of QIS submission is being completed by checking the appropriate box in Element 1.

Check the box that describes what type of QIS submission the issuer is making (i.e., a new QIS, a new QIS after discontinuing a QIS submitted during the most recent QHP Application Period, continuing a QIS with no modifications, or continuing a QIS with modifications). Since the 2017 QHP Application Period marks the first year of QIS implementation in the Marketplace, the issuer has never previously submitted a QIS for the health plans for which it is completing the QIS Implementation Plan and Progress Report form; therefore, all issuers must select "New QIS."

The required sections of the Implementation Plan and Progress Report form are determined by the type of QIS submission.

TIP: During the 2017 QHP Application Period, you must select the "New QIS" box in response to Element 1.

Step 2: Proceed to the appropriate sections of the QIS Implementation Plan and Progress Report form as specified in Element 1.

During the 2017 QHP Application Period, once issuers select "New QIS" in the QIS Submission Type section (Part A), they must continue on to complete the Background Information section (Parts B and C) and the Implementation Plan Section (Parts D and E) before submitting the form to the FFM.

During future application periods, issuers may select from the applicable QIS submission types provided in Element 1. Step-by-step instructions for doing so will be provided in future versions of this User Guide. (See Appendix D for additional information on the QIS submission types.)

2.2 Part B. Issuer Information

Part B of the QIS Implementation Plan and Progress Report collects identifying information about the issuer (e.g., issuer name, Health Insurance Oversight System [HIOS] Issuer ID, state name, QIS contact information, and information about the issuer's current payment models).

Exhibit 8 depicts the elements that issuers must populate in Part B. Responses to all of these elements are required, but will not be scored. There are no associated criteria requested in Part B.

Exhibit 8: Part B. Issuer Information

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
2	Issuer Legal Name	None	This element is required, but will not be scored.	None
3	Company Legal Name	None	This element is required, but will not be scored.	None
4	HIOS Issuer ID	None	This element is required, but will not be scored.	None
5	Issuer State	None	This element is required, but will not be scored.	None
6	QIS Primary Contact's Name	None	This element is required, but will not be scored.	None
7	QIS Primary Contact's Title	None	This element is required, but will not be scored.	None
8	QIS Primary Contact's Telephone	None	This element is required, but will not be scored.	None
9	QIS Primary Contact's Email	None	This element is required, but will not be scored.	None
10	QIS Secondary Contact's Name	None	This element is required, but will not be scored.	None
11	QIS Secondary Contact's Title	None	This element is required, but will not be scored.	None
12	QIS Secondary Contact's Telephone	None	This element is required, but will not be scored.	None
13	QIS Secondary Contact's Email	None	This element is required, but will not be scored.	None
14	Date Issuer Began Offering Coverage Through the Marketplace	None	This element is required, but will not be scored.	None
15	Current Payment Model(s) Description Select the category(ies) of payment models that are used by the issuer across all product lines (e.g., Medicare, Medicaid, commercial, Marketplace), not just applicable to the QIS described in this document [the form]. Provide the percentage of payments tied to quality or value if Fee for Service – Linked to Quality or Value OR if Alternative Payment Models were selected.	None	This element is required, but will not be scored.	None

Follow these steps to complete Part B in the Background Information section of the form:

Step 1: Type the issuer's name into the space provided for Element 2.

Provide the legal name of the issuer that offers the health plan(s) to which the QIS applies.

TIP: The information you provide in your responses to Elements 2 through 5 (i.e., the legal names of the issuer and the issuer's parent company, the issuer's HIOS ID, and the state in which the issuer is located) should match the information you provide on the application templates you complete as part of your 2017 QHP Application.

Step 2: Type the legal name of the issuer's parent company into the space provided for Element 3.

Provide the legal name of the parent company with which the issuer is affiliated. In some cases, the legal name of the issuer and the legal name of the parent company will be the same.

Step 3: Enter the issuer's HIOS Issuer ID in the space provided for Element 4.

The HIOS Issuer ID, or HIOS ID, is a five-digit numeric identifier that is assigned to each issuer during HIOS registration.[17]

TIP: For help obtaining or remembering the issuer's HIOS Issuer ID, please contact the XOSC Help Desk at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

Step 4: In Element 5, name the state in which the issuer is located.

Enter the name of the state or territory in which the issuer is physically located. The state or territory name should be abbreviated using standard postal abbreviations. For example, "Virginia" should be represented as "VA;" Puerto Rico should be represented as "PR."

Step 5: Identify and provide contact information for the issuer's QIS primary point of contact (POC) in Elements 6 through 9.

Provide the first and last name, title, telephone number, and email address of the issuer's staff member who is responsible for filling out the Implementation Plan and/or is familiar with the issuer's QIS.

Step 6: Identify and provide contact information for the issuer's QIS secondary POC in Elements 10 through 13.

Provide the first and last name, title, telephone number, and email address of a second staff member who is responsible for filling out the Implementation Plan and/or is familiar with the issuer's QIS.

[17] The HIOS Issuer ID (HIOS ID) and the HIOS Plan ID (also known as a Standard Component ID, or SCID) referenced elsewhere in this document are two different identifiers. The former is a five-digit numeric identifier assigned to issuers upon HIOS registration; the latter is a unique 14-character assigned to health plans in HIOS.

Step 7: Enter the date the issuer began offering coverage through the Marketplace in the space provided for Element 14.

The date entered should specify the year that the issuer began offering coverage through the Marketplace by following this format: YYYY. For example, an issuer might indicate that it began offering coverage in 2014.

Step 8: Select one or more of the categories of payment models[18] listed in Element 15.

Check the box or boxes that represent the category(ies) of payment models used by the issuer across all product lines (e.g., Medicare, Medicaid, commercial, Marketplace). Responses should reflect all product lines, not just health plans offered through the Marketplace and/or to which the QIS applies. The information provided in Element 15 will help CMS gauge overall progress toward meeting value-based payment goals.[19] Exhibit 9 provides a description of each of the four categories, and examples of payment models by category.

Exhibit 9: Examples of Payment Models by Category[20]

Payment Category	Description	Medicare Examples	Medicaid Examples
Fee For Service (FFS) – No Link to Quality or Value	Payments are based on volume of services and not linked to quality or efficiency.	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Varies by state
FFS – Linked to Quality or Value	At least a portion of payments vary based on the quality or efficiency of health care delivery.	• Hospital value-based purchasing • Physician value-based modifier • Readmissions/Hospital acquired condition reduction program	• Primary care case management • Some managed care models
Alternative Payment Model Built Upon FFS Architecture	Some payment is linked to the effective management of a population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or two-sided risk.	• Accountable care organizations (ACOs) • Medical homes • Bundled payments	• Integrated care models under FFS • Managed FFS models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models • Medicaid waivers for delivery reform incentive payments • Episodic-based payments

[18] Payment models categories are defined in Rajkumar R, Conway PH, Tavenner M. CMS—Engaging Multiple Payers in Payment Reform. JAMA. 311:19.

[19] Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value; January 26, 2015: http://www.hhs.gov/news/press/2015pres/01/20150126a.html

[20] Source: Rajkumar R, Conway PH, Tavenner M. CMS—Engaging Multiple Payers in Payment Reform. JAMA. 311:19.

Payment Category	Description	Medicare Examples	Medicaid Examples
Population-based Payment	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., >1 year).	• Eligible Pioneer ACOs in years 3-5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

If "Fee for Service – Link to Quality or Value" was selected, enter the percentage of FFS payments (i.e., the percentage of payment dollars) to providers that are linked to quality or value in the space provided.

If "Alternative Payment Models" was selected, enter the percentage of payments (i.e., the percentage of payment dollars) to providers tied to quality or value through alternative payment models.

TIP: Percentages should be rounded to the nearest whole number (e.g., 2 percent). Do not enter decimal places (e.g., 1.73 percent) or fractions (e.g., 1 ¾).

2.3 Part C. Data Sources Used for Problem Identification and Monitoring Progress

Part C of the Implementation Plan and Progress Report form collects information about the data sources the issuer used to inform the development and implementation of its QIS.

Exhibit 10 depicts the element that issuers must populate in Part C. An issuer must provide a response to this element, but the response will not be scored.

Exhibit 10: Part C. Data Sources Used for Problem Identification and Monitoring Progress

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
16	Data Sources Indicate the data sources used for identifying QHP enrollee population needs, and health and health care disparities, as well as for monitoring progress.	None	This element is required, but will not be scored.	None

Follow this step to complete Part C in the Background Information section of the form:

Step 1: Indicate the data sources that were used to identify the problem that the QIS aims to address by checking the appropriate box(es) in Element 16.

Issuers may rely on a number of different data sources to inform their strategies. These data sources include, but are not limited to: internal issuer enrollee data; medical records; claims files; surveys such as enrollee satisfaction surveys; plan data such as complaint, appeals, and customer

service records; U.S. Census data; the Area Health Resource Files (AHRF)[21]; all-payer claims data; state health department population data; and/or regional collaborative health data.

Check one or more boxes to indicate which of the data sources listed in Element 16 were used to identify the needs of the QHP enrollee population, identify health and health care disparities within the population (e.g., higher readmission rates in a certain population, prevalence of a particular health condition in a portion of the issuer's Marketplace enrollee population), and/or monitor progress on the QIS. If the issuer used one or more data sources that are not provided on the list, check "Other" and name the appropriate data source(s) in the space provided.

TIP: If you check the box for "Census data," make sure to specify which type of Census data (e.g., tract, zip code, block) the issuer used to identify the problem(s) and to monitor its QIS progress.

2.4 Part D. QIS Summary

Part D of the Implementation Plan and Progress Report form collects information that summarizes the issuer's QIS (e.g., QIS title and description).

Exhibit 11 depicts the elements that issuers must populate in Part D and notes applicable character limits. Responses to both of these elements are required, but will not be scored. There are no associated criteria requested in Part D.

Exhibit 11: Part D. QIS Summary

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
17	QIS Title Provide a short title for the QIS.	None	This element is required, but will not be scored.	100 characters
18	QIS Description Provide a brief summary description of the QIS. The description must include information about all of the following: • Market-based incentive type(s) (see Element 19); • QIS topic area(s) (see Element 20); and • The overall goal(s) of the QIS (no more than two), which should be labeled Goal 1 and Goal 2. (Note: Measures described in Element 24 should be linked to these goals). • Indicate if this is a strategy that the issuer currently has in place for its Marketplace product line and/or other product lines. Also, indicate if this strategy is part of a broader initiative at the state or regional level. • If strategy is part of a state initiative, check "yes" or "no" to indicate whether participation in the initiative is mandatory.	None	This element is required, but will not be scored.	1,000 characters

[21] The AHRF databases can be accessed at: http://ahrf.hrsa.gov/.

Follow these steps to complete Part D in the Implementation Plan Section of the form:

Step 1: Provide a name for the QIS in the space provided for Element 17.

The QIS title provided in Element 17 should be brief, but descriptive.

Step 2: Provide a brief summary description of the QIS in the space provided for Element 18.

The QIS description is a snapshot of some of the QIS elements that are covered in more detail in Part E of the Implementation Plan Section. It should specify the market-based incentive type(s) (e.g., provider, enrollee) and the QIS topic area (e.g., improve health outcomes, prevent hospital readmissions). These two pieces of information should be derived from issuers' responses to Elements 19 and 20, respectively, in Implementation Plan Part E.

The description should also summarize the overall goal or goals (no more than two) of the QIS—drawing a clear link between the goals and the measures identified in Element 24 in QIS Implementation Plan Part E.

Succinctly state if this QIS is one that the issuer currently has in place for its Marketplace product line and/or for other product lines (e.g., Medicaid, commercial). Issuers may use existing strategies that are employed in non-Marketplace product lines if the existing strategy is relevant to their Marketplace population and meets the QIS requirements.[22] Issuers may also use information submitted to a recognized accrediting entity for QIS purposes as long as the information otherwise satisfies the QIS requirements.

Indicate if this QIS is part of a broader quality initiative at the state or regional level. This information will provide context for why the issuer has chosen to implement this QIS. Lastly, if the strategy is part of a state quality initiative, indicate if participation is mandatory.

TIP: Since the QIS description closely relates to your responses to elements and criteria in Part E, double check the consistency, as well as the completeness, of your responses to each element and criteria throughout the Implementation Plan prior to submission.

2.5 Part E. QIS Requirements

Part E of the Implementation Plan and Progress Report form collects detailed information about the QIS (e.g., market-based incentive type, topic area selection, QIS rationale, measure and performance targets to monitor QIS progress) for evaluation.

TIP: Responses are required for all elements and criteria. Six of the elements in Part E are considered must-pass elements; issuers that do not provide sufficient and/or appropriate information for those elements will be required to submit additional information for second review.

[22] For a detailed discussion of the QIS requirements, please refer to Section 5: QIS Requirements.

TIP: QIS submissions will be blinded prior to evaluation. To facilitate timely review, issuers should not include any identifying information in their responses to the elements and criteria in Parts A, C, D, and E.

Exhibit 12 depicts the elements—including must-pass elements—and criteria that issuers must populate in Part E in the Implementation Plan Section of the form. It also notes applicable character limits. Only the critieria (listed in the "Criteria" column in Exhibit 12 below) will be scored. Contextual information (e.g., restatement of goals, listing of activities) is required, but will not be scored.

Exhibit 12: Part E. QIS Requirements

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
19	Market-based Incentive Type(s) (Must Pass)	19a – Check the type of market-based incentive(s) that are used by the QIS. (Check all that apply.) For each market-based incentive type, check the incentive sub-type(s) the QIS includes. (Check all that apply.) If "Other" is selected, briefly describe the market-based incentive sub-type in the space provided.	This element will be scored; Element 19 is a must-pass element.	None
20	Topic Area Selection (Must Pass)	20a – Check box(es) for the topic area(s) this QIS addresses, as defined in the Affordable Care Act. (Check all that apply.) Implementation of activities to reduce health and health care disparities is required. It can be selected as a Topic Area or integrated into relevant Activities (see 23c).	This element will be scored; Element 20 is a must-pass element.	None
21	Targets All Health Plans Offered Through the Marketplace (Must Pass)	21a – Check "All health plans" if the QIS applies to all health plans included in the current QHP Application and Certification Process. Check "Subset of health plans" if the QIS covers a subset of the issuer's health plans.* *Additional QIS Implementation Plan(s) must be submitted for health plans not covered by this QIS. 21b – Indicate the relevant product types to which the QIS applies. (Check all that apply.) 21c – In the space provided, specify all health plans covered by the QIS by listing each Plan's 14-digit unique HIOS Plan ID (Standard Component ID [SCID]). Indicate if each one is a new or existing health plan.	This element will be scored. Element 21 is a must-pass element.	None

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
22	Rationale for QIS (Must Pass) Provide a rationale for the QIS that addresses the criteria at right.	22a – How will the QIS address the needs of the current QHP enrollee population? 22b – If health and health care disparities is not one of the topic areas selected (Element 20), how will the QIS address health and health care disparities?	This element will be scored. Element 22 is a must-pass element.	1,000 characters per criterion
23	Activity(ies) that Will Be Conducted to Implement the QIS (Must Pass) List the activities implemented to achieve the identified goals. Describe how the activities advance the QIS as it relates to the criteria at right.	23a – Market-based incentive selected (see Element 19). 23b – Topic area(s) selected (see Element 20). 23c – Health and health care disparities (if not selected as a separate topic area in Element 20).	This element will be scored. Element 23 is a must-pass element.	1,000 characters per criterion
24	Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress (Must Pass) Restate the goal(s) identified in the QIS Description (Element 18). For each goal, identify at least one (but no more than two) primary measure(s) used to track progress against the goal. For each measure identified, address the criteria at right.	24a – Name of the measure, whether the measure is NQF-endorsed, NQF ID if applicable (NQF-endorsed measures are not required), and if it is not an NQF-endorsed measure OR if NQF specifications were modified, a description of the measure. 24b – Description of how each measure will support tracking of performance related to the goal. 24c – Baseline results for each selected measure, including the rate and associated numerator and denominator, if applicable. If the measure does not have numerator and denominator, provide the appropriate data such as count. 24d – Performance period (e.g., the measurement year) covered by the baseline data assessment. 24e – Performance target.	This element will be scored. Element 24 is a must-pass element.	500 characters per goal; 2,000 characters per measure
25	Timeline for Implementing the QIS Provide information regarding the criteria at right.	25a – The start date for QIS implementation. 25b – Dates for defined milestones (e.g., when updated measure results will be available to assess progress).	This element will be scored. All criteria are required.	100 character limit per milestone in 25b

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
26	Risk Assessment Provide information regarding anticipated barrier(s) and mitigation activities.	26a – List any known or anticipated barriers in implementing QIS activities. 26b – For each barrier identified, describe the mitigation activities that will be incorporated into the QIS if needed.	This element will be scored. All criteria are required.	1,500 character limit per criterion

Follow these steps to complete Part E in the Implementation Plan Section of the form:

Step 1: Select at least one of the market-based incentive types listed in must-pass Element 19.

To complete Criterion 19a, check the box(es) for the market-based incentive type(s) (i.e., provider and/or enrollee) that are used in the QIS.

For each market-based incentive type, check the box or boxes that indicate which incentive sub-type(s) (e.g., increased reimbursement, bonus payment, premium credit, co-insurance reduction) the QIS includes.

If the QIS includes a market-based incentive sub-type that is not listed among the check box options, select "Other" and use the space provided to add the market-based incentive sub-type.

TIP: Refer to Appendix D to complete Element 19.

Step 2: Select at least one of the topic areas listed in must-pass Element 20.

Implementation of activities to reduce health and health care disparities is a priority for the U.S. Department of Health & Human Services (HHS). Issuers are required to address health and health care disparities in their QIS. This may be done in one of two ways: (1) by choosing "Implementation of activities to reduce health and health care disparities" as a topic area addressed by the QIS; *or* (2) by addressing the reduction of health and health care disparities as part of the activities implemented within any other chosen topic area(s).

To complete Criterion 20a, check the box(es) for at least one of the five topic areas defined in the Affordable Care Act.[23]

If "Implementation of activities to reduce health and health care disparities" is not selected as a topic area in Element 20, describe how implementation activities relate to health and health care disparities in Criterion 23c.

[23] Affordable Care Act. Section 1311(g)(1).

Step 3: Identify whether the QIS applies to all health plans the issuer offers or is planning to offer through the Marketplace by checking the appropriate box in must-pass Element 21. Be sure to address all three of the specified criteria.

To complete Criterion 21a, check the box for "All health plans" if the QIS applies to all health plans included in the current QHP Application Period. Check the box for "Subset of health plans" if the QIS covers only some of the health plans offered by the issuer through the Marketplace. If "Subset of health plans" is selected, indicate the number of forms that will be submitted using the space provided (e.g., This is form 1 of 2) since all eligible health plans must be covered by a QIS.

TIP: If this QIS covers only a subset of the issuer's health plans offered through the Marketplace, an issuer must submit additional Implementation Plans so that each health plan offered by the issuer is associated with a QIS.

To complete Criterion 21b, check the appropriate box(es) to indicate the product type(s) (e.g., health maintenance organization [HMO], point of service [POS]) to which the QIS applies.

For Criterion 21c, specify all health plans to which the QIS applies by listing the HIOS Plan ID for each health plan. The HIOS Plan ID, sometimes called the SCID, is a unique 14-character identifier assigned to each health plan. Providing this information will help confirm that each health plan being offered through a Marketplace is associated with a QIS. Also indicate if each one is a new health plan (i.e., a health plan undergoing QHP certification for the first time or a health plan not previously covered by a QIS) or existing health plan.

TIP: For help obtaining the HIOS Plan ID for a health plan, please contact the XOSC Help Desk at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

Step 4: Enter a rationale for the QIS in the space provided for must-pass Element 22. Be sure to address both of the specified criteria.

To complete Criterion 22a, provide a narrative rationale that discusses how the QIS will address the needs of the current[24] QHP enrollee population.

To complete Criterion 22b, describe how the QIS will address health and health care disparities (if health and health care disparities was not one of the topic areas selected in Element 20).

Specifically, the rationale should assess the needs of the QHP enrollee population and identify opportunities to reduce health disparities and gaps related to access, quality, and health outcomes. The following is an evidence-based approach on how health plans may begin to develop interventions to reduce health and health care disparities:

1) Improve data collection on race, ethnicity, language, disability status, sexual orientation, and gender identity;
2) Stratify data and conduct root cause analysis of disparities;
3) Engage consumers and families to identify their needs;

[24] In this context, "current" refers to the QHP enrollee population over the past two years.

4) Develop patient navigation programs to support individuals and create linkages with community resources; and
5) Offer cultural competency trainings for providers and staff.

Step 5: List the activities implemented to achieve the identified goals. Describe how the activities advance the QIS in the space provided in must-pass Element 23. Be sure to address all of the specified criteria.

The activities listed should relate to the goal(s) of the QIS (consistent with the goals identified in Element 18) and should advance the QIS as it relates to: (1) the market-based incentive chosen in Element 19; (2) the topic area(s) chosen in Element 20; and (3) health and health care disparities (if this topic area was not selected in Element 20).

For example, assume an issuer selects "preventing hospital readmissions" as its QIS topic area; "bonus payments to providers" as its market-based incentive; and "reducing readmission rates for the 64-and-under patient population with an index admission of heart failure from the baseline of 22 percent to 15 percent." The activities could include: (1) developing a bonus payment structure based on hospitals meeting measure targets related to providing discharge planning and post-discharge care coordination; (2) establishing an in-hospital visiting nurse program to support development of post-discharge patient care plans; and (3) developing communications materials for patients and providers in Spanish, Mandarin, and Creole that discuss the importance of follow-up care visits and compliance with the post-discharge care plan, and provide information on community supports and services.

To complete Criterion 23a, describe how the QIS activities relate to the selected market-based incentive.

To complete Criterion 23b, describe how the activities relate to the selected topic area(s).

To complete Criterion 23c, describe how the activities relate to health and health care disparities (if not selected as a topic area).

Step 6: Name goal(s), measure(s), and performance targets to monitor QIS progress in the spaces provided in must-pass Element 24. Be sure to address all of the specified criteria.

In the space provided, restate the goal or goals identified in Element 18. For each goal, identify at least one (but not more than two) primary measures that are used to track progress against the goal by providing the measure name for Criterion 24a.

TIP: Issuers may use measures developed by their own organizations (i.e., homegrown measures) or other developers.

Also for Criterion 24a, specify whether the issuer is using a National Quality Forum (NQF)-endorsed measure by checking "Yes" or "No." If yes, provide the NQF ID in the space provided. If no (or if using a measure for which the NQF-specifications have been modified), provide a narrative description of the measure in the space provided.

TIP: You are not required to use NQF-endorsed measures to complete Element 24. However, if you choose to do so, be sure to provide the measures' NQF IDs for identification purposes.

TIP: While CMS does not require issuers to select measures from a set of specific measures for inclusion in their respective QIS implementation plans in the initial years of implementation, use of standardized or uniform performance measures is strongly encouraged.

TIP: CMS encourages issuers to use national benchmarks when establishing their QIS performance targets.

For Criterion 24b, write a narrative description of how each measure supports tracking performance related to the corresponding QIS goal.

For Criterion 24c, enter the baseline data result for each measure (i.e., the rate including numerator and denominator data). If the measure does not have numerator or denominator data, provide a count or other data point in the space labeled "Count or other data point." If there are no applicable data points, enter "Not Applicable."

For Criterion 24d, specify the performance period (e.g., measurement year) covered by the baseline data assessment.

To complete Criterion 24e, provide the performance target for each specified measure.

TIP: In the initial years of implementing a QIS, issuers will not be penalized for failure to meet their performance targets. However, each issuer should strive to achieve progress toward meeting the goals and corresponding performance targets specified in its QIS.

TIP: You should identify no more than two goals in Element 24. Each goal should relate to one or two performance measures.

Step 7: Provide a timeline for implementing the QIS in the space provided for Element 25. Be sure to address all of the specified criteria.

The timeline should include the start date for QIS implementation in Criterion 25a.

For Criterion 25b, the timeline should also include the dates of defined milestones, including, but not limited to, when updated measure results will be available to assess progress.

The dates and milestones provided for those criteria may correspond to the activities identified in Element 23. Issuers will not be penalized if they need to readjust their timelines or redefine their milestones as they move forward with implementation.

Step 8: Provide a risk assessment that describes known or anticipated barriers and mitigation activities in the space provided for Element 26. Be sure to address all of the specified criteria.

Identify any known or anticipated barriers to implementing the QIS activities in Criterion 26a.

To complete Criterion 26b, describe the mitigation activities the issuer will incorporate into the QIS (if needed) for each barrier identified. Issuers will not be penalized for any barriers they may encounter.

Step 9: Save the completed QIS Implementation Plan after verifying that responses have been provided to address all of the elements and criteria.

Review the form to make sure responses have been provided for all elements and criteria. Issuers that leave elements blank and/or do not meet the evaluation threshold for each element must correct and resubmit their Implementation Plans.

TIP: Click the "Check Form" button at the bottom of the form to automatically verify that you have provided responses for all elements. (JavaScript must be enabled for the "Check Form" button to work.) The "Check Form" button will identify any blank fields. Address any omissions by providing responses.

Save the completed QIS Implementation Plan as a PDF file. The file name should follow this naming convention: [HIOS Issuer ID]-[Issuer Name]-QIS. For example, a file named "12345-Issuer ABC-QIS" adheres to the appropriate naming convention.

If an issuer submits more than one Implementation Plan, the file name for each Implementation Plan should also contain a numerical identifier: [HIOS Issuer ID]-[Issuer Name]-QIS-[#]. For example, if an issuer submits two Implementation Plans, the first file should be named "12345-Issuer ABC-QIS-1" and the second file should be named "12345- Issuer ABC-QIS-2." All QIS Implementation Plans must follow these naming conventions when submitted.

TIP: Keep a local copy of the completed Implementation Plan, and make it available to any staff who may be responsible for QIS implementation and reporting. You should refer to your completed Implementation Plan to facilitate any corrective actions you may need to take based on your QIS evaluation results, and to help complete your Progress Report in future years.

3. Submitting the Application and Form

Issuers will submit their completed Implementation Plans, along with all other QHP certification documentation,[25] during the annual QHP Application Period. During the 2017 QHP Application Period, the QHP Application submission window for the FFM will be specified in the 2017 Letter to Issuers. Appendix A contains a detailed timeline of the QHP Application Period for issuers and provides an explanation of each milestone.

TIP: Refer to Appendix A as you develop your QIS implementation timelines, and work to meet reporting deadlines throughout the QHP Application Period.

Issuers submitting quality improvement strategies for health plans offered through the FFM will submit their Implementation Plans through HIOS. Once issuers have typed responses for each applicable element and criteria into the Implementation Plan and saved a local copy of the completed form, they will need to upload to the document to HIOS along with their other QHP Application materials to transmit it to the FFM for evaluation.

[25] The complete set of QHP Application instructions, templates and materials is available at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html.

TIP: Before you submit your Implementation Plan, use the checklist provided in Appendix F to double check your Implementation Plan for completeness, and verify that your QIS addresses all of the elements and criteria, especially the six must-pass elements identified in Exhibit 12.

3.1 Submitting via HIOS

Issuers in the FFM should follow these steps to submit their completed Implementation Plans via HIOS:

Step 1: Open a web browser and go to the CMS Enterprise Portal: https://portal.cms.gov/.

Step 2: Enter the user's Enterprise Identity Management System (EIDM) credentials (i.e., user name and password) to access HIOS.[26]

Step 3: Select the "Issuer Module" to access the QHP Application in HIOS.

Step 4: Select the "Accreditation" section of the QHP Application.

Step 5: Upload the completed Implementation Plan to HIOS.

Issuers must label their submissions according to the aforementioned naming convention: [HIOS Issuer ID]-[Issuer Name]-QIS, for single submissions; and [HIOS Issuer ID]-[Issuer Name]-QIS-[#], for multiple submissions.

TIP: For help accessing HIOS, or for technical assistance related to QIS Implementation Plan submission in HIOS, please contact the XOSC Help Desk at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

3.2 Submitting via SERFF

Issuers submitting quality improvement strategies for health plans offered in states performing plan management functions in the FFM will follow a slightly different submission process. These issuers will submit their Implementation Plans through the System for Electronic Rate and Form Filing (SERFF). Once submitted, their Implementation Plans will be transmitted to the FFM for evaluation.

Issuers operating in states performing plan management functions in the FFM should follow these steps to submit their completed Implementation Plans to the Marketplace via SERFF:

Step 1: Open a web browser and go to the SERFF home page: http://www.serff.com.

Step 2: Enter the user's credentials (i.e., user name and password) to access SERFF.

Step 3: Upload the completed QIS Implementation Plan (in Microsoft Word format) to SERFF.

[26] All issuers must register in the CMS EIDM to gain access to HIOS where they request user roles and obtain HIOS user IDs. Refer to the *Health Insurance Oversight System (HIOS) Portal – User Manual* for detailed instructions and screenshots about how to register in the EIDM to access HIOS.

Issuers must label their submissions according to the aforementioned naming conventions: [HIOS Issuer ID]-[Issuer Name]-QIS, for single submissions; and [HIOS Issuer ID]-[Issuer Name]-QIS-[#], for multiple submissions.

TIP: For information on uploading forms and supporting documents in SERFF, please visit the SERFF website. Questions about SERFF can be directed to the SERFF Help Desk at 1-816-783-8990 or via email at serffhelp@naic.org.

4. Addressing Incomplete or Deficient QIS Submissions

The FFM will evaluate issuers' submissions to determine whether their quality improvement strategies meet the QIS requirements (See Volume I, Section 5). The following steps provide information about what issuers must do if their submissions are incomplete and/or do not meet the QIS requirements.

Step 1: Review the Correction Notice to identify any deficiencies related to the QIS.

The Correction Notice will specify which Implementation Plan elements and criteria need to be addressed by the issuer to meet the QIS requirements, and will offer a brief explanation of why the issuer's response did not meet the QIS evaluation threshold.

Step 2: Open the local copy of the issuer's saved Implementation Plan.

Use the final version that was previously uploaded to HIOS or SERFF and submitted to the FFM for evaluation.

Step 3: Edit the responses to the elements and/or criteria that were identified in the Correction Notice as requiring attention.

The issuer should edit or rewrite its responses to the elements and criteria that the FFM indicated do not meet the QIS requirements. The revised or new responses should be sure to address the identified deficiencies by providing additional information, clarifying existing information, or including missing information as directed by the Correction Notice.

The issuer should not make any changes to its response for elements and/or criteria that were not specifically identified in the Correction Notice.

Step 4: Save a local copy of the revised Implementation Plan.

Make sure to save the local copy of the revised Implementation Plan and make it available to the appropriate staff.

Step 5: Upload the revised Implementation Plan to HIOS or SERFF (as appropriate).

Follow the steps provided in Volume II, Section 3, to submit the revised Implementation Plan to the Marketplace. Issuers operating in the FFM should submit via HIOS; issuers operating in states performing plan management functions in the FFM should submit via SERFF.

5. Completing the QIS Progress Report

In each subsequent year following the submission of its QIS Implementation Plan, an issuer must submit a Progress Report to the applicable Marketplace. The Progress Report is comprised of four sections of the QIS Implementation Plan and Progress Report form that collect information about the issuer's progress in implementing its QIS.

TIP: Issuers must submit only an Implementation Plan during the 2017 QHP Application Period. They do not need to submit a Progress Report until the 2018 Application Period.

To complete the Progress Report, issuers must:

- Complete the **QIS Submission Type** section (Part A)
- Complete the **Background Information** section (Parts B and C);
- Confirm the **Implementation Plan Section** (Parts D and E) is completed with the prior year's information; and
- Complete the **Progress Report Section** (Part F).

TIP: Issuers will already have completed the Background Information section (Parts B and C) when they submitted their Implementation Plans; however, they should review the information in this section and make any updates prior to submitting their Progress Reports.

Exhibit 13 lists Progress Report elements and criteria that issuers must complete in Part F of the QIS Implementation Plan and Progress Report form. Appendix C contains the QIS Implementation Plan and Progress Report form in its entirety.

Exhibit 13: Part F. Progress Report Summary

Element #	Element Name	Criteria
27	Addition of Health Plans to the Issuer's QIS	27a – Check "Add health plan(s)" if the issuer is adding health plans to its existing QIS. Check "No additional health plans" if the issuer is not adding any health plans to its existing QIS. 27b – If "Add health plan(s)" was selected, list all new health plans and provide each plan's 14-digit unique HIOS Plan ID (Standard Component ID). Select "Not Applicable" if no new health plans were included.
28	QIS Modifications	28a – If "Continuing a QIS with Modifications" was selected in Element 1, please indicate what type of modification the issuer is making to its QIS. (Check all that apply.) If "Continuing a QIS with Modifications" was not selected in Element 1, check "Not Applicable." 28b – Provide a justification and brief description of the modification(s) selected in 27a. Check "Not Applicable" if no modifications were/will be made.

Element #	Element Name	Criteria
29	Analyze Progress Using Baseline Data, as Documented in Implementation Plan Restate the goals identified in the Implementation Plan (Elements 18 and 24). For each goal, identify at least one (but no more than two) primary measures used to track progress against the goal. For each measure identified, provide the criteria at right.	29a – Performance period (e.g., the measurement year) covered by the updated data. 29b – Measure name (this should be the same as what was included in the Element 24). 29c – Baseline results for each selected measure, including the rate and associated numerator and denominator, if applicable (this should be the same figure entered in Element 24); - If the measure does not have numerator and denominator, provide the appropriate data such as count. 29d – Most up-to-date numerator and denominator data (if applicable) and rate (if applicable) available since the last QIS submission (last QHP Application Period); - If measure does not have numerator, denominator, and rate, provide a count or other data point (See Criterion 24c). 29e – Summary of progress, including reasons why progress toward the performance target documented in Element 24 was or was not made. (Include the baseline rate and activities.) If applicable, indicate whether the information provided here affects the decision to modify or change the QIS.
30	Summary of Progress	30a – Summary of progress, including reasons why progress was or was not made toward the performance target(s) documented in Element 24. Include a description of activities that led to the outcome. If applicable, indicate whether the information provided here affects the decision to modify or change the QIS.
31	Barriers	31a – Check the appropriate box to indicate if barriers were encountered when implementing the QIS. 31b – Check the appropriate box to indicate if there were problems meeting timelines. 31c – If "Yes" was selected in 31a or 31b, describe the barriers and/or problems in implementing the QIS or meeting timelines. If "No" was selected in 31a or 31b, select "Not Applicable."
32	Mitigation Activities	32a – If "Yes" was selected in 31a or 31b, describe the mitigation activities implemented to address each barrier or problem in meeting the timeline. Also, describe the result(s) of the mitigation activities. If "No" was selected in 31a and 31b, select "Not Applicable."

The *QIS Technical Guidance & User Guide for the 2018 Coverage Year*, which will be published in the fall of 2016, will include additional details on the elements and criteria that are required in the Progress Report, scoring information, and step-by-step instructions on completing the Progress Report sections.

Future versions of this User Guide will also provide specific instructions about how to complete the QIS Implementation Plan and Progress Report form for scenarios that will arise during the

2018 QHP Application Period and beyond (e.g., submitting a QIS with modifications, submitting a new QIS while discontinuing a previous QIS). See Appendix D for an overview of the scenarios an issuer may encounter in future years related to the completion of the QIS Implementation Plan and Progress Report form.

Appendices

Appendix A. QIS Timeline for 2017 QHP Application Period

Event	Stakeholder(s) Responsible	Date[27]
QHP Application Submission and Review Process		
Initial FFM QHP Application Submission Window	Issuer	Spring 2016
FFM Review of QHP Application Submissions as of Initial Submission Deadline of May 15	CMS	Spring 2016
1st Correction Notice Sent	CMS	Spring 2016
Deadline for Submission of Revised QHP Data for Second Review	Issuer	Summer 2016
FFM Reviews of Corrected QHP Application Submissions	CMS	Summer 2016
2nd Correction Notice Sent	CMS	Summer 2016
Final Deadline for Submission of QHP Data; Final Deadline for State Plan Approval; Deadline for All Risk Pools with QHPs to be in "Final" Status in the URR System; Data Lock Down	Issuer, CMS	Summer 2016
Final Review of Corrected QHP Application Submissions	CMS	Late Summer 2016
QHP Agreement/Final Certification		
Certification Notices & QHP Agreements Sent to Issuer	CMS	Fall 2016
Agreements Signed by Issuers & Returned with Final Plan	Issuer	Fall 2016
Validation Notice Confirming Final Plan List & Countersigned Agreements Sent	Issuer and CMS	TBD
Open Enrollment		Fall 2016 – January 2017
Work Plan Stage		**TBD**
FFM coordinates with issuers to develop and approve Work Plan as needed	Issuer and CMS	TBD
Issuer demonstrates that it is meeting the goals of its Work Plan	Issuer	TBD
FFM sends out end-of-year notice for all certification standards	CMS	Winter 2016

[27] These dates will be updated in future iterations of this document to be consistent with the 2017 Letter to Issuers, which will be published in fall 2015.

Appendix B. Relevant Statutory and Regulatory Citations

Patient Protection and Affordable Care Act, 42 U.S.C. Sec. 18031 (March 23, 2010)

Topic	Provisions	Citation
Marketplace standards for quality improvement strategies	(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES — (1) STRATEGY DESCRIBED — A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for— (A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; (B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; (C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; (D) the implementation of wellness and health promotion activities; and (E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings. (2) GUIDELINES — The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1). (3) REQUIREMENTS — The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).	Section 1311(g)

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, 77 Fed. Reg. 18310-18475 (March 27, 2012)

Topic	Provisions	Citation
Marketplace standards for quality activities	(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.	45 CFR § 155.200(d) Functions of an Exchange

Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final Rule, 79 Fed. Reg. 30240-30353 (May 27, 2014)

Topic	Provisions	Citation
QHP certification standards	(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. (b) *QHP issuer requirement.* A QHP issuer must— (5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Affordable Care Act consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act; (h) As a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements described in subparts D, E, H, K, L, and M of this part.	45 CFR § 156.200(a),(b)(5),(h) QHP issuer participation standards
QHP certification standards	a) *Definition.* The following definition applies in this subpart: Multi-State plan means a health plan that is offered in accordance with section 1334 of the Affordable Care Act. (b) *General requirement.* The Exchange must offer only health plans which have in effect a certification issued or are recognized as plans deemed certified for participation in an Exchange as a QHP, unless specifically provided for otherwise. (c) *General certification criteria.* The Exchange may certify a health plan as a QHP in the Exchange if— (1) The health insurance issuer provides evidence during the certification process in §155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156, as applicable; and (2) The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, except that the Exchange must not exclude a health plan— (i) On the basis that such plan is a fee-for-service plan; (ii) Through the imposition of premium price controls; or (iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.	45 CFR § 155.1000, Certification standards for QHPs

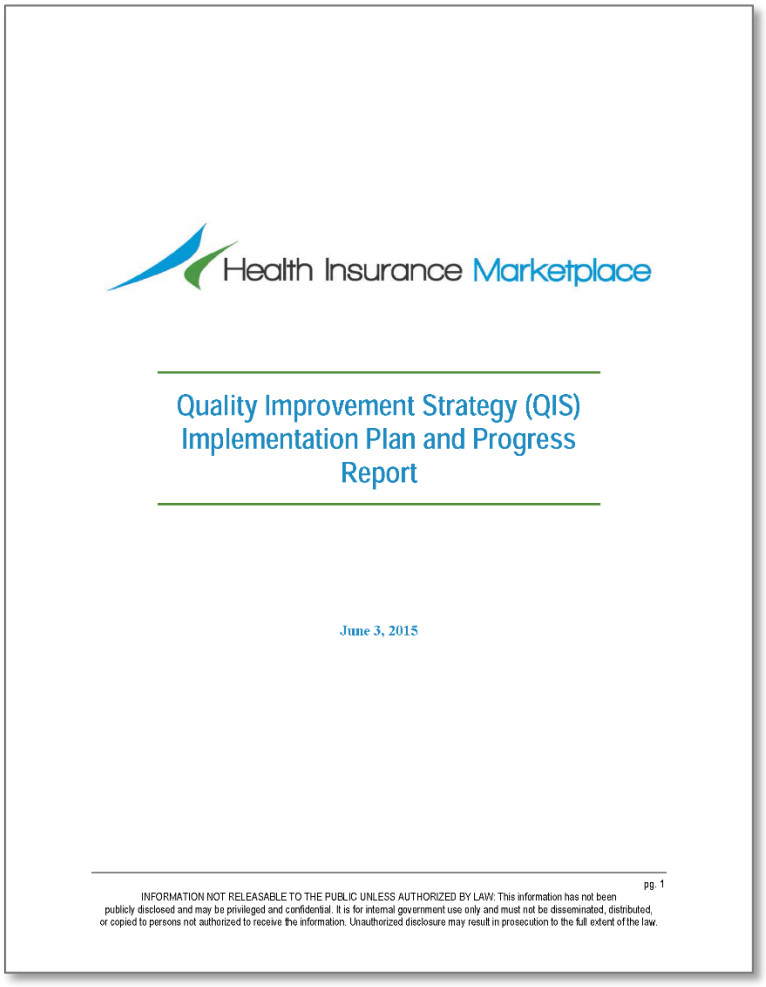
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule, 80 Fed. Reg. 10750-10877 (February 27, 2015)

Topic	Provisions	Citation
Quality improvement strategy	*(a) General requirement*. A QHP issuer participating in an Exchange for 2 or more consecutive years must implement and report on a quality improvement strategy including a payment structure that provides increased reimbursement or other market-based incentives in accordance with the health care topic areas in section 1311(g)(1) of the Affordable Care Act, for each QHP offered in an Exchange, consistent with the guidelines developed by HHS under section 1311(g) of the Affordable Care Act. *(b) Data requirement.* A QHP issuer must submit data that has been validated in a manner and timeframe specified by the Exchange to support the evaluation of quality improvement strategies in accordance with § 155.200(d) of this subchapter. *(c) Timeline.* A QHP issuer must submit data annually to evaluate compliance with the standards for a quality improvement strategy in accordance with paragraph (a) of this section, in a manner and timeframe specified by the Exchange. *(d) Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (b) of this section to the U.S. Office of Personnel Management, in the manner and timeframe specified by the U.S. Office of Personnel Management.	45 CFR § 156.1130, Quality Improvement Strategy

Appendix C. QIS Implementation Plan and Progress Report Form

The QIS Implementation Plan and Progress Report Form is currently available for review and public comment on the CMS website at: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10540.html

Public comments on the form will be accepted on the Regulations.gov website until July 20, 2015. To submit comments, visit: http://www.regulations.gov/#!documentDetail;D=CMS_FRDOC_0001-1722



Health Insurance Marketplace

Quality Improvement Strategy (QIS) Implementation Plan and Progress Report

June 3, 2015

pg. 1

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Appendix D. Scenarios for Form Completion Based on Type of QIS Submission

This appendix outlines common situations for issuers seeking to comply with the QIS requirements, and provides information about what sections of the QIS Implementation Plan and Progress Report form they should complete based on the type of QIS submission.

The "Type of QIS Submission" column in the table below corresponds to the check box selections found in the QIS Submission Type section (Part A) of the QIS Implementation Plan and Progress Report form. All issuers must complete the QIS Submission Type section (Part A) of the form annually, in additional to any other required sections.

Scenarios for Form Completion Based on Type of QIS Submission

Type of QIS Submission	Issuer and Prior QIS Submission History	QIS Implementation Plan and Progress Report Sections to be Completed
New QIS[28] with No Previous QIS Submission	▪ The issuer has offered health plans through a Marketplace for at least two consecutive years, AND ▪ Has not previously submitted a QIS Implementation Plan[29]	▪ Complete the Background Information section (Parts B and C), AND ▪ Complete the QIS Implementation Plan Section (Parts D and E)
New QIS After Discontinuing a QIS Submitted During the Most Recent QHP Application Period	▪ The issuer has previously submitted a QIS Implementation Plan and a QIS Progress Report based upon that Plan, AND ▪ The issuer intends to discontinue its previous strategy to implement a new QIS (i.e., one with a different market-based incentive and/or topic area than its previous QIS)	▪ Complete two forms; one to close out the discontinued QIS: ▪ Complete the Background Information section (Parts B and C) ▪ Complete the QIS Implementation Plan Section (Parts D and E) ▪ Complete the QIS Progress Report Section (Part F), AND ▪ Complete a new/separate form to submit the new QIS: ▪ Complete the Background Information section (Parts B and C) ▪ Complete the QIS Implementation Plan Section (Parts D and E) section

[28] Note: A "new QIS" is defined as a QIS that has not been previously submitted to the FFM for evaluation, or is a QIS that is based upon a different market-based incentive(s) and/or topic area(s) than the issuer's previous QIS.
[29] The issuer must not have submitted a QIS Implementation Plan for the health plans that will be covered by the QIS for which the issuer is currently completing the QIS Implementation Plan and Progress Report form. If a subset of an issuer's health plans is covered by a different QIS, then the issuer may have previously submitted a QIS for those plans, but may still select "New QIS with No Previous QIS Submission" as long as the current QIS addresses a different subset of health plans entirely from what was previously submitted.

Type of QIS Submission	Issuer and Prior QIS Submission History	QIS Implementation Plan and Progress Report Sections to be Completed
Continuing a QIS with No Modifications	▪ The issuer previously submitted an QIS Implementation Plan and will continue without any changes	▪ Update the Background Information section (Parts B and C) as needed, AND, ▪ Confirm the QIS Implementation Plan Section (Parts D and E) is completed with the prior year's information, AND ▪ Complete the QIS Progress Report Section (Part F) ▪ ▪ *Note: Parts D and E should remain unchanged. Those sections will have been populated during the previous QHP Application Period.*
Continuing a QIS with Modifications	▪ The issuer previously submitted a QIS Implementation Plan, AND ▪ Made changes to the QIS related to performance measures, targets, and/or activities that do not meet the definition of a new strategy *Note: Only the types of modifications listed above are permissible when modifying a QIS. If the issuer would like to make other types of changes to its QIS, it should follow the instructions provided for "New Strategy After Discontinuing A QIS Submitted During the Most Recent QHP Application Period."*	▪ Update the Background Information section (Parts B and C) as needed, AND ▪ Update the QIS Implementation Plan Section (Parts D and E) as needed based on modifications, AND ▪ Complete the QIS Progress Report Section (Part F)

Appendix E. Market-Based Incentive Examples

The tables below provide definitions and examples of provider and enrollee market-based incentive strategy types, respectively. The examples are demonstrative of the type of market-based incentives an issuer's QIS should include, but the list is not exhaustive. Issuers should refer to these tables when responding to Element 19 in the Implementation Plan and Progress Report form.

Examples and Definitions of Market-Based Incentives for Providers

Provider Market-based Incentive Examples	Market-based Incentive Type Definition
Increased Reimbursement	Providers receive a higher payment based on whether they meet certain quality performance targets. If providers meet performance targets, they receive the maximum eligible payment but if they do not meet all of the performance targets, they receive only a portion of the maximum payment they are eligible to receive.
Bonus Payments	An additional incentive payment (beyond regular FFS payments) to providers, contingent on meeting certain measure-based performance targets.
In-kind Incentives	In-kind incentives do not use a direct financial payment. In-kind incentives are the provision of non-financial resources for the purpose of supporting quality improvement. These may include, but are not limited to, in-office nurses or physician extenders, staffing support to conduct care coordination, technical support for data collection, and/or health IT implementation.

Examples and Definitions of Market-Based Incentives for Marketplace Enrollees

QHP Enrollee Market-based Incentive Examples	Market-based Incentive Type Definition
Premium Credit	A reduction in the member's premium (i.e., the monthly, quarterly or yearly amount a member pays for health insurance coverage).
Co-payment Reduction or Waiver	A decrease in the co-payment or waiver of the entire co-payment amount a member would pay for a covered health care service, usually at the time of service.
Co-insurance Reduction	A decrease in co-insurance. Co-insurance is typically calculated as a percentage (e.g., 20%) of the allowed amount for the service, not including the deductible.
Cash or Cash Equivalents	The health plan pays the member cash or a cash equivalent as a reward for making certain choices or exhibiting behaviors associated with improved health. Examples of cash equivalent rewards include gift cards, gift certificates, diner's club points, provision of transportation, and memberships to gyms or other programs.

Appendix F. QIS Implementation Plan Pre-Submission Checklist

This checklist is intended to help issuers verify the completeness of their Implementation Plans, check that their responses address all of the elements and criteria—especially the must-pass elements, and guide them through the QIS submission process.

QIS IMPLEMENTATION PLAN PRE-SUBMISSION CHECKLIST

A. PREPARATION

- ☐ Review the entire 2017 QIS Technical Guidance & User Guide, as well as the relevant sections of the 2017 Letter to Issuers and 2017 Payment Notice Final Rule.
- ☐ Print or save each QIS-related document listed on the QHP Application website.
- ☐ Download and save a local copy of the fillable PDF of the QIS Implementation Plan and Progress Report.

B. COMPLETE THE FORM

- ☐ Enable JavaScript in the fillable PDF form before you entered your QIS information.
- ☐ Use the character count function to provide responses that stay within the character limits for each field.
- ☐ Pay attention to the pop-up messages that will notify you if you have not provided a response in any of the fields.
- ☐ Complete the QIS Submission Type section (Part A) by checking "New QIS with No Previous QIS Submission."
- ☐ Complete all elements in Part B: Issuer Information, in the Background Information section.
- ☐ In Elements 2-5 in Part B, use the same information that was included elsewhere in the QHP Application templates.
- ☐ Complete Part C: Data Sources Used for Problem Identification and Monitoring Progress, in the Background Information section.
- ☐ Complete all of the elements and criteria in Part D: QIS Summary, in the QIS Implementation Plan Section.
- ☐ Complete all of the elements and criteria in Part E: QIS Requirements, in the QIS Implementation Plan Section.
- ☐ Confirm that you have provided responses for all elements—including must-pass elements—and criteria in all parts the form, either by providing QIS information or by selecting "Not Applicable."
- ☐ Confirm that you were consistent in your answers across all elements and criteria.
- ☐ Use the "Check Form" button at the bottom of the form to highlight any fields that are missing responses; complete these highlighted fields.

C. SUBMIT THE FORM

- ☐ Save a local copy of the form using the appropriate file naming convention.
- ☐ Upload the completed copy of the QIS Implementation Plan and Progress Report form to HIOS or SERFF, as appropriate.
- ☐ Share your QIS submission with the issuer's staff who are responsible for the QIS, so they may refer to it throughout the year as needed and access it during the next QHP Application Period.
- ☐ Verify that each applicable health plan offered by the issuer is covered by a QIS; submit additional QIS Implementation Plan and Progress Report forms as necessary.

Appendix G. Glossary

Unless otherwise stated in this document, the definitions below apply to key terms and are QIS-specific; some of these terms may be defined differently in other contexts.

Term	Definition
Areas Health Resources Files (AHRF)	The AHRF are Health Resources and Service Administration (HRSA) databases that provide a comprehensive set of county, state and national data. The data offer a broad range of health resources and socioeconomic indicators which impact demand for health care.
certification	The process by which health plan issuers are evaluated and recognized as meeting the predetermined criteria and standards described in 45 CFR 156 Subpart C.[30]
CMS Quality Strategy	The vision for the CMS Quality Strategy is to optimize health outcomes by leading clinical quality improvement and health system transformation. The CMS Quality Strategy is built on the foundation of the CMS Strategy, and the HHS National Quality Strategy. The CMS Quality Strategy pursues and aligns with the three broad aims of the National Quality Strategy and its six priorities. Each of these priorities has become a goal in the CMS Quality Strategy. Four foundational principles guide the Agency's action toward each of these goals: 1. Make care safer by reducing harm caused in the delivery of care. 2. Strengthen person and family engagement as partners in their care. 3. Promote effective communication and coordination of care. 4. Promote effective prevention and treatment of chronic disease. 5. Work with communities to promote best practices of healthy living. 6. Make care affordable.[31]
co-insurance	A QHP enrollee's share of the costs of a covered health care service, calculated as a percent (e.g., 20%) of the allowed amount for the service.[32]
co-payment	A fixed amount a QHP enrollee pays for a covered health care service, usually at the time of service. The amount can vary by the type of covered health care service.[33]
Criteria	The rules that a Marketplace will use to evaluate whether an issuer's quality improvement strategy fulfills requirements; the specifics listing how the issuers are developing and implementing their QIS submissions. Criteria are associated with an element and describe the type of information issuers must provide.
element	Identifying and descriptive information that issuers will use to complete the QIS Implementation Plan and QIS Progress Report. Each element has associated criteria that describe the type of information issuers must provide.
evaluation tool	Tool used to provide issuers with the evaluation results of their QIS Implementation Plan and subsequent QIS Progress Reports. The evaluation tool lists the QIS criteria with options to score as "meets," "does not meet," or "not applicable."
Exclusive Provider Organization (EPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO enrollees will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.

[30] Affordable Care Act. http://housedocs.house.gov/energycommerce/ppacacon.pdf

[31] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy-Goals-Poster.pdf

[32] https://www.healthcare.gov/glossary/co-insurance/

[33] https://www.healthcare.gov/glossary/co-payment/

Term	Definition
Federally-facilitated Marketplace (FFM) or Federally-facilitated Exchange (FFE)	The Marketplace model operated by HHS for individual and small group market coverage.
Health Insurance Marketplace (Marketplace) or Health Insurance Exchange (Exchange)	A resource in each state where qualified individuals, families, and small businesses can learn about their health insurance options; compare QHPs based on quality, costs, benefits, and other important features; choose a QHP; and enroll in coverage. In some states, the Marketplace is operated by the state. In others, it is operated by the federal government.
Health Insurance Oversight System (HIOS)	A data submission tool that allows CMS to collect data from states and individual and small group market QHP issuers, which will be aggregated with other data sources and made public on a consumer-facing website. The initial mechanism for the states and QHP issuers to submit their data is through the use of the HIOS form.
health maintenance organization (HMO)	A type of health insurance plan that usually limits coverage to care from providers who work for or contract with the HMO and generally will not cover out-of-network care, except in an emergency.
hospital value-based purchasing program	Hospital Value-Based Purchasing is part of the Centers for Medicare & Medicaid Services' long-standing effort to link Medicare's payment system to a value-based system to improve health care quality, including the quality of care provided in the inpatient hospital setting. The program attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country. Participating hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide. Congress authorized Inpatient Hospital VBP in Section 3001(a) of the Affordable Care Act. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting (IQR) Program, which was authorized by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[34]
Medicare Shared Savings Program	The Centers for Medicare & Medicaid Services has established a Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by: ▪ Promoting accountability for the care of Medicare FFS beneficiaries ▪ Requiring coordinated care for all services provided under Medicare FFS ▪ Encouraging investment in infrastructure and redesigned care processes The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Participation in an ACO is purely voluntary.[35]
National Quality Forum (NQF)	NQF is an organization that—as part of its mission—uses a multi-stakeholder process to evaluate quality measures for endorsement. All NQF-endorsed measures are given an ID number. A list of endorsed measures can be found in NQF's Quality Positioning System (http://www.qualityforum.org/QPS/QPSTool.aspx).

[34] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing/

[35] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/

Term	Definition
National Quality Strategy (NQS)	The NQS was first published in March 2011 as the National Strategy for Quality Improvement in Health Care, and is led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHJS). Mandated by the Patient Protection and Affordable Care Act, the NQS was developed through a transparent and collaborative process with input from a range of stakeholders. More than 300 groups, organizations, and individuals, representing all sectors of the health care industry and the general public, provided comments. Based on this input, the NQS established a set of three overarching aims that builds on the Institute for Healthcare Improvement's Triple Aim®, supported by six priorities that address the most common health concerns that Americans face. To align with NQS, stakeholders can use nine levers to align their core business or organizational functions to drive improvement on the aims and priorities.[36]
payment structure	Provider payments or enrollee benefits used by health plans to improve quality and reduce costs by incentivizing providers and enrollees towards high-value rather than volume-driven care.[37]
physician value-based payment modifier	Section 3007 of the Affordable Care Act mandated that, by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule. Both cost and quality data are to be included in calculating payments for physicians. • Physicians in group practices of 100 or more eligible professionals (EPs) who submit claims to Medicare under a single tax identification number (TIN) will be subject to the value modifier in 2015, based on their performance in calendar year 2013. • Physicians in group practices of 10 or more EPs who participate in Fee-For Service Medicare under a single TIN will be subject to the value modifier in 2016, based on their performance in calendar year 2014. • For 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group practice's physicians participate in the Medicare Shared Savings Program, Pioneer ACOs, or the Comprehensive Primary Care Initiative. • All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017.[38]
performance measure	The quantitative data that issuers will use to measure whether their quality improvement strategy is meeting their established goals.
Point of Service (POS)	A type of health insurance product modeled after an HMO, but with an opt-out option. In this type of product, enrollees may choose to receive services either within the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner). The level of benefits or reimbursement is generally determined by whether the enrollee uses in-network or out-of-network services.
Preferred Provider Organization (PPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. PPO enrollees may use providers outside of this network, but out-of-network services are usually covered at a reduced rate (e.g., reduced reimbursement percentages, higher deductibles, higher co-payments).
premium	The amount that must be paid monthly, quarterly or yearly for an enrollee's health insurance.
provider	A provider is an organization, institution, or individual that is a supplier of medical services.

[36] http://www.ahrq.gov/workingforquality/about.htm

[37] http://www.innovations.ahrq.gov/issue.aspx?id=157

[38] http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Term	Definition
QIS evaluation	The process for assessing and scoring an issuer's QIS submission to determine whether the issuer has fulfilled the QIS requirements.
QIS evaluation threshold	The standard for demonstrating compliance with the QIS requirements, which will be meeting a predefined number of evaluation criteria and must-pass criteria.
QIS Implementation Plan and Progress Report	The QIS Implementation Plan and Progress Report is a form issuers use for annual reporting to the Marketplace. The form is comprised of four sections: QIS Submission Type, Background Information, QIS Implementation Plan Section, and QIS Progress Report Section. Issuers will complete the QIS Implementation Plan Section of the form, along with the QIS Submission Type and Background Information sections, to describe their quality improvement strategies and submit them to the Marketplace beginning with the 2017 QHP Application Period. Taken together, these three sections of the form are called the Implementation Plan, and are referred to as such throughout this User Guide. Beginning with the 2018 QHP Application Period, issuers that submitted QIS Implementation Plans in 2017 QHP Application Period will complete the QIS Progress Report Section of the form annually to communicate their quality improvement strategies' progress to the Marketplace.
QIS requirements	The statutory requirements, according to 1311(g) and subsequent federal regulations including: (1) Implementation of a quality improvement strategy described as a payment structure that provides increased reimbursement or other incentives for; (2) Addressing at least one of the five topic areas listed in Section 1311(g); (3) Complying with guidelines established by the Secretary of HHS in consultation with experts in health care quality and stakeholders; and (4) Reporting strategy progress to the applicable Marketplace on a periodic basis.
QIS scoring methodology	The criteria used to systematically determine a strategy's merit, using criteria governed by a set of standards.
QHP Application and Certification Process	The process by which issuers apply for QHP certification, and through which the Marketplace reviews applications and makes QHP certification determinations.
QHP Application Submission and Review Period (QHP Application Period)	The specific timeframe in which an issuer submits its QIS to the Marketplace for evaluation and review, and the Marketplace notifies issuers if their QIS submissions have been approved. The period typically takes place from mid-March to mid-September.
Qualified Health Plan (QHP)	A QHP is a health insurance plan that has in effect a certification that it meets the standards established by the Affordable Care Act and supporting regulation, issued or recognized by each Marketplace through which such plan is offered.[39]
Qualified Health Plan issuer (QHP issuer)	A health insurance issuer that offers a QHP in accordance with a certification from a Marketplace, as defined by 45 CFR § 155.20. Each QHP issuer is defined by a separate federal Health Insurance Oversight (HIOS) Issuer ID. Each QHP issuer is defined by a state geographic unit.[40] An issuer is considered to be a "QHP issuer" once certification has been completed.
quality improvement	Documented improvement in defined health care quality indicators. Quality improvement is process-based, data driven and a continuous process.
quality improvement strategy (QIS)	A QIS (as a noun) as described in Section 1311(g) of the Affordable Care Act is implemented by an issuer to satisfy the statutory requirements to participate in Marketplaces.

[39] Final Rule on Exchange and Insurance Market Standards for 2015 and Beyond. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf

[40] Final Rule on Exchange and Insurance Market Standards for 2015 and Beyond. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf

Term	Definition
QIS (as a modifier)	The QIS acronym can also be used as a modifier to provide context (e.g., QIS legislation, QIS implementation).
Quality Rating System (QRS)	The QRS is a rating system, similar to CMS' Medicare Stars, designed to inform consumer and employer selection of QHPs offered through the Marketplaces.
State-based Marketplace (SBM) or State-based Exchange	A Marketplace model in which a state operates its own Health Insurance Marketplace, for both the individual and small group markets. An SBM is responsible for certifying QHP issuers, overseeing QHP issuer compliance with federal Marketplace quality standards as a condition of certification, and, starting with the open enrollment period that begins in the fall of 2016, displaying quality rating information on the SBM website for consumer access.
States performing plan management functions in the FFM	Includes FFM states where the states perform plan management functions. Consumers in these states apply for and enroll in coverage through the FFM.
System for Electronic Rate Filing and Forms (SERFF)	SERFF is an electronic filing mechanism that allows for standardized health product filings, including rate review and QHP submissions. SERFF is affiliated with the National Association of Insurance Commissioners (NAIC).
topic areas	The specific areas for quality improvement cited in Section 1311(g) of the Affordable Care Act. They include health outcomes, readmissions, patient safety, wellness and health promotion, and disparities.
Work Plan	A detailed plan developed by an issuer that provides a resolution for any identified errors during the QHP Application Period. An issuer's Work Plan is submitted to the Marketplace for evaluation following the QHP Application Submission and Review Period.

Appendix H. Acronym List

This appendix includes a list of commonly used acronyms and their definitions.

Acronym	Complete Term or Name
CCIIO	Center for Consumer Information & Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
FFM	Federally-facilitated Marketplace
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
NQF	National Quality Forum
NQS	National Quality Strategy
POC	Point of Contact
QHP	Qualified Health Plan
QIS	Quality Improvement Strategy
QRS	Quality Rating System
SBM	State-based Marketplace
SERFF	System for Electronic Rate and Form Filing
XOSC	Exchange Operations Support Center