Health Insurance Marketplace℠

Quality Improvement Strategy: Technical Guidance and User Guide for the 2018 Plan Year

January 2017

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List of Exhibits

Technical Assistance

Technical assistance is available for issuers, Marketplaces, and other entities that may have questions related to the quality improvement strategy (QIS) requirements for qualified health plans (QHPs) offered through the Marketplaces. For additional information or assistance, please see the sections that follow.

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 the subject line of all requests or questions.

Website Links

Website	Description	Link
Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace.[SM][1] Quality Initiatives (MQI) website	This website provides resources related to CMS MQI activities, including the Quality Rating System (QRS), Consumer Experience Surveys (i.e., the QHP Enrollee Satisfaction Survey), QIS requirements, and Patient Safety Standards. As the central location for QIS resources, this website 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 Plan (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 application 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
State Exchange Resource Virtual Information System (SERVIS)	This website serves as an information hub for CMS technical assistance related to State-based Marketplace (SBM) requirements. Registered State users can access relevant resources organized by the Center for Consumer Information and Insurance Oversight (CCIIO) State Exchange Group.	https://servis.cms.gov/

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

Other Resources

- SBMs should contact their respective CCIIO State Officers for resolution of their inquiries.

- Issuers offering Multi-State Plan (MSP) options should contact the Office of Personnel Management (OPM) to confirm the requirements and timing associated with QIS implementation and reporting. (Please use the email MSPPIssuer@opm.gov.)

- 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 final *2018 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 Federally-facilitated Marketplaces (FFMs), whether through the Individual Marketplace or the Small Business Health Options Program (SHOP) Marketplace, with operational and technical guidance to help them successfully participate in those Marketplaces during the 2018 plan year. The final 2018 Letter to Issuers was released in December 2016.

- 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 beginning with the 2016 plan year.

Document Purpose and Scope

The *QIS Technical Guidance and User Guide for the 2018 Plan Year* 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 2018 QHP Application Submission and Review Period (QHP Application Period, which applies to the 2018 plan year).[2] This document is organized into two volumes:

- [Volume I: QIS Technical Guidance for the 2018 Plan Year](#); and
- [Volume II: QIS User Guide for the 2018 Plan Year](#).

Issuers should read through the entire QIS Technical Guidance and User Guide on an annual basis, regardless of QIS submission type, as both volumes will be updated yearly to reflect any relevant changes. Information contained in this document may change as the QHP certification process evolves. This document will be updated, as necessary.

VOLUME I: QIS TECHNICAL GUIDANCE FOR THE 2018 PLAN YEAR

The QIS Technical Guidance for the 2018 Plan Year (Technical Guidance) provides information on the QIS participation criteria and reporting requirements for all issuers offering or seeking to offer QHP coverage through a Marketplace, and on the evaluation methodology for the FFMs, including FFMs where States perform plan management, to review issuers' QIS submissions.

Where applicable, the section descriptions highlight key differences between the initial version of the QIS Technical Guidance for the 2017 Plan Year, released in November 2015, and this QIS Technical Guidance for the 2018 Plan Year. Throughout this document, unless otherwise noted, references to an FFM (or FFMs) refer to both FFMs and FFMs where the State performs plan management. Similarly, references to an SBM (or SBMs) refer to both SBMs and SBMs on the Federal Platform (SBM-FPs), unless otherwise noted.

The requirements outlined in this document are based on statute and CMS regulations, including the Patient Protection and Affordable Care Act and the U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016 Final Rule.[3] The Technical Guidance provides:

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

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[2] The 2018 QHP Application Period occurs in the 2017 calendar year.

[3] 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).

Key Differences Between the 2017 QIS Technical Guidance and 2018 QIS Technical Guidance
Section 4.1 – Updated to clarify how FFMs where States perform plan management will review QIS submissions
Section 5.2 – Updated to remove the QIS health savings account (HSA)-eligible plan exclusion
Section 6.3 – Updated to include Part F *(Progress Report Summary)* scoring methodology

VOLUME II: QIS USER GUIDE FOR THE 2018 PLAN YEAR

The User Guide for the 2018 Plan Year (User Guide) provides issuers offering coverage in an FFM with directions to meet the QIS requirements for the 2018 QHP Application Period. The User Guide provides procedural, step-by-step instructions for issuers on how to access, complete, and submit QIS Implementation Plan and Progress Reports to the FFMs. Where applicable, the section descriptions highlight key differences between the initial version of the QIS User Guide for the 2017 Plan Year, released in November 2015, and this QIS User Guide for the 2018 Plan 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 and/or Progress Report sections,
- Instructions on what steps issuers may need to take after their QIS submissions have been evaluated, and
- Instructions for completing the QIS Progress Report sections.

Key Differences Between the 2017 QIS User Guide and 2018 QIS User Guide
Section 4 – Updated to include instructions on completing the QIS Progress Report
Appendix D – Updated to include a checklist for completing the QIS Progress Report

Volume I. QIS Technical Guidance for the 2018 Plan Year

1. Background

An 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 entitled "Rewarding Quality Through Market-Based Incentives."[4] A QIS should incentivize quality by tying payments to measures of performance when providers meet specific quality indicators or enrollees make certain choices or exhibit behaviors associated with improved health.

The QIS requirements apply to all issuers offering QHPs and MSP options through a Marketplace, whether through the Individual Marketplace or through the SHOP Marketplace. Throughout this document, references to "issuers" refer to issuers offering or applying to offer QHPs in a Marketplace. The issuer's QIS or strategies must cover all of its QHPs and/or MSP options offered through a Marketplace that meet the participation criteria described in Section 5.1 of this Technical Guidance. An issuer has the option of implementing one QIS that covers all eligible health plans and product types, or implementing multiple quality improvement strategies to cover all eligible health plans and product types.

All 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/or
   v. Activities to reduce health and health care disparities.

(3) Adhere to guidelines, including the QIS Technical Guidance and User Guide, established by 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?**
>
> An issuer is encouraged to address health and health care disparities in each QIS. This may be done in one of two ways:
> (1) Choosing "Implementation of activities to reduce health and health care disparities" as a topic area addressed by the QIS; _or_
> (2) Addressing the reduction of health and health care disparities as part of the activities implemented within any other chosen topic area(s).
>
> Disparities can and will vary depending on regional location and enrollee populations. An issuer has the opportunity to submit more than one QIS to meet the needs of its enrollee population (see Section 2 of the Technical Guidance).

Many health improvement activities will benefit the overall population, which is one of the key goals of the CMS Quality Strategy. However, the QIS statutory requirements require the use of market-based incentives to improve the quality and value of health care and services specifically

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

for Marketplace enrollees. Section 1311(g) specifies two market-based incentives types that issuers may include in their quality improvement strategies: (1) increased reimbursement or (2) other incentives. These incentive types are defined below; additional examples are provided in Appendix C.

(1) Increased Reimbursement

   o Providers receive an increased or higher level of payment and/or a bonus payment based on whether they meet certain quality performance targets. If providers do not meet all of the performance targets, they receive only a portion of the maximum payment they are eligible to receive.

(2) Other Incentives

   o "Other Provider Incentives" is defined as the provision of provider resources, such as physician practice transformation and clinical support for meeting certain quality performance targets.

   o "Enrollee Financial Incentives" is defined as a monetary reduction of what an enrollee pays for premiums and other out-of-pocket costs (e.g., co-payment, co-insurance) as a result of the consumer making certain choices or exhibiting behaviors associated with improved health (e.g., seeking preventive services, seeking "high-value" providers, accessing nutritional counseling).[5]

All QIS activities must be linked to an incentive. An issuer may choose to implement a provider market-based incentive, an enrollee market-based incentive, or both. Population- or community-based activities may meet the QIS standard if they are linked to an incentive. See Exhibit 1 for examples of activities cited in the Affordable Care Act that may be included in issuers' quality improvement strategies.

<center>Exhibit 1: Examples of QIS Activities Cited in the Affordable Care Act[6]</center>

QIS Topic Area	Examples of QIS Activities
Improve Health Outcomes	▪ Quality reporting ▪ Effective case management ▪ Care coordination ▪ Chronic disease management ▪ Medication and care compliance initiatives

Preventing Hospital Readmissions	▪ Comprehensive program for hospital discharge that includes:
	  – Patient-centered education and counseling
	  – Comprehensive discharge planning
	  – Post discharge reinforcement by an appropriate health care professional

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[5] Any enrollee financial incentives used as part of an issuer's QIS must comply with other applicable federal and State requirements, including but not limited to, those applicable to premiums and rating, plan design, and actuarial value. For example, wellness program incentives must comply with the federal wellness program regulations at 26 CFR 54.9802-1(f); 29 CFR 2590.702(f); 45 CFR 146.121(f)).

[6] The wellness and health promotion activities are cited in Section 2717(b) of the Public Health Service Act. All other activities are cited in Section 1311(g)(1) of the Affordable Care Act.

QIS Topic Area	Examples of QIS Activities
Improve Patient Safety and Reduce Medical Errors	▪ Appropriate use of best clinical practices ▪ Evidence-based medicine ▪ Health information technology
Implement Wellness and Health Promotion Activities	▪ Smoking cessation ▪ Weight management ▪ Stress management ▪ Healthy lifestyle support ▪ Diabetes prevention
Reduce Health and Health Care Disparities	▪ Language services ▪ Community outreach ▪ Cultural competency trainings

All Marketplaces are required[7] to evaluate issuers' QIS submissions, and issuers must submit separate QIS submissions by State. In addition:

- CMS will evaluate the QIS submissions for issuers applying to offer QHPs in an FFM.

- In FFMs where the State performs plan management, issuers applying to offer QHPs will undergo a joint review of their QIS submissions by the State and the relevant FFM, with final determination being made by the FFM.

- SBMs will evaluate the QIS submissions of the issuers applying to offer QHPs in their State's Marketplace. SBMs (including SBM-FPs) have the flexibility to establish the timeline, reporting form, validation of data, and other requirements related to annual submission of QIS data by the issuers participating in their respective Marketplaces. However, SBMs must comply with the federal minimum reporting requirements.

  For the 2018 QHP Application Period, SBMs must, at a minimum, require issuers to submit QIS information in accordance with the elements and criteria included in the QIS Implementation Plan and Progress Report form. SBMs are encouraged to use the reporting manner and frequency requirements established by the FFMs to minimize the burden of reporting. However, SBMs may establish their own reporting forms, evaluation methodologies, and reporting manner and frequency requirements.

- OPM will evaluate QIS submissions for MSP products. If an issuer offers products through the Marketplace that are in the form of:

  - Only MSP options, then the issuer must contact OPM at MSPPIssuer@opm.gov for specific instructions.

  - Both QHPs and MSP options, then the issuer must send the QIS submission to the applicable Marketplace, and notify OPM of the action via the MSP Program Application. Once the Marketplace approves the QIS submission, the issuer must submit the final QIS submission, along with evidence of such approval to OPM.

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[7] 45 CFR 155.200(d).

o Issuers offering MSP options should contact OPM at MSPPIssuer@opm.gov to confirm the requirements and timing associated with QIS implementation and reporting.

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 that reward quality health 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.[8]

- Align the statutory requirements with other quality improvement programs. As applicable, the QIS will align with the Marketplace QRS, the Marketplace QHP Enrollee Satisfaction Survey, and the Medicare Advantage Quality Improvement Program/Chronic Care Improvement Program.

- Offer flexibility to encourage issuer innovation and to promote a culture of continuous quality improvement. This includes allowing issuers to use existing quality improvement strategies that are in place for non-Marketplace enrollee populations and/or implemented in response to such initiatives as the Medicare Shared Savings Program or other Accountable Care models if the existing strategy is relevant to the issuer's Marketplace population and meets the QIS requirements.

- Allow for flexibility for State implementation, meaning QIS implementation will establish minimum requirements upon which States with SBMs, if desired, can build additional program requirements in accordance with their local priorities.

- Develop requirements in a public and transparent manner.

Section 1311(c)(1)(E) of the Affordable Care Act and the implementing regulation require an issuer participating in a Marketplace for two or more consecutive years to implement and report on a QIS. There are two ways an issuer may accomplish this: (1) implement one QIS that applies to all of its eligible product types and QHPs in a given Marketplace; or (2) implement more than one QIS, if having just one QIS does not address all of its eligible product types and QHPs. All of the issuer's QHPs offered through a Marketplace that meet the participation criteria described in Section 5.1 of the Technical Guidance (referred to as "eligible QHPs") must be covered by a QIS.

Issuers have the benefit of 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

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

maintain regular doctor visits for diabetes care, and/or incentivize physicians to focus on improving diabetic patient outcomes).

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 of a QHP's enrollee population, depending on the sub-population's identified needs.

An issuer that offered an eligible QHP through a Marketplace in the 2015 and 2016 plan years must make at least one initial QIS Implementation Plan submission to the applicable Marketplaces in 2017 for the 2018 plan year. In subsequent years, the issuer must submit an annual update on its implementation progress via the QIS Progress Report. See Exhibit 2 for examples of the timeline for QIS submissions.

Exhibit 2: QIS Submission Timeline

Issuer's Initial QHP Certification Application Year	Two Consecutive Years of Providing Coverage	Calendar Year of Initial QIS Implementation Plan Submission	Initial QIS Implementation Plan Year	Initial QIS Progress Report Plan Year
2013	2014 and 2015	2016	2017	2018
2014	2015 and 2016	2017	2018	2019
2015	2016 and 2017	2018	2019	2020
2016	2017 and 2018	2019	2020	2021
2017	2018 and 2019	2020	2021	2022

In the event coverage is not continuous, the two-year window restarts each time the issuer begins offering coverage through the Marketplace again. For example, if an issuer offered QHPs through a Marketplace in 2015, does not offer any QHPs through that Marketplace in 2016, and offers QHPs through that Marketplace again in 2017 and 2018, the issuer will be required to submit a QIS Implementation Plan in 2019 for the 2020 plan year for its QHPs that meet the participation criteria described in Section 5.1 of the Technical Guidance. The issuer would submit a QIS Progress Report in 2020 for the 2021 plan year.

The QIS Implementation Plan and Progress Report form is a consolidated form that can be accessed on the [MQI website](#) by all issuers that are required by the FFMs to provide information on their quality improvement strategies. For the 2018 plan year, CMS developed an updated QIS Implementation Plan and Progress Report form. All issuers that meet the QIS participation criteria, regardless of submission type, must use the updated QIS Implementation Plan and Progress Report form when submitting their QIS Implementation Plan and/or QIS Progress Report.

The QIS elements and criteria in the QIS Implementation Plan and Progress Report form are described in detail in Volume II, Sections 2, 3, and 4 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 this Technical Guidance.

3.   QIS Schedule for the 2018 Plan Year

Issuers applying for QHP certification in the FFMs will submit QIS forms during the annual QHP Application Period, and should refer to the 2018 Letter to Issuers[9] for final dates for the 2018 QHP Application Period. Exhibit 3 highlights the major stages of the QIS process for the 2018 plan year in the FFMs, offering timeframes based on a November 1, 2017 start date for the Individual Marketplace annual Open Enrollment Period as specified by the final 2018 Letter to Issuers. Issuers operating in SBMs (including SBM-FPs) should refer to their Marketplaces regarding specific timeframes, and issuers offering MSP options should refer to OPM.

Exhibit 3: Stages of the QIS Process

Stages	Timeframe
Issuer develops/refines quality improvement strategies for the 2018 plan year	Fall 2016 – April 2017
Initial QHP application submission window for the 2018 plan year	4/5/2017 – 5/3/2017
CMS reviews initial QHP applications as of 5/3/2017	5/4/2017 – 6/5/2017
Deadline for submission of revised QHP data	6/27/2017
CMS reviews revised QHP submission as of 6/27/2017	6/28/2017 – 7/28/2017
Final deadline for submission of changes to QHP data	8/21/2017
CMS sends QHP Certification Notices to issuers	9/21/2017 – 9/22/2017

4.   Marketplace Oversight Responsibilities

Marketplaces are responsible for QHP certification and oversight of compliance with certification standards by QHP issuers operating in their respective Marketplaces. All Marketplaces are responsible for evaluating issuers' QIS submissions as a condition of QHP certification for the 2018 plan year.

4.1   Federally-facilitated Marketplaces

The FFMs will follow the QHP Application and Certification Process, which is outlined in the 2018 Letter to Issuers, as it pertains to the QIS requirements.

FFMs where the State performs plan management will receive QIS Implementation Plan and Progress Report forms directly from issuers offering coverage through their States, as part of the issuers' QHP applications, via the System for Electronic Rate and Form Filing (SERFF). In FFMs where the State performs plan management, these States must evaluate the QIS submissions of the issuers offering coverage through the States using the federal QIS evaluation methodology, but issuers should contact the States for additional details. CMS will also review the QIS submissions of issuers offering coverage in FFMs where the State performs plan management.

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[9] The final 2018 Letter to Issuers was released on December 16, 2016, and is available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf.

CMS may conduct targeted compliance reviews under 45 CFR 156.715 to examine QHP issuer compliance with the federal reporting requirements. Compliance with the QIS data submission and reporting requirements may be included as part of a more general compliance review of an issuer participating in an FFM. CMS intends to coordinate with State regulators, the applicable State entity for FFMs where the State performs plan management, and SBMs, when appropriate, to avoid duplication of efforts for these compliance reviews.

4.2   State-based Marketplaces

The QIS requirements are designed to provide SBMs with flexibility to establish the timeline, reporting form, validation, and other requirements related to annual submission of QIS data by the issuers that participate in their respective Marketplaces. The FFMs' standards provide the minimum requirements as a foundation for SBMs. SBMs that establish and implement such standards and other requirements would support compliance with 45 CFR 155.200(d), which requires Marketplaces to evaluate and oversee implementation of each QIS submitted by issuers operating in their States (among other issuer quality initiatives for coverage offered through the Marketplaces).

SBMs will evaluate the QIS submissions of the issuers applying to offer QHPs in their State's Marketplace. SBMs must ensure issuers that meet the QIS participation criteria and operate in their respective Marketplaces comply with the federal minimum reporting requirements, which include the QIS requirements outlined in the QIS Technical Guidance and User Guide and the information collected in the QIS Implementation Plan and Progress Report form. SBMs are encouraged to use the reporting manner and frequency requirements established by CMS for the FFMs to minimize the burden of reporting. Issuers operating in SBMs should consult these States for information about how to comply with the States' QIS requirements as SBMs may have established their own reporting manner, frequency requirements, and additional reporting requirements.

4.3   Multi-State Plan Program

OPM is responsible for MSP certification and MSP issuer oversight and, therefore, will oversee MSP issuer compliance with QIS requirements. Issuers offering MSP options should contact the OPM at MSPPIssuer@opm.gov to confirm the requirements and timing associated with QIS implementation and reporting.

5.   QIS Requirements

This section outlines the criteria for determining which issuers must submit a QIS Implementation Plan to the applicable Marketplace.

5.1   Participation Criteria

This section describes the QIS participation criteria for issuers. Issuers applying for QHP certification in the Marketplaces for the 2018 plan year that meet the QIS participation criteria are expected to submit a QIS Implementation Plan and Progress Report form in 2017 to either: (a) implement a new QIS beginning no later than January 2018, or (b) provide a progress update

on an existing QIS.[10] Issuers must submit a QIS Implementation Plan and Progress Report form to a Marketplace for the 2018 plan year if:

- **An issuer offered coverage through a Marketplace in 2015 and 2016**. The QIS reporting requirements apply to issuers that have been operating in a Marketplace for two consecutive years, regardless of whether their QHPs have changed during that time. This phased-in approach gives issuers the necessary time to understand the populations enrolling in a QHP offered through the Marketplace and to build quality performance data on their respective QHP enrollees. If an issuer offered coverage in 2016 and 2017 (but not in 2015), the issuer would <u>not need</u> to submit a QIS until 2018 for the 2019 plan year.

- **An issuer provides family and/or adult-only medical coverage**. The QIS (or more than one QIS) should cover all eligible QHPs. Eligible QHPs are QHPs offered through the Marketplace at all levels of coverage (Bronze, Silver, Gold, Platinum, and Catastrophic) for all of the following product types: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS) plans, exclusive provider organizations (EPOs), and indemnity plans. At this time, the QIS requirements do not apply to child-only plans or SADPs. The QIS requirements have been revised to **<u>include</u>** QHPs that are compatible with HSAs (also known as HSA-eligible plans). The inclusion of HSA-eligible plans better aligns the QIS requirements with the QRS requirements, and will increase QIS participation overall by ensuring issuers that meet the other QIS participation criteria, but offer only HSA-eligible plans, are required to implement a QIS. Issuers are therefore expected to include HSA-eligible plans that meet the other QIS participation criteria in their 2018 QIS submissions.

> **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 and Progress Report form 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 product types and/or QHPs within the same Marketplace.
> - Each eligible QHP must be included in a QIS.

- **An issuer meets the QIS minimum enrollment threshold.** An issuer must submit a QIS if it had more than 500 enrollees within a product type per State as of July 1, 2016.[11, 12] Specifically, for a product type offered through the Marketplace that has more than 500 enrollees as of July 1, 2016, all

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

[11] Patient Protection and Affordable Care Act; U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016, Final Rule, available at:
https://www.federalregister.gov/articles/2015/02/27/2015-03751/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2016

[12] CMS established the minimum enrollment requirement for the QRS and QIS to align with the QHP Enrollee Survey minimum enrollment requirement set forth in 45 CFR 156.1125(b)(1).

QHPs within that product type must be covered by a QIS. Enrollees who purchased insurance outside the Marketplace (off-Marketplace) should not be included in the minimum enrollment calculation.

To determine whether a product type and, therefore, an issuer meets the minimum threshold, issuers must include all enrollees in eligible QHPs. When determining which enrollees to include, issuers must consider the following requirements:

- Issuers should include only enrollees in QHPs offered through a Marketplace (on-Marketplace). Enrollees who purchased insurance outside the Marketplace (off-Marketplace) are not included in the minimum enrollment calculation.

- All enrollees in QHPs that provide family and/or adult-only medical coverage should be included. Enrollees in child-only plans or SADPs should not be included in the minimum enrollment calculation. New for the 2018 plan year, enrollees in HSA-eligible plans should also be **included** in the minimum enrollment calculation.

- If an issuer offers QHPs of the same product type in both the Individual Marketplace and in the SHOP Marketplace within a State, the issuer must combine the enrollee totals from both the Individual Marketplace and SHOP Marketplace.

- If an issuer offers both a QHP and an MSP option of the same product type in the same State through a Marketplace, the issuer must combine the enrollee totals from both QHP and MSP products.

Example: A fictional issuer that offered certified QHPs (all offering family medical coverage) through the Marketplaces in 2015 and 2016 in three States—West Virginia (WV), Maryland (MD), and North Carolina (NC)—has applied for certification of those QHPs in 2017 for the 2018 plan year. Exhibit 4 shows the characteristics and enrollment size of the issuer's product types in each State. In accordance with the participation criteria defined above, this issuer must develop and submit a QIS Implementation Plan to the Marketplace for only the following States: West Virginia and Maryland. The issuer does not need to submit a QIS Implementation Plan in North Carolina because it did not have sufficient number of enrollees within each product type as of July 1, 2016.

Exhibit 4: Example Issuer Submissions Assessed Against 2018 QIS Participation Criteria

Reporting Unit	Number of enrollees in the product type as of July 1, 2016 (total and per Individual Marketplace vs. SHOP)	Issuer should submit QIS	All product types and applicable QHPs need to be covered by a QIS
ABC issuer - WV	HMO: 505 (505 individual, 0 SHOP) PPO: 600 (500 individual, 100 SHOP)	Yes	Yes
ABC issuer - MD	HMO: 601 (501 individual, 100 SHOP) PPO: 400 (300 individual, 100 SHOP)	Yes	No – only the HMO and applicable QHPs must be covered by a QIS
ABC issuer – NC	HMO: 300 (200 individual, 100 SHOP) PPO: 400 (300 individual, 100 SHOP)	No	No

5.2   QIS Implementation Plan and Progress Report Form

Issuers applying for QHP certification in the FFMs for the 2018 plan year that meet the QIS participation criteria are expected to submit a QIS Implementation Plan and Progress Report form in 2017 to either: (a) implement a new QIS beginning no later than January 2018, or (b) provide a progress update on an existing QIS.[13] Issuers may also use the form to modify an existing QIS. This section provides details about the specific elements and criteria that an issuer needs to address when submitting information about its QIS.

For the 2018 plan year, CMS developed an updated QIS Implementation Plan and Progress Report form. All issuers, regardless of submission type, must use the updated QIS Implementation Plan and Progress Report form when submitting their QIS Implementation Plan and/or QIS Progress Report.

> **Commonly Used QIS Terms**
>
> - **QIS requirements:** The information issuers are required to submit for evaluation by a Marketplace
> - **Elements:** Identifying and descriptive information issuers use to complete the QIS Implementation Plan and Progress Report form
> - **Criteria:** Descriptions of the type of information issuers must provide and the rules that a Marketplace uses to evaluate whether an issuer's QIS fulfills the QIS requirements

5.2.1   QIS Form Purpose and Use

The goal of the Implementation Plan and Progress Report form is to collect QIS information from issuers. This information will demonstrate compliance with section 1311(c)(1)(E) of the Affordable Care Act. It will also facilitate understanding of the issuer's payment structure framework that provides increased reimbursement or other market-based incentives for the implementation of activities related to the topics specified in section 1311(g) of the Affordable Care Act.

HHS anticipates displaying a subset of this information to promote transparency and will provide additional details through future guidance. It is not intended that the public display of payment structure information will include information that is considered confidential or proprietary.

The QIS Implementation Plan and Progress Report form provides a structure for an issuer to show 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 it has examined its enrollee population and designed a QIS that provides market-based incentives to drive quality improvement and improved health outcomes.

Issuers will use the QIS Implementation Plan and Progress Report form to submit a QIS Implementation Plan and/or Progress Report to the relevant Marketplace. During the 2018 QHP Application Period,[14] issuers that meet the QIS participation criteria, regardless of whether they

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[13] 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 and is relevant to their Marketplace population.

[14] The 2018 QHP Application Period occurs in the 2017 calendar year.

are submitting an Implementation Plan and/or Progress Report, will indicate in the form which of the following types of information they are submitting (see Exhibit 5):

- New QIS with No Previous QIS Submission,
- New QIS after Discontinuing a QIS Submitted during a Prior QHP Application Period,
- Continuing a QIS with No Modifications, or
- Continuing a QIS with Modifications.

Exhibit 5: When Is a New QIS Needed?

Issuers may continue with an existing QIS even if they make the following modifications:	Issuers must implement a new QIS if they make the following changes:
▪ Update Issuer Information, ▪ Update Current Payment Model(s) Description, ▪ Update Data Sources, ▪ Change QIS activities, ▪ Change QIS goals,[15] and/or ▪ Change QIS measures.	▪ QIS market-based incentive type or sub-type change, ▪ QIS topic area change, ▪ One or more of the QIS performance targets are reached or changed, or ▪ The QIS results in negative outcomes or unintended consequences.

Issuers are strongly encouraged to leave a QIS in place for at least two years before modifying it or developing a new QIS to allow time to determine whether the market-based incentives are working as expected.

5.2.2   QIS Form Structure

The sections of the QIS Implementation Plan and Progress Report form and their parts are listed in Exhibit 6.

Exhibit 6: 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 and User Guide. References to the Implementation Plan sections of the overall form relate specifically to Parts D and E. Part F of the form is the Progress Report section, which an issuer must complete during the 2018 QHP Application Period for the 2018

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[15] In Part D of the form, an issuer must summarize the overall goal or goals (no more than two) of the QIS. The goal(s) must be linked to the issuer's QIS topic area(s), as well as the quantitative performance targets identified in Part E of the form, to track the issuer's progress toward meeting its QIS goals.

plan year if it submitted an Implementation Plan during the 2017 QHP Application Period for the 2017 plan year.

The Progress Report elements and criteria that issuers must submit during annual reporting are further detailed in the User Guide, and will be scored as part of the QIS evaluation. See Section 4 of the User Guide for more information about Part F, in particular.

Issuers *must* complete all elements included in the Implementation Plan that are being submitted. For example, if an issuer is submitting or modifying a QIS Implementation Plan, the issuer should complete Parts A, B, C, D, and E, which include Elements 1–26. An issuer required to submit a Progress Report must also complete Part F, which includes Elements 27–32.

If an issuer fails to provide responses to any criteria within any of the elements, CMS will ask the issuer to revise and complete the missing information and resubmit the form. If no changes are being made to an issuer's QIS Implementation Plan from the previous year, issuers should: (1) update Parts A and B to reflect QIS submission type and updated contact information, as necessary; (2) copy in the information submitted in Element 15 and Parts C, D, and E from the initial submission of the Implementation Plan; and (3) complete Part F. The information submitted in Parts A, B, C, and D will be reviewed for completeness, while the information submitted in Parts E and F will be reviewed for completeness **and** scored (refer to Section 6.3 in this volume for an explanation of QIS scoring).

Some elements in Part E of the Implementation Plan and Part F of the Progress Report are associated with criteria that will be evaluated. Criteria describe the type of information issuers must provide and are the rules that a Marketplace uses to evaluate whether an issuer's QIS fulfills the QIS requirements.

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 2017, issuers submitting a QIS Implementation Plan for the first time will be required to provide information on the following parts of the form as part of their QHP application for the 2018 plan year:

- 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.

Issuers that submitted quality improvement strategies as part of their 2017 QHP applications are expected to submit Progress Reports during the 2018 QHP Application Period. These issuers are required to submit information on the following parts of the form as part of their QHP Application for the 2018 plan year:

- 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,
- Part E: QIS Requirements, and
- Part F: Progress Report Summary.

6.1 QIS Implementation Plan and Progress Report Completeness Assessment Process

Each respective FFM[16] evaluates an issuer's QIS Implementation Plan and Progress Report form to determine whether an issuer's QIS meets the applicable requirements. There are three stages of review in the QHP Application Period—first, second, and final review—during which the FFM evaluates issuers' QIS submissions. These review stages are part of the QHP Application and Certification Process, the timing of which is determined annually in the Letter to Issuers.

QIS submissions that are received during the QHP Application Period will be assessed for completeness. Issuers whose submissions contain blank fields or are missing information will receive Correction Notices after the first and second rounds of review during the application process indicating which fields were missing information. Issuers that receive such Correction Notices must correct and resubmit their QIS forms during subsequent review periods. Issuers that meet the QIS participation criteria, but did not submit at least one QIS as expected, will also receive Correction Notices. Issuers will not be notified if their QIS submissions are assessed as complete.

As soon as each QIS submission is assessed as complete (i.e., contains no blank fields or missing information), the FFM begins a full evaluation (see Section 6.3.3) of each QIS submission to determine whether it meets the QIS requirements, or whether the submission is deficient. Issuers' submissions will be scored during this part of the process as "Meets" or "Does Not Meet."

6.2 QIS Evaluation Methodology

The QIS Evaluation Methodology reflects how the FFMs review and evaluate an issuer's responses to the elements and criteria of the QIS Implementation Plan and Progress Report form. The fields in Elements 1–18 in Parts A–D of the QIS Implementation Plan and Progress Report form are required and will be assessed for completeness, but will not be scored.

For Parts E and F, CMS uses a "Partial-Credit plus Must-Pass" scoring approach. This approach includes the following characteristics: (1) 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 (2) certain elements are considered "must-pass" and, therefore, issuers must meet each criterion in that element to receive the full 1.00 point and demonstrate compliance with the QIS requirements. In Part E, for the elements that are not designated as must-pass, receiving a

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[16] 45 CFR 155.200(d) directs the Marketplace to evaluate QIS submissions. For an FFM State, CMS will perform the evaluations; however, for FFMs where the State performs plan management, the submission will be jointly reviewed by CMS and the State, with the final determination being made by CMS. For SBM States (including SBM-FPs), the SBM will perform evaluations. OPM will evaluate QIS submissions for MSP products.

score of .50 is equivalent to receiving 1.00. In Part F, for all elements that are not designated as must-pass, issuers must meet the majority of all those elements' criteria to demonstrate compliance with the QIS requirements.

Further details on must-pass and other scored elements are provided in Section 6.3 of this Technical Guidance.

6.3   Scoring the QIS Form

Scoring is done at the element level and only for those elements included in Parts E and F of the QIS Implementation Plan and Progress Report form.

6.3.1   Implementation Plan (Part E) Scoring

All elements included in Part E are worth 1.00 point, regardless of must-pass designation. An issuer will receive a passing score for Part E if it: (1) meets all of 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.

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 0.00 point (i.e., 0 percent) if no criteria are met. Elements 25 and 26 are also scored, but issuers may receive partial credit for these two elements. See Exhibit 7 for details on the scored elements that issuers will be required to address.

Exhibit 7: Implementation Plan (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 a 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% (0.50 point) on each of these elements to receive full credit.	▪ Element 25: Timeline for Implementing the QIS ▪ Element 26: Risk Assessment

Element 25 (Timeline for Implementing the QIS) and Element 26 (Risk Assessment) are not must-pass. Each of these elements has two criteria, meaning issuers receive full credit (1.00 point) even if their submission meets just one of the two criteria (i.e., 50 percent or 0.50 point). An issuer also receives 100 percent (1.00 point) credit for meeting both criteria. See Exhibit 8 for details.

Exhibit 8: 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	1.00 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	1.00 point awarded	N/A	0.00 point awarded

6.3.2   Progress Report (Part F) Scoring

All elements included in Part F are worth 1.00 point, regardless of must-pass designation. An issuer will receive a passing score for Part F if it: (1) meets all of the criteria for the predetermined must-pass elements (i.e., receives 1.00 point for each must-pass element); **and** (2) meets the minimum score thresholds of 0.50 point (i.e., 50 percent) for each other scored element.

Elements 29 and 30 are must-pass, and there is no partial credit offered for these elements. For must-pass elements, an issuer either receives 1.00 point (i.e., 100 percent) for meeting all criteria, or receives 0.00 point (i.e., 0 percent) if no criteria are met. Elements 27, 28, 31, and 32 are also scored. Issuers may receive partial credit based on the number of criteria they meet for each of these four elements. See Exhibit 9 for details on the scored elements that issuers will be required to address.

Exhibit 9: Progress Report (Part F) 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 29: Analyze Progress Using Baseline Data, as Documented in the Implementation Plan ▪ Element 30: Summary of Progress
Other Scored Elements	▪ Issuer may receive partial credit based on how many criteria are met. ▪ Issuer must receive at least 50% (0.50 point) on each of these elements to receive full credit.	▪ Element 27: Addition/Removal of QHPs to the Issuer's QIS ▪ Element 28: QIS Modifications ▪ Element 31: Barriers ▪ Element 32: Mitigation Activities

Elements 27, 28, 31, and 32 are not must-pass. For issuers to demonstrate compliance with the QIS requirements, they must meet at least half (50 percent) of the criteria per element in each of these four elements. Elements 27 and 28 each have three criteria, meaning issuers receive full credit (1.00 point) even if their submission meets just two of the three criteria (i.e., at least 50 percent or 0.50 point). Elements 31 and 32 have two criteria each, meaning issuers receive full

credit (1.00 point) if their submission meets just one of the two criteria (i.e., at least 50 percent or 0.50 point). An issuer also receives full credit (1.00 point) for meeting all criteria in each of the four elements. See Exhibit 10 for details.

Exhibit 10: Scoring Scale for Elements 27, 28, 31, and 32

		100%	80%	50%	20%	0%
Element 27, QHPs and product type (3 criteria)	# of Criteria Met	Issuer meets 3 criteria	No scoring available	Issuer meets 2 criteria	No scoring available	Issuer meets no criteria
	Points Awarded	1.00 point awarded	N/A	1.00 point awarded	N/A	0.00 point awarded
Element 28, QIS Modifications (3 criteria)	# of Criteria Met	Issuer meets 3 criteria	No scoring available	Issuer meets 2 criteria	No scoring available	Issuer meets no criteria
	Points Awarded	1.00 point awarded	N/A	1.00 point awarded	N/A	0.00 point awarded
Element 31, Barriers (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	1.00 point awarded	N/A	0.00 point awarded
Element 32, Mitigation Activities (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	1.00 point awarded	N/A	0.00 point awarded

6.3.3 QIS Implementation Plan and Progress Report Full Evaluation Process and Evaluation Outcomes

Full evaluations of complete QIS submissions will begin after the close of the 2018 QHP Application Period. Full evaluation results for QIS submissions for the 2018 plan year will be communicated to issuers in late fall 2017/early winter 2018.

If an issuer is still missing any critical information or does not receive a score at or above the predetermined minimum evaluation threshold for Part E (if the issuer submitted an Implementation Plan) or Part F (if the issuer submitted a Progress Report) after full evaluation, the issuer will receive a "Does Not Meet" score and CMS may require the issuer to develop a Work Plan.

An issuer will achieve a compliance designation of "Meets" for its QIS Implementation Plan submission if it: (1) successfully completes all fields in Elements 1–18 in Parts A–D, and (2) successfully completes all elements and criteria AND receives a passing score for Part E (see Section 6.3.1).

An issuer will achieve a compliance designation of "Meets" for its QIS Progress Report submission if it: successfully completes all fields AND receives a passing score for Part F.

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). Issuers will not receive numerical scores; however, issuers will be notified if their QIS submissions were found incomplete or deficient. Issuers will not be notified if their QIS submissions receive an overall outcome of "Meets."

At this time, issuers will <u>not</u> be penalized if they do not achieve the performance targets set out in their QIS Implementation Plans; however, these issuers are required to track progress and make adjustments, as appropriate.[17]

6.3.4   QIS Results Communication

CMS assesses QIS submissions for completeness upon receipt. As noted above, in the case of blank fields or missing data in the initial submission, issuers will receive Correction Notices to inform them that corrections are required for the parts of the QIS submission that were incomplete or missing. Once a submission is deemed complete, CMS conducts a full evaluation. Full evaluation results will be communicated to issuers in the late fall/early winter timeframe, following the close of the QHP Application Period and after QHP Certification. If a submission is incomplete and/or receives a "Does Not Meet" score, the issuer will have an opportunity to correct any deficiencies and may be required to develop a Work Plan.

As part of the annual QHP Application and Certification Process, an issuer will attest to complying with each Marketplace certification standard.[18] The FFMs will rely on that statement to affirm issuers' commitment to submit complete and accurate data.

CMS may conduct compliance reviews under 45 CFR 156.715 to examine issuer compliance with the federal QIS data submission and reporting requirements.

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[17] 80 Fed. Reg. 10848 (Feb. 27, 2015).

[18] The Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses includes the following statement: "Applicant attests that it will comply with the specific quality disclosure, reporting, and implementation requirements at 45 CFR 156.200(b)(5) and 45 CFR 156 Subpart L."

Volume II. QIS User Guide for the 2018 Plan 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 operating in an FFM versus those that operate in FFMs where the State performs plan management. An issuer operating in the latter will work directly with the State in which it is offering QHPs through the Marketplace to submit its QIS. Throughout the User Guide, references to "issuers" refer to issuers offering or applying to offer QHPs in a Marketplace.

Issuers that meet the QIS participation criteria operating in an FFM should review the QIS materials, including the entirety of this *QIS Technical Guidance and User Guide for the 2018 Plan Year*, and the QIS Implementation Plan and Progress Report form, prior to beginning their 2018 QHP Applications.[19] Issuers should also review the 2018 Letter to Issuers for additional guidance specific to the 2018 plan year. The QIS materials can be accessed on the CMS MQI website or via the CMS QHP Application website.

1.1 Access the QIS Materials on the MQI Webpage

The QIS materials specific to each plan year 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 QRS[20] 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 specific to each plan year will also be accessible via the CMS QHP Application website prior to the start of the applicable QHP Application Period. The QHP

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[19] The 2018 QHP Application Period occurs in calendar year 2017.

[20] 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 QHP 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 QHPs as a condition of QHP certification in the Marketplace.

Application website houses instructions and forms for issuers to complete the annual QHP Application to be certified by an FFM.

1.2   Prepare to Complete the Implementation Plan and Progress Report Form

For the 2018 plan year, CMS developed an updated QIS Implementation Plan and Progress Report form. Issuers that meet the QIS participation criteria, regardless of submission type (i.e., QIS Implementation submission, QIS Progress Report submission, or both), must use the updated QIS Implementation Plan and Progress Report form when submitting their QIS Implementation Plan and QIS Progress Report.

After reviewing the Technical Guidance and User Guide, issuers must complete the applicable sections of the QIS Implementation Plan and Progress Report form (Parts A–E for the Implementation Plan and Parts A–F for the Progress Report) 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 with JavaScript enabled to an easily accessible folder.**

Step 4:   **Begin populating or updating the QIS Submission Type, Background Information, and the QIS Implementation Plan and/or the QIS Progress Report Summary sections, as applicable, by following the instructions provided in Volume II, Sections 2, 3, and 4 below.**

Issuers are responsible for maintaining records that provide the detail required by the Marketplaces and that may be necessary to demonstrate compliance with applicable Marketplace requirements as part of an audit, compliance review, or other monitoring effort.[21] Additional materials beyond the form itself cannot be uploaded via the SERFF or Health Insurance Oversight System (HIOS) systems, and will not be accepted as part of the QIS submission.

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

TIP: To view and save the form, download and install Adobe Acrobat Reader, a free electronic file reader that is available online. To complete the form, follow the prompts to enable JavaScript.

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

TIP: Print a copy of this User Guide so it can be viewed side-by-side with the form and referred to it as often as necessary. Save the form regularly as responses are entered.

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[21] See 45 CFR 156.705.

2. Complete Parts A-C of the QIS Implementation Plan and Progress Report Form

An issuer must complete Parts A–C of the QIS Implementation Plan and Progress Report form for each QIS submission. An issuer must submit the form to each Marketplace in which the QHP associated with the QIS is offered. Parts A–C consist of the following two 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)

TIP: Fill out all of the above parts of the form to submit a complete QIS. *If any element and/or criteria is left blank, the issuer will receive a Correction Notice indicating that the submission is missing information; the notice will include specific information on which element(s) and/or criteria are missing information.*

The subsections below provide instructions on how to complete each section. 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 will not be accepted. 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.

TIP: The character limits specified include spaces and punctuation.

2.1 Part A. New or Continuing QIS Submission

Part A of the QIS Implementation Plan and Progress Report form asks issuers to identify what type of QIS submission they are making. During the 2018 QHP Application Period, an issuer may use the QIS Implementation Plan and Progress Report form to submit a new QIS, continue a QIS without making any modifications, continue a QIS with some modifications, or implement a new QIS while discontinuing an existing QIS.[22] 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 11 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.

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[22] Appendix B 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.

<div align="center">Exhibit 11: Part A. New or Continuing QIS Submission</div>

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
1	**Type of QIS Submission** Select the option that describes the type of QIS submission, and follow the instructions to complete the submission.	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 selecting the appropriate option in Element 1.

Select the option that describes what type of QIS submission the issuer is making (i.e., a new QIS with no previous QIS submission, a new QIS after discontinuing a QIS submitted during a prior QHP Application Period, continuing a QIS with no modifications, or continuing a QIS with modifications). An issuer that did not submit a QIS during the 2017 QHP Application Period and meets the requirements to do so during the 2018 QHP Application Period must select "New QIS with No Previous QIS Submission." [23] An issuer that submitted a QIS during the 2017 QHP Application Period must select from the other submission type options, and complete the required sections of the form.

The required sections of the Implementation Plan and Progress Report form are determined by the type of QIS submission as specified in Part A.

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

If issuers select "New QIS with No Previous QIS Submission" in Element 1 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 an FFM.

If issuers select from the other QIS submission types provided in Element 1, they should follow the step-by-step instructions provided throughout this User Guide to complete the required sections of the form. (See Appendix B for additional information on the QIS submission types.)

2.2 Part B. Issuer Information

Part B of the QIS Implementation Plan and Progress Report form collects identifying information about the issuer (e.g., issuer legal name, company legal name, HIOS Issuer ID, issuer State, QIS contact information, date issuer began offering coverage through the Marketplace, and information about the issuer's current payment models).

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[23] A "new QIS" is defined as either a QIS that has not been previously submitted to a Marketplace OR a QIS that differs from an issuer's prior QIS due to changes in market-based incentive, topic area, or other aspects. See Exhibit 5 for a full list of changes that require submission of a new QIS.

Exhibit 12 depicts the elements 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 12: 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 Phone**	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 Phone**	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 its Marketplace product line. If "Fee for Service – Linked to Quality and Value" AND/OR "Alternative Payment Models Built on Fee for Service Architecture" is checked, provide the percentage of payments tied to quality and value.	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 legal 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 Issuer 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 2018 QHP Application.

TIP: If you previously completed Elements 2–15 as part of your Implementation Plan and are now submitting a Progress Report for your existing QIS, review your prior responses to these elements and make any necessary updates. It is important to make sure your responses to these elements are current.

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 is a five-digit numeric identifier that is assigned to each issuer during HIOS registration.[24]

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 domiciled.

Enter the name of the jurisdiction (e.g., the State, territory, or the District of Columbia) in which the issuer is domiciled. The jurisdiction name should be abbreviated using standard postal abbreviations. For example, Virginia should be represented as "VA," and the District of Columbia should be represented as "DC."

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, phone 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, phone 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.

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[24] The HIOS Issuer ID and the HIOS Plan ID (also known as a Standard Component ID [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-digit number 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 when the issuer began offering coverage through the Marketplace by following this format: MM/DD/YYYY. For example, an issuer might indicate that it began offering coverage through the Marketplace on 01/01/2014.

TIP: Issuers operating in multiple Marketplaces must submit at least one QIS to each State in which they operate.

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

Check the box or boxes that represent the category(ies) of payment models used by the issuer across its Marketplace product line.

The information provided in Element 15 will help CMS gauge progress toward meeting value-based payment goals.[25] Exhibit 13 provides a description of each of the four categories.

<div align="center">Exhibit 13: Examples of Payment Models by Category[26]</div>

Payment Category	Description
Fee For Service (FFS) – No Link to Quality and Value	Payments are based on volume of services and not linked to quality and efficiency.
Fee for Service – Linked to Quality and Value	At least a portion of payments vary based on the quality and efficiency of health care delivery.
Alternative Payment Models Built on FFS Architecture	Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or two-sided risk.
Population-based Payment	Payment is not directly triggered by service delivery, so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., more than one year).

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

If "Alternative Payment Models Built on Fee For Service Architecture" was selected, enter the percentage of payments (i.e., the percentage of payment dollars) to providers tied to quality and 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).

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[25] 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

[26] Categories of payment models are defined in the *APM FPT Work Group – APM Framework Final White Paper.* https://hcp-lan.org/workproducts/apm-whitepaper.pdf.

🔖 **TIP:** To calculate the percentage of payments for Fee for Service payments linked to quality and value, and/or Alternative Payment Models tied to quality and value, issuers should use the calculation methodologies defined in the Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs (APM Measurement Effort) Final Paper. https://hcp-lan.org/groups/apm-fpt/apm-report/. See Table 1 (p. 7-10) for instructions to calculate the percentage of payments for these two payment model categories.

2.3 Part C. Data Sources Used for Goal 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. The information requested in this element is used to understand how an issuer identified the goals and developed the rationale for its QIS. Exhibit 14 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 14: Part C. Data Sources Used for Goal 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 supporting the QIS rationale (see Element 22). Check all that apply.	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 or topic area 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; registries; U.S. Census data; the Area Health Resource File (AHRF)[27]; 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 and supporting QIS rationale. 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.

Issuers checking the box for "Other" should not include company identifying information in your data source description.

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

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.

TIP: If you previously completed Element 16 as part of your Implementation Plan and are now submitting a Progress Report for your existing QIS, review your prior submission and make any necessary updates to your data sources. It is important to make sure your response to this element is current.

3.   Complete the QIS Implementation Plan (Parts D and E)

An issuer must complete one Implementation Plan for each QIS it intends to implement and must submit the Implementation Plan to each Marketplace in which the QHP associated with the QIS is offered. An Implementation Plan consists of the following section of the Implementation Plan and Progress Report form:

- **QIS Implementation Plan Section** (consisting of Part D: QIS Summary, and Part E: QIS Requirements)

TIP: Fill out all of the above parts of the form to submit a complete Implementation Plan. *If any element and/or criteria are left blank, the issuer will receive a Correction Notice indicating that the submission is missing information. The notice will include specific information on which element(s) and/or criteria need information to be resubmitted.*

The subsections below provide instructions on how to complete each section of the 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 will not be accepted. 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.

TIP: The character limits specified include spaces and punctuation.

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

3.1   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 15 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 15: 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.	200 characters
18	**QIS Description** Provide a brief summary description of the QIS. The description must include the market-based incentive type and topic area (see Elements 19 and 20). • Is the QIS described above part of a mandatory State initiative? • Is the QIS submission a strategy that the issuer currently has in place for its Marketplace product line and/or for other product lines? – If "Yes" was checked for either/both of the above, please describe the State initiative and/or current issuer strategy. Describe the overall goal(s) of the QIS (no more than two). (Note: The topic area(s) selected in Element 20 and the measures described in Element 24 should be linked to these goals). • Is Goal 1 modified from the most recent QIS submission? • Is Goal 2 modified from the most recent QIS submission?	None	This element is required, but will not be scored.	1,000 characters for the brief summary description, 1,000 characters for a description of initiatives, and 500 characters per goal

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 spaces provided for Element 18.

The QIS description is a snapshot of some of the QIS elements covered in more detail in Part E of the Implementation Plan Section. The QIS description 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 the issuer's responses to Elements 19 and 20, respectively, in Implementation Plan Part E.

As mentioned in the Technical Guidance, a QIS must incentivize quality by tying payments to measures of performance when providers meet specific quality indicators or enrollees make certain choices or exhibit behaviors associated with improved health. Failing to incentivize quality will result in the QIS submission receiving an overall score of "Does Not Meet."

Indicate if this QIS is part of a mandatory State initiative. This information will provide context for why the issuer has chosen to implement this QIS.

Indicate if this QIS is one that the issuer currently has in place for a 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.[28] Issuers may also use information submitted to a recognized accrediting entity for QIS purposes as long as the information otherwise satisfies the QIS requirements.

If "Yes" was checked for the mandatory State initiative question or the currently existing strategy question, describe the initiative(s) in the space provided.

TIP: If you selected "Continuing a QIS with Modifications" in Element 1, indicate whether the issuer modified its goal(s) from its most recent QIS Implementation Plan submission (i.e., the QIS Implementation Plan submitted during the previous year's QHP Application Period) by checking "Yes" or "No." If this is a new QIS submission or the issuer is continuing its QIS with no modifications, check "Not Applicable."

TIP: The QIS description should specify the overall goal or goals (no more than two) of the QIS—drawing a clear link between the goal(s) and the topic area(s) selected in Element 20, as well as the measures identified in Element 24 in QIS Implementation Plan Part E.

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.

3.2   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; whether the strategy targets all health plans offered through a Marketplace; QIS rationale; activities that will be conducted to implement the QIS; goal, measure, and performance targets to monitor QIS progress; timeline for implementing the QIS; and risk assessment) 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.

TIP: Submissions will be blinded prior to full 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.

TIP: If you previously completed Elements 19–26 as part of your QIS Implementation Plan and are now submitting a QIS Progress Report for an existing QIS, review your prior responses to Elements 19–26. If you selected "Continuing a QIS with Modifications," the steps below will provide directions for how to modify your QIS Implementation Plan.

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

Exhibit 16 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 criteria (listed in the "Criteria" column in Exhibit 16) will be scored. Contextual information (e.g., restatement of goals, listing of activities) is required, but will not be scored. If any element is left blank, the issuer will receive a notification via a Correction Notice that its submission is missing information. The Correction Notice will specify which element(s) and/or criteria need to be revised.

<p align="center">Exhibit 16: Part E. QIS Requirements</p>

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
19	**Market-based Incentive Type(s)** (**Must Pass**)	19 – Select the type and sub-type of market-based incentive(s) the QIS includes. Check all that apply. If either "In-kind incentives" or "Other provider market-based incentives" is selected, provide a brief description in the space provided.	This element will be scored; Element 19 is a must-pass element.	None
20	**Topic Area Selection (Must Pass)**	20 – Select the topic area(s) this QIS addresses, as defined in the Affordable Care Act. Check each topic area that applies.	This element will be scored; Element 20 is a must-pass element.	None
21	**Targets All Health Plans Offered Through a Marketplace** (**Must Pass**)	21a – Indicate if this QIS is applicable to <u>all eligible</u> QHPs you offer or are applying to offer through the Marketplaces, or to a subset of eligible QHPs.* * If "Subset of QHPs" was selected above, an additional QIS Implementation Plan(s) (Parts D and E of this form) must be submitted for eligible QHPs not covered by this QIS. If "Subset of QHPs" was selected above, please indicate the number of forms that will be submitted: This is form _____ of _____. 21b – In the space provided, specify all eligible QHPs covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]). Indicate if each one is a new or existing eligible QHP. For initial submissions, specify all eligible QHPs covered by the QIS. To update a prior QIS submission by adding or removing SCIDs, use Element 27. Note: Please list additional health plans covered by the QIS on page 26. 21c – Select the relevant product types to which the QIS applies. Check all that apply.	This element will be scored; Element 21 is a must-pass element.	None
22	**Rationale for QIS** (**Must Pass**)	22 – Provide a rationale for the QIS that describes the issuer's current QHP enrollee population and how the QIS will address the needs of the current QHP enrollee population(s).	This element will be scored; Element 22 is a must-pass element.	1,000 characters per criterion

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
23	**Activity(ies) that Will Be Conducted to Implement the QIS (Must Pass)**	Is the activity(ies) modified from the most recent QIS submission? 23a – List the activities that will be implemented to achieve the identified goals. 23b – Describe how the activities relate to the selected market-based incentive (see Element 19). 23c – Describe how the activities relate to the topic area(s) selected (see Element 20). 23d – If the issuer did not choose health and health care disparities as a topic area in Element 20, but the QIS does include activities related to addressing health and health care disparities, describe the activities below. If (1) health and health care disparities is one of the topic areas selected in Element 20; OR (2) health and health care disparities are not addressed in this QIS, check "Not Applicable."	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 – Is the Measure modified from the most recent QIS Implementation Plan submission; Name of the measure; narrative description of the measure numerator and denominator; whether the measure is National Quality Forum (NQF)-endorsed; NQF ID if applicable (NQF-endorsed measures are not required); if NQF-endorsed, whether the measure specifications were modified; 24b – Describe how the measure supports the tracking of performance related to the goal. 24c – Baseline Assessment. Provide the baseline results by calculating the rate and providing the associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator. 24d – Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment. 24e – Provide numerical value performance target for the measure.	This element will be scored; Element 24 is a must-pass element.	500 characters per goal; 500 characters per measure description; 1,000 characters per description of how the measure supports tracking of goals
25	**Timeline for Implementing the QIS** Provide information regarding the criteria at right.	25a – The QIS initiation/start date. 25b – Describe the milestone(s) and provide the date(s) for each milestone (e.g., when activities described in Element 23 will be implemented). At least one milestone is required.	This element will be scored. Both criteria must be completed.	100 character limit per milestone in 25b

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
26	**Risk Assessment**	26a – List all known or anticipated barriers in implementing QIS activities. If no barriers were identified, please describe how you assessed barriers. 26b – Describe the mitigation activities that will be incorporated to address each barrier identified in Criterion 26a.	This element will be scored. Both criteria must be completed.	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 Element 19, select the box(es) for the market-based incentive type(s) (i.e., provider and/or enrollee[29]) the QIS includes. An issuer may choose to implement a provider market-based incentive, an enrollee market-based incentive, or both.

TIP: An issuer that previously submitted an Implementation Plan and is completing a Progress Report on an existing QIS should NOT change its market-based incentive type and sub-type selections in Element 19. If an issuer wishes to change its market-based incentive type and sub-type, it must discontinue its previous QIS and submit a new Implementation Plan.

For each market-based incentive type, select 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 "In-kind incentives" is selected as a market-based incentive sub-type, provide a brief description in the space provided. 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 C to complete Element 19.

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

To complete Element 20, check the box(es) for at least one topic area this QIS addresses, as defined in the Affordable Care Act.[30]

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[29] Any enrollee financial incentives used as part of an issuer's QIS must comply with other applicable federal and State requirements, including but not limited to those applicable to premiums and rating, plan design, and actuarial value. For example, wellness program incentives must comply with the federal wellness program regulations at 26 CFR 54.9802-1(f); 29 CFR 2590.702(f); 45 CFR 146.121(f)).

[30] Affordable Care Act, section 1311(g)(1).

🌿 **TIP:** An issuer that previously submitted an Implementation Plan and is completing a Progress Report on an existing QIS should NOT change its topic area selections in Element 20. If an issuer wishes to change its topic area selections, it must discontinue its previous QIS and submit a new Implementation Plan.

Step 3: **Identify whether the QIS applies to all eligible QHPs the issuer offers or is applying 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 QHPs" if the QIS applies to all eligible QHPs included in the current year's QHP Application. Check the box for "Subset of QHPs" if the QIS covers only some of the eligible QHPs offered by the issuer through the Marketplace.

🌿 **TIP:** Eligible QHPs are health plans within a product type that meets the minimum enrollment threshold (i.e., the product type had more than 500 on-Marketplace enrollees per State as of July 1, 2016). QHPs within product types that do not meet the minimum enrollment threshold (i.e., non-eligible QHPs) are not required to be covered by a QIS. For more information about QHP eligibility with respect to an issuer's QIS, refer to Section 5.2 of the Technical Guidance.

If "Subset of QHPs" 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 QHPs must be covered by a QIS.

🌿 **TIP:** If this QIS covers only a subset of the issuer's eligible QHPs offered through the Marketplace, an issuer must submit additional Implementation Plan and Progress Report forms so that each eligible QHP offered by the issuer through a Marketplace is associated with a QIS.

For Criterion 21b, specify all eligible QHPs included in the QIS by listing the HIOS Plan ID for each QHP. The HIOS Plan ID, sometimes called the SCID, is a unique 14-character identifier assigned to each QHP. Providing this information will help confirm that each eligible QHP being offered through a Marketplace is associated with a QIS. Enter the HIOS Plan ID(s) into the appropriate text box to indicate if each one is a new QHP (i.e., a health plan undergoing QHP certification for the first time) or an existing QHP (i.e., a previously QHP-certified health plan).

🌿 **TIP:** For each HIOS Plan ID listed, indicate if the plan is a new QHP (i.e., a health plan undergoing QHP certification for the first time) or an existing QHP (i.e., a previously QHP-certified health plan).

To complete Criterion 21c, check the appropriate box(es) to indicate the product type(s) (e.g., HMO, point of service) to which the QIS applies.

🌿 **TIP:** If you wish to add or remove HIOS Plan IDs (SCIDs) or product types to an existing QIS, please enter that information in Element 27. Do not change your prior responses to Criterion 21a, Criterion 21b, and Criterion 21c.

🌿 **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.

To complete Element 22, provide a narrative rationale that describes the issuer's current[31] enrollee population and how the QIS will address the needs of the current QHP enrollee population.

🌱 **TIP:** An issuer that previously submitted an Implementation Plan and is completing a Progress Report on an existing QIS should NOT change its rationale in Element 22.

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 the issuer addressed them in the context of another topic area.

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.

🌱 **TIP:** If you selected "Continuing a QIS with Modifications" in Element 1, indicate whether the issuer modified its goal(s) from its most recent QIS Implementation Plan submission (i.e., the QIS Implementation Plan submitted during the previous year's QHP Application Period) by checking "Yes" or "No." If this is a new QIS submission or the issuer is continuing its QIS with no modifications, check "Not Applicable."

To complete Criterion 23a, list the activities that will be implemented to achieve the identified goals.

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

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

To complete Criterion 23d, if "Implementation of activities to reduce health and health care disparities" is not selected as a topic area in Element 20, but relevant activities are included in the context of another topic area in the issuer's QIS, describe how implementation activities relate to health and health care disparities. If health and health care disparities are not addressed

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

in the QIS, or if health and health care disparities is one of the topic areas selected in Element 20, check "Not Applicable."

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. If the issuer selected "Continuing a QIS with Modifications" in Element 1, indicate if the measure was modified from the most recent QIS Implementation Plan submission. If this is a new QIS submission or the issuer is continuing a QIS with no modifications, check "Not Applicable."

Issuers have flexibility in selecting their measures, which are required to be quantitative measures. Outcome measures, as well as measures of patient experience and value, are preferred over process measures. Issuers will submit an annual Progress Report, including a description of progress of QIS implementation activities and analysis of progress using proposed measures and targets (Element 29). Issuers will also have the opportunity to provide narrative description of progress made against those measures in the Progress Report (Element 30).

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

TIP: Issuers are not required to use QHP enrollee survey results and/or QRS survey results as QIS baseline data. Issuers may choose to use survey results or may choose to use other data sources that identify QHP enrollee population needs and support their QIS rationale for QIS baseline data in Element 24 of the Implementation Plan.

Also for Criterion 24a, please provide a narrative description of the measure, including the measure numerator and denominator. Next, specify whether the issuer is using an NQF-endorsed measure by checking "Yes" or "No." If yes, provide the NQF ID in the space provided and indicate whether the issuer modified the NQF-endorsed measure specifications.

TIP: Issuers are not required to use NQF-endorsed measures to complete Element 24. However, if an issuer chooses to do so, it must include the measures' NQF IDs in the spaces provided.

TIP: While CMS does not currently require issuers to select measures from a set of specific measures, use of standardized or uniform performance measures is strongly encouraged.

CMS encourages issuers to use national, State, or regional benchmarks when establishing their QIS performance targets. Further, CMS encourages issuers to select measures and performance targets in areas where there is room for improvement, based on these established benchmarks.

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

For Criterion 24c, provide the baseline results by calculating the rate (a numerical value) and providing the associated numerator and denominator, if applicable. If the measure is not a rate, but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

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 QIS initiation/start date in Criterion 25a. Enter the date using the following format: MM/YYYY. The QIS initiation/start date should be the date the issuer first began implementing the QIS for the Marketplace product types and health plans specified in the Element 21. This date is most often the first month of the plan year in which the QIS was implemented. For example, if an issuer submits a QIS Implementation Plan for the first time during the 2018 QHP Application period for the 2018 plan year, it should list its QIS initiation/start date as 01/2018.

For Criterion 25b, the timeline should also include the dates of defined milestones. At least one milestone is required. Enter the dates of defined milestones using the following format: MM/YYYY. Dates of defined milestones should occur after the QIS initiation/state date entered in Criterion 25a.

The dates and milestones provided for those criteria may correspond to the activities described in Element 23. Issuers will not be penalized if they need to adjust 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.

Describe all known or anticipated barriers to implementing QIS activities in Criterion 26a. If no barriers were identified, describe how you assessed barriers.

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 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 will be notified of these deficiencies and instructed to correct and resubmit their Implementation Plans.

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.

4.   Complete the QIS Progress Report (Part F)

In each subsequent year following the submission of a QIS Implementation Plan, an issuer must submit a Progress Report to the applicable Marketplace. The Progress Report collects information about the issuer's progress in implementing its QIS.

Issuers that submitted an Implementation Plan during the 2017 QHP Application Period are required to submit a Progress Report during the 2018 QHP Application Period, reporting on activities conducted to implement the QIS. Issuers submitting a QIS for the first time during the 2018 QHP Application Period are not required to submit a Progress Report until the 2019 QHP Application Period.

To complete the Progress Report, issuers must:

- Complete the **QIS Submission Type** section (Part A);
- Confirm the **Background Information** section (Part B) and **Data Sources** section (Part C) are accurate or include updates from the prior year, if necessary;
- Complete the **Implementation Plan Section** (Parts D and E) with the prior year's information and specify whether the information has changed, if applicable; and
- Complete the **Progress Report Section** (Part F).

📌 **TIP:** Issuers submitting Progress Reports for the 2018 plan year must submit their Progress Reports via the updated QIS Implementation Plan and Progress Report form for the 2018 plan year. If an issuer is making no modifications to its QIS Implementation Plan,

then the issuer may copy and paste its previous QIS Implementation Plan information into the updated QIS Implementation Plan and Progress Report form.

4.1   Part F. Progress Report Summary

Exhibit 17 lists Progress Report elements and criteria that issuers must complete in Part F of the QIS Implementation Plan and Progress Report form.

<p align="center">Exhibit 17: Part F. Progress Report</p>

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
27	**Addition/Removal of Health Plans to the Issuer's QIS**	27a – Indicate if the issuer is adding or removing any QHPs to the QIS originally listed in Criterion 21b. 27b – If "Add QHP(s)" or "Remove QHP(s)" was selected, list the QHPs that were added or removed (all newly QIS-eligible QHPs should be listed) and provide each plan's unique 14-digit HIOS Plan ID (SCID). If "No additions or removals" was selected, check "Not Applicable." 27c – Indicate if the issuer is adding or removing any product types to the QIS originally listed in Criterion 21c. Check all that apply. If there are no additions or removals, check "Not Applicable."	This element will be scored. All criteria must be completed.	None
28	**QIS Modifications** If "**Continuing a QIS with Modifications**" was selected in Part A, Element 1, please indicate what type of modification(s) the issuer is making to its QIS and provide a rationale for the modification(s). Note that modifications only apply to elements in Part D (Implementation Plan). If no modifications are being made, select "Not Applicable" for each criterion.	28a – Modifying the activities of the QIS (Element 23)? If no, check "Not Applicable." 28b – Modifying the goals of the QIS? If no, check "Not Applicable." 28c – Modifying the measure(s) of the QIS? If no, check "Not Applicable."	This element will be scored. All criteria must be completed.	500 characters per criterion

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit
29	**Analyze Progress Using Baseline Data, as Documented in the Implementation Plan (Must Pass)** Restate the goals identified in the most recent Implementation Plan. For each goal, restate the measure(s) identified in the most recent Implementation Plan, and complete the fields below.	29a – Baseline performance period (e.g., the measurement year covered by the updated data). 29b – Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment. 29c – Measure name. 29d – Restate the baseline results from Criterion 24c of your most recent QIS submission, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator. 29e – Provide the follow-up results by calculating the rate and providing the associated numerator and denominator, if applicable. If the measure is not a rate, but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator. Was the performance target (Criterion 24e) achieved?	This element will be scored; Element 29 is a must-pass element.	500 characters per criterion
30	**Summary of Progress (Must Pass)**	30 – Indicate 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 modifications were checked in Element 28, indicate whether the information provided here affects the decision to modify or change the QIS.	This element will be scored; Element 30 is a must-pass element.	1,500 characters
31	**Barriers**	31a – Were barriers encountered in implementing the QIS? If "Yes," describe the barriers. 31b – Were there challenges meeting timelines as indicated in Element 25? If "Yes," describe the challenges.	This element will be scored. Both criteria must be completed.	1,500 characters per criterion
32	**Mitigation Activities**	32a – If "Yes" was selected in Criterion 31a, describe the mitigation activities implemented to address each barrier. Also, describe the result(s) of the mitigation activities. If "No" was selected in Criterion 31a, check "Not Applicable." 32b – If "Yes" was selected in Criterion 31b, describe the mitigation activities implemented to address each problem in meeting the timeline. Also, describe the result(s) of the mitigation activities. If "No" was selected in Criterion 31b, check "Not Applicable."	This element will be scored. Both criteria must be completed.	750 characters per criterion

Follow these steps to complete Part F in the Progress Report Section of the form:

Step 1: Identify whether any eligible QHPs will be added to or removed from the QIS. For each QHP added or removed, indicate the 14-digit HIOS Plan ID (SCID) in the appropriate box in Element 27. Be sure to address both of the specified criteria.

To complete Criterion 27a, indicate whether any eligible QHPs will be added to or removed from the QIS by checking "Add QHP(s)," "Remove QHP(s)," or "No additions or removals." An additional eligible QHP is defined as a QHP that was **not** previously listed in Criterion 21b of the issuer's Implementation Plan, but will be newly covered by the QIS. An issuer should select "Add QHP(s)" to add a QHP that was previously covered by a different QIS, or to add a QHP that is newly eligible to be covered by a QIS.

A removed QHP is defined as a QHP that was previously listed in Criterion 21b of the issuer's most recent QIS Implementation Plan submission, but is no longer covered by the QIS. An issuer should select "Remove QHP(s)" to remove a QHP that was previously covered by the QIS, but is no longer covered by the QIS, or to remove a QHP that has been discontinued. If "Add QHP(s)" or "Remove QHP(s)" is selected, identify which QHPs were added or removed in Criterion 27b.

To complete Criterion 27b, indicate the 14-digit HIOS Plan ID (SCID) for each QHP added to or removed from the QIS described in the Implementation Plan section of the form. Providing this information will help confirm that each eligible QHP being offered through a Marketplace is associated with a QIS. If no new QHPs (i.e., health plans undergoing QHP certification for the first time) will be covered by or removed from the QIS, check "Not Applicable."

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

🪧 **TIP:** When completing Criterion 27b, indicate all newly QIS-eligible QHPs being offered through the Marketplace that will be covered by this QIS.

🪧 **TIP:** To list additional QHPs beyond the allotted space for twelve 14-digit HIOS Plan IDs (SCIDs) in Criterion 27b, use the space provided under "Criterion 27b continued" on page 28 of the form.

To complete Criterion 27c, indicate any product types being added or removed from the QIS described in the Implementation Plan section of the form. If no product types will be added or removed from the QIS, check "Not Applicable" and continue to Element 28.

Step 2: In Element 28, indicate what type of modifications, if any, were made to the QIS if "Continuing a QIS with Modifications" was selected in Part A, Element 1 of the form. Be sure to address all three of the specified criteria.

To complete Element 28, check the appropriate box(es) to indicate the type of modification(s) (i.e., Activities, Goals, and/or Performance measure[s]) the issuer is making to the elements in Part D of the Implementation Plan Section of the form. If no modifications are being made, select "Not Applicable" for each criterion. If any modifications are being made, provide a brief justification and description of each QIS modification.

Step 3: Restate the goals and baseline data provided in Elements 18 and 24 of your most recent QIS Implementation Plan, and analyze progress by providing follow-up results and indicating whether the performance target in Criterion 24e was met in must-pass Element 29. Be sure to address all five of the specified criteria.

In the space provided, restate the goal or goals identified in Element 24 of the issuer's most recent QIS Implementation Plan (i.e., the Implementation Plan submitted to the Marketplace the prior year).

🖈 **TIP:** When completing Element 29, an issuer should reference the goal(s) and measure(s) used in Element 24 of its most recent QIS Implementation Plan submission. If an issuer chooses to modify its most recent Implementation Plan during completion of its Progress Report submission (e.g., if an issuer selected "Continuing a QIS with modifications" in Element 1), the issuer's response to Element 29 should reflect progress made on its most recent QIS Implementation Plan submission prior to modification.

For example, if an issuer submitted a QIS Implementation Plan during the 2017 QHP Application Period, and chooses to modify the measures in Element 24 of its QIS Implementation Plan during the 2018 QHP Application Period, the Progress Report submitted by the issuer during the 2018 QHP Application Period should reflect progress made against the measures originally specified in its 2017 QIS Implementation Plan (as opposed to its newly modified measures).

To complete Criterion 29a, specify the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment as indicated in Criterion 24d of your most recent QIS submission. Enter the response in MM/YYYY format.

To complete Criterion 29b, specify the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment. Enter the response in MM/YYYY format.

To complete Criterion 29c, provide the measure name as indicated in Criterion 24a of your most recent QIS Implementation Plan (i.e., the QIS Implementation Plan submitted to the Marketplace the prior year). Note the tip above about matching goals and measures.

To complete Criterion 29d, restate the baseline results from Criterion 24c of your most recent QIS submission, including the rate (a numerical value) and associated numerator and denominator, if applicable. If the measure is not a rate, but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator.

To complete Criterion 29e, provide the follow-up results by calculating the rate (a numerical value) and providing the associated numerator and denominator, if applicable. If the measure is not a rate, but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator. Indicate whether the original performance target specified in Criterion 24e of your most recent QIS submission was achieved by selecting "Yes" or "No."

🖈 **TIP:** Issuers will **not** be penalized if they do not achieve performance target(s); however, issuers may revise their performance target(s) if the original performance target(s), as

specified in Criterion 24e of the most recent QIS Implementation submission, is no longer feasible or accurate.

Step 4: **Provide a summary of progress toward achieving the performance target(s) documented in Element 24 of your most recent QIS Implementation Plan submission. Include a description of the activity(ies) leading to the outcome in must-pass Element 30.**

Indicate why progress was or was not made toward achieving the performance target(s) documented on Element 24 of your most recent QIS Implementation Plan. Include a description of activities that led to the outcome. If at least one modification was checked in Element 28, specify whether the information included in the summary of progress provided in Element 30 affected the decision to modify or change the QIS.

Step 5: **In Element 31, indicate whether the issuer faced any barriers implementing its QIS and/or any problems meeting the timelines specified in Criterion 25b of your most recent QIS Implementation Plan submission. Be sure to address both of the specified criteria.**

To complete Criterion 31a, indicate whether any barriers were encountered in implementing the QIS. If "Yes" is selected, describe the barriers encountered while implementing the QIS.

To complete Criterion 31b, indicate whether there were any problems meeting the timelines specified in Criterion 25b of your most recent QIS Implementation Plan. If "Yes" is selected, describe the problems in meeting timelines.

Step 6: **In Element 32, describe any mitigation activities implemented to address the barriers and/or challenges meeting timelines that were specified in Element 31, if applicable. Describe the results of the mitigation activities.**

If the issuer selected "Yes" in Criterion 31a describe any activities implemented by the issuer to address barriers encountered in implementing the QIS in Criterion 32a. Be sure to indicate the results of any mitigation activities (i.e., did the mitigation activities work as intended). If the issuer selected "No" in Criterion 31a, check "Not Applicable." If the issuer selected "Yes" in Criterion 31b describe any activities implemented by the issuer to address challenges with meeting timelines in Criterion 32b. If the issuer selected "No" in Criterion 31b, check "Not Applicable."

5.   Submit the Form

Issuers will submit their completed Implementation Plan and Progress Report forms, along with all other QHP certification documentation,[32] during the annual QHP Application Period. For the 2018 QHP Application Period, the QHP Application submission window for the FFMs is specified in the 2018 Letter to Issuers. For the 2018 plan year, the QIS Implementation Plan and Progress Report form will be submitted through the accreditation module.

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[32] 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.

Issuers operating in the FFMs will submit via HIOS. Issuers operating in FFMs where States perform plan management will submit via SERFF. Issuers operating in SBMs or SBM-FPs should contact their Marketplaces for specific instructions on QHP Application submission details, including QIS submission requirements.

Issuers submitting quality improvement strategies for QHPs offered through an FFM will submit their Implementation Plan and Progress Report form(s) through HIOS.[33] Once issuers have typed responses for each applicable element and criteria into the Implementation Plan and Progress Report form and saved a local copy of the completed form, they will need to upload the document to HIOS along with their other QHP Application materials to transmit it to the relevant FFM for evaluation.

TIP: Before you submit your Implementation Plan or Progress Report, use the checklist provided in Appendix D to double check your Implementation Plan and Progress Report form for completeness, and verify that your QIS addresses all of the elements and criteria, especially the six must-pass elements identified in Exhibit 16, and the must-pass element identified in Exhibit 17 (if applicable).

TIP: Issuers should not password protect or scan their QIS Implementation Plan and Progress Report forms prior to submission via HIOS or SERFF. Issuers should submit their QIS Implementation Plan and Progress Report forms as fillable-PDF files, as opposed to files that have been scanned. Password protecting QIS submissions prevents CMS from processing QIS submissions for evaluation. Issuers who submit password protected QIS Implementation Plan and Progress Report forms will be asked to remove password protection and resubmit.

5.1   Submit via HIOS

Issuers in FFMs where the State does not perform plan management should follow these steps to submit their completed Implementation Plan and Progress Report form(s) 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 credentials (i.e., user name and password) to access HIOS.[34]**

Step 3: **Select "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 and Progress Report form to HIOS.**

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[33] Note: Issuers submitting quality improvement strategies for QHPs offered in FFMs where the State performs plan management will follow a slightly different submission process. See Section 5.2 of this User Guide for further details. In addition, OPM will evaluate QIS submissions for MSP products.

[34] To gain access to HIOS, all issuers must register in the CMS Enterprise Identity Management System (EIDM) and 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.

📌 **TIP:** In the HIOS Accreditation module, an issuer should use the "Upload File(s)" function to upload its QIS as part of its "Supplementary Documentation." When asked to select the document type, the issuer should use the drop-down menu to select "QIS Document."

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.

5.2   Submit via SERFF

Issuers submitting quality improvement strategies for QHPs offered in FFMs where the State performs plan management will follow a slightly different submission process. These issuers will submit their Implementation Plan and Progress Report forms through SERFF. Once submitted, these issuers' Implementation Plan and Progress Report forms will be transmitted to the State and the FFMs for joint evaluation.

Issuers operating in FFMs where the State performs plan management 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 and Progress Report form (in Adobe Acrobat PDF format) to SERFF.

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.

6.   Address Incomplete or Deficient QIS Submissions

The FFMs 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 an FFM determines that their submissions are incomplete and/or do not meet the QIS requirements.[35]

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[35] Issuers offering coverage in FFMs where the State performs plan management should contact the applicable State regulator(s) for additional details on the State process for evaluating QIS submissions. Issuers offering coverage in

6.1   Revise and Resubmit a Form during the QHP Application Period

During the QHP Application Period, the FFMs will assess issuers' QIS submissions for completeness. If an issuer's submission contains blank fields or is missing information, the issuer will receive a Correction Notice. If an issuer's submission is complete, the issuer will not receive a Correction Notice that contains QIS deficiencies. The following steps provide information about what issuers should do if they receive a Correction Notice.

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

The Correction Notice will specify any Implementation Plan and Progress Report form elements and criteria that were left blank or are missing information.

Step 2:   Open the local copy of the issuer's saved QIS Implementation Plan and Progress Report form.

Use the final version that was previously uploaded to HIOS or SERFF and submitted to the relevant 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 provide responses or make corrections to the elements and criteria the FFMs indicated were left blank or were missing information. The new responses should address the identified deficiencies by providing additional information or including missing information as directed by the Correction Notice.

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

Step 4:   Save a local copy of the revised QIS Implementation Plan and Progress Report form.

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

Step 5:   Upload the revised QIS Implementation Plan and Progress Report form to HIOS or SERFF (as appropriate).

Follow the steps provided in Section 5 above, to submit the revised form to the FFMs and the State (if applicable). Issuers operating in FFMs where the State performs plan management should submit via SERFF; for all other FFM States, issuers should submit via HIOS. For MSP products, issuers should follow the guidance provided by OPM.

SBMs (including SBM-FPs) should contact the applicable Marketplace for details on the process for evaluating QIS submissions. Issuers offering MSP products in FFMs should contact OPM for additional details on its process for evaluating QIS submissions.

Appendices

Appendix A. Relevant Statutory and Regulatory Citations

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

Topic	Provisions	Citation
QHP certification standards for quality improvement strategies	(c) RESPONSIBILITIES OF THE SECRETARY.— (1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum— (E) implement a quality improvement strategy described in subsection (g)(1).	Section 1311(c)(1)(E)
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 oversight responsibilities 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 issuer participation 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
Marketplace 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 standards	*(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 B. 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. Issuers that meet the QIS participation criteria must complete the QIS Submission Type section (Part A) of the form annually, in addition 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[36] with No Previous QIS Submission	• The issuer has offered QHPs through a Marketplace for at least two consecutive years, <u>AND</u> • Has not previously submitted a QIS Implementation Plan[37]	• Complete the Background Information section (Parts B and C), <u>AND</u> • Complete the QIS Implementation Plan Section (Parts D and E)

New QIS after Discontinuing a QIS Submitted during a Prior QHP Application Period	• The issuer has previously submitted a QIS Implementation Plan and a QIS Progress Report based upon that Plan, <u>AND</u>
	• 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
		▪ Complete 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

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[36] Note: A "new QIS" is defined as a QIS that has not been previously submitted to the Marketplace for evaluation, or as a QIS that is based upon a different market-based incentive(s) and/or topic area(s) than the issuer's previous QIS.

[37] The issuer must not have submitted a QIS Implementation Plan for the QHPs 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 QHPs 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 an entirely different subset of QHPs 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, <u>AND,</u> • Confirm the QIS Implementation Plan Section (Parts D and E) is completed with the prior year's information, <u>AND</u> • 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, <u>AND</u> • Made changes to the QIS related to QIS goals and/or activities that do not meet the definition of a new QIS *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 QIS After Discontinuing A QIS Submitted During a Prior QHP Application Period."*	• Update the Background Information section (Parts B and C) as needed, <u>AND</u> • Update the QIS Implementation Plan Section (Parts D and E) as needed based on modifications, <u>AND</u> • Complete the QIS Progress Report Section (Part F)

Appendix C. 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 incentives 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 enrollee'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 an enrollee 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 covered service, not including the deductible.
Cash or Cash Equivalents	The QHP pays the enrollee 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 D. QIS Implementation Plan and Progress Report Form Pre-submission Checklist

This checklist is intended to help issuers verify the completeness of their Implementation Plan and Progress Report forms, 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 AND PROGRESS REPORT FORM PRE-SUBMISSION CHECKLIST

A. PREPARATION

☐ Review the applicable regulations, the entire 2018 QIS Technical Guidance and User Guide, as well as the relevant sections of the 2018 Letter to Issuers.

☐ 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 IMPLEMENTATION PLAN

☐ Enable JavaScript in the fillable PDF form before you enter your QIS information.

☐ Complete the QIS Submission Type section (Part A) by checking the applicable Type of 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 of 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.

C. COMPLETE THE PROGRESS REPORT (IF NECESSARY)

☐ Update relevant elements and criteria in the QIS Implementation Plan section, if necessary.

☐ Complete all of the elements and criteria in Part F: Progress Report Summary, in the QIS Progress Report Section.

☐ Confirm that you have provided responses for all elements—including must-pass elements—and criteria in all parts of 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.

D. SUBMIT THE FORM

☐   Save a local copy of the form using the appropriate file naming convention. Do not password protect or flatten the completed fillable PDF form.

☐   Upload the completed copy of the QIS Implementation Plan and Progress Report form to HIOS or SERFF, as appropriate, for submission to the FFMs. For MSP products, issuers should follow the guidance provided by OPM. For coverage offered through an SBM, issuers should follow the guidance provided by the applicable Marketplace.

☐   Share your QIS submission with 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 QHP offered by the issuer through a Marketplace is covered by a QIS; submit additional QIS Implementation Plan and Progress Report forms as necessary.

Appendix E. Glossary

Unless otherwise stated in this document, the definitions below apply to key terms, are QIS-specific, and are defined within the context of the QIS requirements. 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 that impact demand for health care.
certification	The process by which issuers are evaluated and their health plans are recognized as meeting the predetermined criteria and standards described in 45 CFR 156 Subpart C.[38]
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.[39]
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.[40]
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.[41]
criteria	Criteria describe the type of information issuers must provide and are the rules that a Marketplace will use to evaluate whether an issuer's QIS fulfills the QIS requirements.
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.
exclusive provider organization (EPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, that 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.
Federally-facilitated Marketplaces (FFM) or Federally-facilitated Exchanges (FFE)	The Marketplace models operated by HHS for individual and small group market coverage.

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

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

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

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

Term	Definition
Health Insurance Marketplace^{SM} (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 issuers, which will be aggregated with other data sources and made public on a consumer-facing website. The initial mechanism for the States and issuers to submit their data is through the use of the HIOS form.
health maintenance organization (HMO)	A type of health insurance product that usually limits coverage to care from providers that 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.[42]
Medicare Shared Savings Program	CMS 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.[43]
Multi-State Plan (MSP)	A Multi-State Plan is a private health insurance plan offered through the Marketplaces under contract with the Office of Personnel Management. MSP options are recognized as QHPs, per 45 CFR 155.1010, and therefore are subject to the same federal quality reporting requirements. When describing requirements for "QHP issuers" within this document, it is assumed the same requirements apply to issuers offering MSP options, unless otherwise noted. OPM will provide any additional guidance to MSP issuers.
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).

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

[43] 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 (HHS). 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.[44]
Office of Personnel Management (OPM)	OPM administers the Federal Employees Health Benefits (FEHB) Program. The Affordable Care Act directs OPM to contract with private health insurers in each state to offer high-quality, affordable health insurance options (Multi-State Plan options) through the Multi-State Plan Program to drive competition and choice in the Marketplaces.
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.[45]
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.[46]
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.

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

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

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

Term	Definition
provider	A provider is an organization, institution, or individual that is a supplier of medical services.
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 form is a form issuers use for annual reporting to the applicable 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 applicable Marketplace.
QIS requirements	The statutory requirements, according to section 1311(g) and accompanying 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 applicable 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 applicable 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 the applicable Marketplace through which such plan is offered.[47]
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 HIOS Issuer ID. Each QHP issuer is defined by a State geographic unit.[48] 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 related statutory certification requirement to participate in Marketplaces.

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

[48] Ibid.

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^{SM}, for both the individual and small group markets. An SBM is responsible for certifying issuers, overseeing issuer compliance with federal Marketplace quality standards as a condition of certification.
State-based Marketplace on the Federal Platform (SBM-FP)	A Marketplace model in which a State operates its own Health Insurance Marketplace ^{SM}, for both the individual and small group markets, but relies on the federal platform to perform certain eligibility and enrollment functions. An SBM-FP is responsible for certifying issuers, overseeing issuer compliance with federal Marketplace quality standards as a condition of certification.
States performing plan management	FFMs where the State performs plan management for QHPs offered through the Marketplace. Consumers in these States apply for and enroll in coverage through the FFMs.
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 with the issuer's QIS submission. An issuer's Work Plan is generally submitted to the Marketplace for evaluation following the QHP Application Submission and Review Period.

Appendix F. Acronym List

This appendix includes a list of acronyms used in this document and their complete term or name.

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
HSA	Health Savings Account
MQI	Marketplace Quality Initiatives
MSP	Multi-State Plan
NQF	National Quality Forum
NQS	National Quality Strategy
OPM	U.S. Office of Personnel Management
POC	Point of Contact
QHP	Qualified Health Plan
QIS	Quality Improvement Strategy
QRS	Quality Rating System
SADP	Stand Alone Dental Plan
SBM	State-based Marketplace
SBM-FP	State-based Marketplace on the Federal Platform
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program
XOSC	Exchange Operations Support Center