Health Insurance Marketplace

# Quality Improvement Strategy: Overview of 2017 Requirements for Issuers

Issue Brief November 2015

## Background

In accordance with section 1311(g) of the Affordable Care Act entitled "Rewarding Quality Through Market-Based Incentives,"[1] an eligible issuer participating in a Marketplace for two or more consecutive years must implement, and report on, a quality improvement strategy (QIS). A QIS should incentivize quality by tying payments to performance measures when providers meet specific quality indicators. A QIS may also tie payments to measures related to incentivizing enrollees to make certain choices or exhibit behaviors associated with improved health.

## QIS Participation Criteria

### Who must participate?

An issuer applying for QHP certification in the Federally-facilitated Marketplaces (FFMs) for the 2017 coverage year must submit a QIS if it: 1) offered coverage through the Marketplace in 2014 and 2015; 2) provides family and/or adult-only medical coverage; and 3) meets the QIS minimum enrollment threshold. An issuer meets the QIS minimum enrollment threshold if it had more than 500 enrollees within a product type[2] as of July 1, 2015. Additionally, each eligible Qualified Health Plan (QHP) within a product type that has more than 500 enrollees as of July 1, 2015, must be included in a QIS.

The QIS requirements apply to all issuers offering QHPs and Multi-state Plan (MSP) options, whether through the individual market or through the Small Business Health Options Program (SHOP). At this time, QIS requirements do not apply to child-only plans, stand-alone dental plans, or QHPs that are compatible with health savings accounts.

### What is required?

All eligible issuers must comply with the following requirements:

(1) Implement a QIS, described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
(2) Implement a QIS that includes 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. Activities for wellness and health promotion; and
   v. Activities to reduce health and health care disparities.
(3) Adhere to guidelines, including the QIS Technical Guidance and User Guide for the 2017 Coverage Year, established by HHS in consultation with health care quality experts and stakeholders.
(4) Report on progress implementing the QIS to the applicable Marketplace on a periodic basis.

Issuers seeking to offer coverage through the FFMs or in states performing plan management functions in the FFMs[3] should refer to the QIS Technical Guidance and User Guide for details. Issuers in State-based Marketplaces (SBMs) should contact the Marketplace through which they are offering coverage for information. Issuers offering MSP options should contact the Office of Personnel Management (OPM) to confirm the timing and requirements associated with QIS implementation for MSPs. The following table outlines key timeframes associated with the QHP Application Submission and Review Period (QHP Application

[1] Section 1311(c)(1)(E) of the Affordable Care Act, 45 CFR. § 156.200(b) and 45 CFR. § 156.1130.

[2] QIS eligible product types include: health maintenance organizations (HMO), preferred provider organizations (PPO), point of service (POS) plans, exclusive provider organizations (EPO), and indemnity plans. At this time, QIS requirements do not apply to child-only plans, stand-alone dental plans (SADPs), or Qualified Health Plans (QHPs) that are compatible with health savings accounts.

[3] Includes FFM states where the states perform plan management functions. Consumers in these states apply for and enroll in coverage through the FFMs.

Period) for the 2017 Coverage Year, assuming a November 1, 2016, open enrollment start date.

### Stages of QIS Implementation

| Activity | Timeframe |
|---|---|
| Issuers develop quality improvement strategies for the 2017 coverage year | Fall 2015 – April 2016 |
| QHP application submission window for the 2017 coverage year | April 2016 – May 2016 |
| QHP application evaluation window for the 2017 coverage year | May 2016 – August 2016 |
| Final QHP certification for the 2017 coverage year | September 2016 |

## QIS Reporting Requirements

### What needs should a QIS address?

A QIS does not have to address the needs of all enrollees in a given QHP offered through a Marketplace. Based on the rationale an issuer provides in its QIS submission, a QIS may address a sub-population in a QHP's enrollee population, depending on the sub-population's identified needs. Eligible issuers must use data to identify and describe the health outcome needs and priorities of their enrollees when reporting on their QIS Implementation Plan. For example, if an issuer has a large proportion of diabetic enrollees, it may elect to tailor its QIS to the topic areas of improving health outcomes and increasing health and wellness activities, and incentivize physicians that demonstrate improvement in performance measures related to specific diabetic care, or that are focused on improving other diabetic patient health outcomes.

### How will an issuer complete a QIS?

An issuer applying for QHP certification in the FFMs for the 2017 coverage year is expected to submit a QIS Implementation Plan and Progress Report form during the 2016 QHP application submission window, and then implement the QIS beginning no later than January 2017.[4] 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.

There are two ways an issuer may implement and report on a QIS: (1) implement one QIS that applies to all of its eligible QHPs in a given Marketplace; or (2) implement more than one QIS, if having just one QIS does not address all of its eligible QHPs. All of the issuer's QHPs offered through a Marketplace that meet the participation criteria described in in the QIS Technical Guidance and User Guide must be covered by a QIS.

### How will QIS submissions be evaluated?

For issuers operating in the FFMs, the QIS evaluation process will take place annually as part of the QHP Application Period. This process is explained in more detail in the QIS Technical Guidance and User Guide. To determine whether an issuer's QIS meets the requirements, FFMs will review and evaluate an issuer's QIS submitted via the Implementation Plan and Progress Report form.

Based on the results of the QIS evaluation, an overall outcome 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 QHP Application Period. The Correction Notice will indicate any necessary corrections that an issuer must make to its QIS.

### Access to materials

The QIS Technical Guidance and User Guide for the 2017 Coverage Year and the QIS Implementation Plan and Progress Report form are available on the Marketplace Quality Initiatives (MQI) website, at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

### Additional Resources

***QHP Application Website:***

http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html

***Registration for Technical Assistance Portal (REGTAP) (key word search "QIS"):***

https://REGTAP.info

***Exchange Operations Support Center (XOSC) Help Desk:***

- Email: CMS_FEPS@cms.hhs.gov
- Phone: 1-855-CMS-1515 (1-855-267-1515)

[4] 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.