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

November 5, 2015

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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 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 site for QIS resources, this site contains instructional documents regarding QIS implementation and reporting, including this document.	http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html
CMS Qualified Health Plans (QHP) Application website	This website provides issuers with detailed application instructions, forms—including the QIS Implementation Plan and Progress Report form—as well as justifications, supporting documents, and tools to complete the annual QHP 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

Other Resources

- State-based Marketplaces (SBMs) should contact their respective Center for Consumer Information and Insurance Oversight (CCIIO) State Officers for resolutions of their inquiries.
- Issuers offering Multi-State Plan (MSP) products should contact the Office of Personnel Management (OPM) to confirm the requirements and timing associated with QIS implementation (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 *2017 Letter to Issuers in the Federally-facilitated Marketplaces* (Letter to Issuers) will provide issuers seeking to offer QHPs, including stand-alone dental plans (SADPs), in the Federally-facilitated Marketplaces (FFM), whether through the individual market or the Small Business Health Options Program (SHOP) with operational and technical guidance to help them successfully participate in those Marketplaces in 2017. The draft 2017 Letter to Issuers is expected to be released in late 2015.
- The **Patient Protection and Affordable Care Act; U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016** (Payment Notice) includes implementation requirements for QHP quality improvement strategies beginning with the 2016 coverage year.

Document Purpose and Scope

The *QIS Technical Guidance and User Guide for the 2017 Coverage 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 2017 QHP Application Submission and Review Period[1] (QHP Application Period, which applies to the 2017 coverage year).[2] This document is organized into two volumes:

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

Both volumes will be updated annually to reflect any relevant changes or updates.

VOLUME I: QIS TECHNICAL GUIDANCE FOR THE 2017 COVERAGE YEAR

The QIS Technical Guidance for the 2017 Coverage Year (Technical Guidance) provides information on the QIS participation 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 states performing plan management functions, to review issuers' QIS submissions. Throughout this document, unless otherwise noted, references to an FFM includes states performing plan management functions in State Partnership states.

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 2017 coverage year;
- Marketplace oversight responsibilities;
- The QIS requirements;
- An overview of the QIS evaluation process and methodology; and
- An overview of progress report submission.

[1] The information in this document incorporates stakeholder feedback (including input from the QIS Technical Expert Panel and public comments on the *Quality Improvement Strategy: Technical Guidance and User Guide for the 2017 Coverage Year* draft made available for public comment for 30 days on July 1, 2015. Based on the feedback, some of the substantive changes included in this document involve further clarifying: (1) the purpose of collecting the Payment Model categories information and percentage of payment linked to quality or value; (2) requirement to provide quantitative measures; (3) emphasis that State-based Marketplaces may build on the FFM requirements; and (4) issues related to health and health care disparities.

[2] The 2017 QHP Application Period occurs in the 2016 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).

VOLUME II: QIS USER GUIDE FOR THE 2017 COVERAGE YEAR

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

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

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

Volume I. QIS Technical Guidance for the 2017 Coverage Year

1. Background

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 market 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 quality improvement strategy or strategies must cover all of its QHPs offered through a Marketplace that meet the participation criteria described in Section 5.2 of this Technical Guidance, and/or that offer MSP options.

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 this document).

Many health improvement activities will benefit the overall population, which is one of the key goals of the CMS Quality Strategy. However, the statutory requirements related to the QIS require the use of market-based incentives to improve the quality and value of health care and services specifically for Marketplace enrollees. Section 1311(g) specifies two market-based incentives types that issuers may include in their quality improvement strategies: (1) increased

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

reimbursement or (2) other incentives. These incentive types are defined below; additional examples are provided in Appendix C.

(1) Increased Reimbursement

- 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

- "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.
- "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. 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.

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

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
Improve Patient Safety and Reduce Medical Errors	▪ Appropriate use of best clinical practices ▪ Evidence-based medicine ▪ Health information technology

[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
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 an issuer's QIS, 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 states performing plan management functions in an FFM, 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 strategies of the issuers applying to offer QHPs in their respective Marketplaces. SBMs must comply with the federal minimum reporting requirements. They may establish their own reporting forms and evaluation methodologies, as well as their own reporting manner and frequency requirements, or they may choose to use those established by CMS for the FFMs.
- 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 follow any OPM technical guidance on QIS submissions.
    - Both QHPs and MSP options, then the issuer must send the QIS submission to the applicable Marketplace, along with a copy to OPM. Once the Marketplace approves the QIS submission, the issuer must submit the final QIS submission along with evidence of such approval to OPM.

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.
- Align the statutory requirements with other quality improvement programs. In particular, the QIS will align with the Marketplace QRS, the Marketplace QHP Enrollee Satisfaction

[7] 45 CFR 155.200(d).

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 that 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.

Issuers will 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 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.

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 that an issuer may accomplish this: (1) implement one QIS that applies to all of its eligible QHPs in a given Marketplace; or (2) implement more than one QIS, if having just one QIS does not address all of its eligible QHPs. ***All*** of the issuer's QHPs offered through a Marketplace that meet the participation criteria described in Section 5.2 of the Technical Guidance must be covered by a QIS (referred to as "eligible QHPs").

An issuer that offered an eligible QHP through a Marketplace in the 2014 and 2015 coverage years must submit all required QIS information to the applicable Marketplaces in 2016 for the 2017 coverage year. (In subsequent years, the issuer must submit an annual update on its implementation progress.) See Exhibit 2 for examples of the timespan for QIS submissions.

Exhibit 2: QIS Initial Implementation Plan Submission Timespan

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 Coverage Year
2013	2014 and 2015	2016	2017
2014	2015 and 2016	2017	2018
2015	2016 and 2017	2018	2019
2016	2017 and 2018	2019	2020

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 2014, does not offer any QHPs through that Marketplace in 2015, and offers QHPs through that Marketplace again in 2016 and 2017, the issuer will only be required to submit a QIS Implementation Plan and Progress Report form in 2018 for the 2019 coverage year for its QHPs that meet the participation criteria described in Section 5.2 of the Technical Guidance.

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

3. QIS Schedule for the 2017 Coverage Year

Issuers applying for QHP certification in the FFMs will submit QIS information during the annual QHP Application Period, and should refer to the 2017 Letter to Issuers[8] for finalized dates for that period. Exhibit 3 highlights the major stages of the QIS process for the 2017 coverage year in the FFMs, offering approximate timeframes assuming a November 1, 2016, start date for the open enrollment period for illustrative purposes. Issuers operating in other Marketplace types 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	Approximate Timeframe
Issuer develops quality improvement strategies for the 2017 coverage year	Fall 2015 – April 2016
QHP application submission window for the 2017 coverage year	April 2016 – May 2016
QHP application evaluation window for the 2017 coverage year	May 2016 – August 2016
Final QHP certification for the 2017 coverage year	September 2016

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 an issuer's QIS as a condition of QHP certification for the 2017 coverage year.

[8] The Draft 2017 Letter to Issuers is expected to be released in late 2015.

4.1 Federally-Facilitated Marketplaces

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

States performing plan management functions 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). States performing plan management functions in an FFM must evaluate the QIS submissions of the issuers offering coverage through their states using the federal QIS evaluation methodology, but issuers should contact the states for additional details.

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; states performing plan management functions in an FFM; 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, format, 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 Marketplaces).

SBMs must comply with the federal minimum reporting requirements. SBMs are encouraged to use the reporting manner and frequency requirements established by 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 the SBM may have established its own reporting manner, frequency requirements, and additional reporting requirements.

5. QIS Requirements

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

5.1 Participation Criteria

This section describes the QIS participation criteria for issuers. Issuers must submit a QIS to a Marketplace for the 2017 coverage year if:

- **An issuer offered coverage through a Marketplace in 2014 and 2015**. Requiring only those issuers that have been operating in a Marketplace for two consecutive years, regardless of whether their QHPs have changed during that time, to comply with the QIS requirements allows for a phased-in approach. This approach will give 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 2015 and 2016 (but not in 2014), the issuer would not need to submit a QIS until 2017 for the 2018 coverage year.

- **An issuer provides family and/or adult-only medical coverage**. The QIS (or more than one QIS) should cover all eligible QHPs, which 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, QIS requirements do not apply to child-only plans, stand-alone dental plans (SADPs), or QHPs that are compatible with health savings accounts (HSAs).

- **An issuer meets the QIS minimum enrollment threshold.** An issuer must submit a QIS if it had more than 500 enrollees within a product type per state as of July 1, 2015.[9, 10] Furthermore, for any product type that has more than 500 enrollees as of July 1, 2015, all QHPs within that type must be covered by a QIS.

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 QHPs within the same Marketplace.
- Each eligible QHP must be included in a QIS.

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 all enrollees in QHPs offered through a Marketplace. Enrollees in QHPs offered outside the Marketplace (off-Marketplace) and non-QHPs are not included in the calculation of the minimum enrollment.

- All enrollees in QHPs that provide family and/or adult-only medical coverage should be included. Enrollees in child-only plans, SADPs, or QHPs that are compatible with HSAs should not be included in the calculation of the minimum enrollment.

[9] Patient Protection and Affordable Care Act; U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016 , 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

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

- If an issuer offers QHPs of the same product type in both the individual Marketplace and in the SHOP within a state, the issuer must combine the enrollee totals from both the individual Marketplace and SHOP.
- If an issuer offers both a QHP and an MSP option of the same product type in the same state 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 2014 and 2015 in three states—West Virginia (WV), Maryland (MD), and North Carolina (NC)—has applied for certification of those QHPs for plan years in 2016 for the 2017 coverage 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 to the Marketplace for only the following states: West Virginia and Maryland. The issuer does not need to submit a QIS in North Carolina because it did not have sufficient number of enrollees within each product type as of July 1, 2015.

Exhibit 4: Example Issuer Submissions Assessed Against 2017 QIS Participation Criteria

Reporting Unit	Number of enrollees in the product type as of July 1, 2015 (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 have to 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 2017 coverage year are expected to submit a QIS Implementation Plan and Progress Report form in 2016 and then implement the QIS beginning no later than January 2017.[11] This section provides details about the specific elements and criteria that an issuer will need to address when submitting information about its QIS.

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 and 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

[11] 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.

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

Commonly Used QIS Terms

- **QIS requirements:** The information issuers are required to submit for evaluation by a Marketplace
- **Elements:** Identifying and descriptive information issuers will 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 will use to evaluate whether an issuer's QIS fulfills the QIS requirements

Issuers will use the QIS Implementation Plan and Progress Report form to submit a QIS Implementation Plan to the relevant Marketplace.[12] During the 2017 QHP Application Period,[13] when QIS implementation is in its initial year, every issuer will indicate in the Implementation Plan and Progress Report form that it is submitting a new QIS. In subsequent application periods, issuers will indicate in the form which of the following types of information they are submitting (see Exhibit 5):

- New QIS;
- 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 an Issuer Makes the Following Modifications:	A New QIS Is Required If the Following Changes are Made:
▪ Changes QIS activities; ▪ Changes QIS goals;[14] and/or ▪ Changes 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.

[12] Part F: Progress Report Summary (QIS Progress Report Section) is not required to be completed as part of the QIS Implementation Plan and Progress Report form for the 2017 QHP Application Period. It will be covered in full detail in the *QIS Technical Guidance and User Guide for the 2018 Coverage Year*, as the 2018 QHP Application Period will be the first time that an issuer would need to provide a progress report.

[13] The 2017 QHP Application Period occurs in the 2016 calendar year.

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

To provide an opportunity for full QIS implementation, and to allow time to determine whether the market-based incentives are working as expected, issuers are strongly encouraged to leave a QIS in place for at least two years before modifying it or developing a new QIS.

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 issuers will need to complete in future years for the annual updates, but which should not be completed during the QHP Application Period for the 2017 coverage year.

The annual reporting elements are further detailed in the User Guide, and will be scored as part of the QIS evaluation. See Section 5 of the User Guide for more information about Part F in particular.

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

Each element in Part E of the Implementation Plan is associated with criteria that will be assessed. 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.

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

6. QIS Evaluation

On an annual basis, issuers must meet the QIS requirements as part of QHP certification. In 2016, issuers will be required to provide information on the following parts of the form as part of their QHP Application for the 2017 coverage 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.

6.1 QIS Evaluation Process

The QIS evaluation process for the FFMs will take place annually as part of the QHP Application Period and will be outlined as part of the Annual Letter to Issuers.

To determine whether an issuer's QIS meets the applicable requirements, the respective FFM[15] will review and evaluate an issuer's QIS information submitted via the Implementation Plan and Progress Report form. There are three stages of review—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.

All issuers will go through first review. Only issuers whose submissions are incomplete or deficient will go through subsequent reviews. Correction Notices will be sent to issuers after each round of review during the application process. These notices will either indicate that no corrections are required (and no further review is required), or they will identify how the QIS submission is deficient, including whether the QIS submission was incomplete. If an issuer is still missing any information or does not receive a score that is at or above the predetermined minimum evaluation threshold for the Part E elements after the final review, CMS may require the issuer to develop a Work Plan.

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

6.2 QIS Evaluation Methodology

The QIS Evaluation Methodology reflects how the 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 reviewed for completeness, but will not be scored. For Part E, CMS uses a "Partial-Credit plus Must-Pass" scoring approach. This approach includes the

[15] 45 CFR. 155.200(d) directs the Marketplace to evaluate QIS submissions. For an FFM state, CMS will perform the evaluations; although for states performing plan management functions in the FFMs, the submission will be jointly reviewed by CMS and the state, with the final determination being made by CMS. For SBM states, the SBM will perform evaluations. OPM will evaluate QIS submissions for MSP products.

following three 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; (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; and (3) for the elements that are not designated as must-pass, receiving a score of .50 is equivalent to receiving 1.00.

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

6.3 Scoring

Scoring is done at the element level and only for those elements included in Part E. All elements included in Part E are worth 1.00 point, regardless of designation as must-pass. An issuer will receive a passing score for Part E if it: (1) meets 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 (see Section 6.3.1).

Elements 19-24 are must-pass, and there is no partial credit offered for these six elements. For must-pass elements, an issuer either receives 1.00 point (i.e., 100 percent) for meeting all criteria, or receives zero credit if any criteria are not met. Elements 25 and 26 are also scored, but issuers may receive partial credit for these two elements. See Exhibit 7 for details on the scored elements that issuers will be required to address, by type.

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

At this time, an issuer will <u>not</u> be required to demonstrate that its QIS has resulted in improvement. The issuer is required to track progress and make adjustments as appropriate. In other words, issuers will not be penalized if they do not achieve the performance targets set out in their QIS Implementation Plans.[16]

[16] 80 Fed. Reg. 10848 (Feb. 27, 2015).

6.3.1 Other Scored Elements

Element 25 (Timeline for Implementing the QIS) and Element 26 (Risk Assessment) are not must-pass. Each of these elements 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 Evaluation Outcomes

An issuer will achieve a compliance designation of "meets" for its QIS submission if it: (1) successfully completes all fields in elements 1–18 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).

Based on the results captured in the QIS evaluation, an overall outcome of "meets" or "does not meet" will be assigned to each issuer's QIS submission(s) and will be reflected in the Correction Notices that are sent to issuers after each round of review during the application process. Issuers will not receive actual scores; however, if applicable, they will be notified of how their QIS submissions were found deficient, including whether their QIS submissions were incomplete. If no corrections are needed, the Correction Notice will state this. Issuers receiving Correction Notices requiring no QIS corrections will not have to go through additional review.

6.3.3 Data Submission Validation

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

issuer will certify to complying with each Marketplace certification standard.[17] The FFMs will rely on that statement to affirm issuers' commitment to submit complete and accurate data.

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

7. Overview of Progress Report Submission

An issuer must submit a completed Progress Report to the FFMs in which it offers QHPs during the QHP Application Period in the year after the issuer submitted its QIS Implementation Plan. For example, an issuer that offers coverage through the FFMs during the 2014 and 2015 coverage years will submit an Implementation Plan to those Marketplaces during the 2017 QHP Application Period, which takes place in 2016. That issuer will then submit a QIS Implementation Plan and Progress Report form providing an update on its QIS during the 2018 QHP Application Period, which takes place in 2017. Exhibit 9 provides additional examples to demonstrate these reporting requirements.

Exhibit 9: Examples of QIS Implementation Plan and Progress Report Submission Timespans

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

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

An issuer needs to submit a new QIS Implementation Plan when:

- The market-based incentive type or sub-type (Element 19) is changed;
- The topic area (Element 20) is changed;
- One or more of the QIS performance targets are reached or changed; or
- The QIS results in negative outcomes or unintended consequences.

Issuers may make some adjustments (i.e., modifications) in each QIS they develop, such as redefining QIS activities, goals, or measures, throughout the course of implementation without having to submit a new QIS Implementation Plan. Issuers will provide information on these

[17] The Federally-facilitated Marketplace Issuer Attestations: Statement of Detailed Attestation Responses includes the following: "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."

types of modifications via the Progress Report section of the form, but do not have to wait until the submission of the form to implement these modifications.

When issuers complete the QIS Submission Type section (Part A) of the QIS Implementation Plan and Progress Report form, they will be asked to identify the type of QIS submission (e.g., new or continuing QIS). Beginning with the 2018 QHP Application Period, a QHP issuer may indicate that it is changing its existing QIS (i.e., the QIS for which it previously submitted an Implementation Plan) for any of the reasons specified above.

If an issuer changes its existing QIS beyond the modifications noted above, it must submit a QIS Implementation Plan for its new QIS ***and*** a Progress Report for its existing QIS. For example, assume an issuer submits an Implementation Plan in the 2017 QHP Application Period and submits a subsequent Progress Report in the 2018 QHP Application Period, but decides mid-year that it would like to change its QIS during the next QHP Application Period. In this instance, the issuer would need to submit both a Progress Report (for its existing QIS, initially submitted in the 2017 QHP Application Period) and an Implementation Plan (for its new QIS) during the 2019 QHP Application Period. The issuer does not need to wait until it has submitted a new QIS Implementation Plan and Progress Report form before implementing these changes. This scenario, and other common QIS submission scenarios, are discussed in greater detail in Appendix B.

Volume II. QIS User Guide for the 2017 Coverage Year

1. User Guide Introduction

This User Guide provides instructions for issuers about compliance with QIS requirements, and also describes differences in the submission process for issuers that operate in an FFM versus those that operate in states performing plan management functions in an FFM. 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 in alignment with existing FFM electronic form filing processes for states. Throughout this document, references to "issuers" refer to issuers offering or applying to offer QHPs in a Marketplace.

Issuers seeking to comply with the QIS requirements in an FFM should review the QIS materials, including the entirety of this *QIS Technical Guidance and User Guide for the 2017 Coverage Year*, and the QIS Implementation Plan and Progress Report form, prior to beginning their 2017 QHP Applications.[18] Issuers should also review the 2017 Letter to Issuers for additional guidance specific to the 2017 coverage year. The QIS materials can be accessed on the CMS MQI website or via the CMS QHP Application website.

1.1 Accessing the QIS Materials on the MQI Webpage

The QIS materials specific to each coverage 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[19] 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 coverage year will also be accessible via the CMS QHP Application website prior to the start of the applicable QHP Application Period. The QHP

[18] The 2017 QHP Application Period occurs in calendar year 2016.

[19] 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 Preparing to Complete the Implementation Plan and Progress Report Form

After reviewing the Technical Guidance and User Guide, complete sections A–E of the QIS Implementation Plan and Progress Report form that comprise the Implementation Plan by following these instructions:

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

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

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

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

A consistent evaluation methodology depends on all issuers submitting the same types of data via the Implementation Plan and Progress Report form. 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.[20] Additional materials beyond the form itself cannot be uploaded via the SERFF/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 only available electronically; issuers may not request hard copies by mail.

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

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 you can view it side-by-side with the form and refer to it as often as necessary. Be sure to save the form regularly as you enter your responses.

2. Completing the QIS Implementation Plan

An issuer must 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 three sections of the Implementation Plan and Progress Report form:

[20] See 45 CFR 156.705.

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

TIP: You must fill out all three of the above sections of the form and their corresponding parts (Parts A–E) to submit a complete Implementation Plan. **If any element is left blank, the issuer will receive a notification via a Correction Notice that the submission is incomplete; the notice will include specific information on which element(s) need information to be resubmitted.**

The subsections below provide instructions on how to complete each part of the three sections of the form that, taken together, make up an issuer's Implementation Plan. They also provide information about the elements and criteria, the level of detail expected in issuers' responses, and applicable character limits. Issuers must use the space provided in the QIS Implementation Plan and Progress Report form to provide their responses; inclusion of additional attachments and/or supporting documentation 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 for certain elements 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.

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 2017 QHP Application Period, when QIS implementation is just beginning, all issuers will indicate that they are submitting new quality improvement strategies. In future years, however, an issuer may use the QIS Implementation Plan and Progress Report form not only to submit a new QIS, but also to continue a QIS without making any modifications, continue a QIS with some modifications, or implement a new QIS while discontinuing an existing QIS.[21] 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.

[21] 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. As a reminder, most of these scenarios will not apply until the 2018 QHP Application Period and beyond; all issuers will submit a new QIS during the 2017 QHP Application Period.

Exhibit 10 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.

Exhibit 10: Part A. New or Continuing QIS Submission

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). Since the 2017 QHP Application Period marks the first year of QIS implementation in the Marketplaces, the issuer has never previously submitted a QIS for the QHPs for which it is completing the QIS Implementation Plan and Progress Report form; therefore, all issuers must select "New QIS with No Previous QIS Submission." [22]

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

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

During the 2017 QHP Application Period, once issuers select "New QIS with No Previous QIS Submission" 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.

During future QHP Application Periods, issuers may select from the other QIS submission types provided in Element 1. Step-by-step instructions for doing so will be provided in future versions of this User Guide. (See Appendix 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,

[22] 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.

issuer state, QIS contact information, date issuer began offering coverage through the Marketplace, and information about the issuer's current payment models).

Exhibit 11 depicts the elements that issuers must populate in Part B. Responses to all of these elements are required, but will not be scored. There are no associated criteria requested in Part B.

Exhibit 11: 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 or Value" AND/OR "Alternative Payment Models Built upon Fee for Service Architecture" is checked, provide the percentage of payments tied to quality or 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 2017 QHP Application.

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

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

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

The HIOS Issuer ID is a five-digit numeric identifier that is assigned to each issuer during HIOS registration.[23]

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;" 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.

[23] 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 16-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.

Step 8: Select one or more of the categories of payment models[24] 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 12 provides a description of each of the four categories.

Exhibit 12: Examples of Payment Models by Category[26]

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

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

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

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

[24] Payment models categories are defined in Rajkumar R, Conway PH, Tavenner M. "CMS—Engaging Multiple Payers in Payment Reform," *Journal of the American Medical Association* (JAMA). 311:19.

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

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 for the purpose of understanding how an issuer identified the goals and developed the rationale for its QIS. Exhibit 13 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 13: 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 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.

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.

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

2.4 Part D. QIS Summary

Part D of the Implementation Plan and Progress Report form collects information that summarizes the issuer's QIS (e.g., QIS title and description). Exhibit 14 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 14: 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.	500 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: Measures described in Element 24 should be linked to these goals).	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; 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 that are covered in more detail in Part E of the Implementation Plan Section. It should specify the market-based incentive type(s) (e.g., provider, enrollee) and the QIS topic area (e.g., improve health outcomes, prevent hospital readmissions). These two pieces of information should be derived from the issuer's responses to Elements 19 and 20, respectively, in Implementation Plan Part E.

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

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 its Marketplace product line and/or for other product lines (e.g., Medicaid, commercial). Issuers may use existing strategies that are employed in non-Marketplace product lines if the existing strategy is relevant to their Marketplace population and meets the QIS requirements.[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: Since the QIS description closely relates to your responses to elements and criteria in Part E, double check the consistency, as well as the completeness, of your responses to each element and criteria throughout the Implementation Plan prior to submission.

2.5 Part E. QIS Requirements

Part E of the Implementation Plan and Progress Report form collects detailed information about the QIS (e.g., market-based incentive type; topic area selection; 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 evaluation. To facilitate timely review, issuers should not include any identifying information in their responses to the elements and criteria in Parts A, C, D, and E.

Exhibit 15 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 15) 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 incomplete, including specific information on which element(s) need to be revised.

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

Exhibit 15: Part E. QIS Requirements

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 all QHPs you offer or are applying to offer through the Marketplaces, or to a subset of QHPs.* *If "Subset of health plans" was selected, an additional QIS Implementation Plan(s) (Parts D and E of this form) must be submitted for those 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 QHPs covered by the QIS by listing each plan's 14-digit unique HIOS Plan ID (also known as a Standard Component ID [SCID]). Indicate if each one is a new or existing QHP. Note: Please list additional health plans covered by the QIS on page 24. 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 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)**	23a – List the activities that will be implemented to achieve the identified goals. 23b – Describe how the activities related 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 health and health care disparities was not chosen as a selected topic area in Element 20, does the QIS include any activities related to addressing health and health care disparities? If yes, describe the activities below. Check "Not Applicable" if 1) health and health care disparities is one of the topic areas selected in Element 20; or 2) if health and health care disparities is not addressed in this QIS.	This element will be scored; Element 23 is a must-pass element.	1,000 characters per criterion
24	**Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress (Must Pass)** Restate the goal(s) identified in the QIS description (Element 18). For each goal, identify at least one (but no more than two) primary measure(s) used to track progress against the goal. For each measure identified, address the criteria at right.	24a – Name of the measure; 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 was used without modification to the measure specifications; 24b – Describe how the measure supports the tracking of performance related to the goal. 24c – Baseline Assessment. Provide the baseline results, 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. 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 descript-tion 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. All criteria must be completed.	100 character limit per milestone in 25b
26	**Risk Assessment**	26a – List any known or anticipated barriers in implementing QIS activities. 26b – Describe the mitigation activities that will be incorporated to address each barrier identified in Criterion 26a.	This element will be scored. All 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 Criterion 19, select the box(es) for the market-based incentive type(s) (i.e., provider and/or enrollee[29]) the QIS includes.

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 B to complete Element 19.

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

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

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 health plans" if the QIS applies to all eligible QHPs included in the current year's QHP Application. Check the box for "Subset of health plans" if the QIS covers only some of the eligible QHPs offered by the issuer through the Marketplace. If "Subset of health plans" is selected, indicate the number of forms that will be submitted using the space provided (e.g., this is form 1 of 2) since all eligible 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 QHPs to which the QIS applies 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

[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).

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 a QHP not previously covered by a QIS) or an existing QHP.

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

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

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

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.

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

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

relate to health and health care disparities. If health and health care disparities are not addressed 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. Issuers have broad flexibility in selecting their measures but are required to provide 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 other developers.

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 NQF-endorsed measure is used without modification to the measure specifications.

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

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

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, 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.

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.

For Criterion 25b, the timeline should also include the dates of defined milestones. At least one milestone is required. Enter the dates of defined milestone(s) using the following format: MM/YYYY.

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 readjust their timelines or redefine their milestones as they move forward with implementation.

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

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

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

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

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

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

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

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

3. Submitting the 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. During the 2017 QHP Application Period, the QHP Application submission window for the FFMs will be specified in the 2017 Letter to Issuers.

Issuers submitting quality improvement strategies for QHPs offered through an FFM will submit their Implementation Plans 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, use the checklist provided in Appendix D to double check your Implementation Plan for completeness, and verify that your QIS addresses all of the elements and criteria, especially the six must-pass elements identified in Exhibit 15.

3.1 Submitting via HIOS

Issuers in an FFM where the state does not perform plan management functions should follow these steps to submit their completed Implementation Plans via HIOS:

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

Step 2: Enter the user's Enterprise Identity Management System credentials (i.e., user name and password) to access HIOS.[34]

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

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

Step 5: Upload the completed Implementation Plan to HIOS.

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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.

[33] Note: Issuers submitting quality improvement strategies for QHPs offered in states performing plan management functions in the FFMs will follow a slightly different submission process. See Section 3.2 of this User Guide for further details. In addition, OPM will evaluate QIS submissions for MSP products.

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

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

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

3.2 Submitting via SERFF

Issuers submitting quality improvement strategies for QHPs offered in states performing plan management functions in an FFM will follow a slightly different submission process. These issuers will submit their Implementation Plan and Progress Report forms through SERFF. Once submitted, their Implementation Plan and Progress Report forms will be transmitted to the state and the FFMs for joint evaluation.

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

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

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

Step 3: Upload the completed QIS Implementation Plan (in 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.

4. Addressing 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]

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

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

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

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

Use the final version that was previously uploaded to HIOS or SERFF and submitted to the 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 edit or rewrite its responses to the elements and criteria that the FFMs indicated are incomplete or do not meet the QIS requirements. The revised or new responses should be sure to address the identified deficiencies by providing additional information, clarifying existing information, or including missing information as directed by the Correction Notice.

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

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

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

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

Follow the steps provided in Volume II, Section 3, to submit the revised Implementation Plan to the FFMs and the state (if applicable). Issuers operating in states performing plan management functions in an FFM 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.

5. Completing the QIS Progress Report

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

Issuers subject to the QHP certification standard requirement to implement and report a QIS for plan years beginning in 2017 are required to submit only an Implementation Plan during the 2017 QHP Application Period. They do not need to submit a Progress Report until the 2018 QHP Application Period.

To complete the Progress Report, issuers must:

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

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

Exhibit 16 lists Progress Report elements and criteria that issuers must complete in Part F of the QIS Implementation Plan and Progress Report form.

Exhibit 16: Part F. Progress Report Summary

Element #	Element Name	Criteria
27	**Addition of Health Plans to the Issuer's QIS**	27a – Indicate if the issuer is adding any QHPs to the QIS originally listed in 21b. 27b – If "Add QHP(s)" was selected, list all new QHPs and provide each plan's unique 14-digit HIOS Plan ID (SCID). If no additional QHPs were included, check "Not Applicable."
28	**QIS Modifications**	28a – If "**Continuing a QIS with Modifications**" was selected in Part A, Element 1, please indicate what type of modification the issuer is making to its QIS. Check all that apply. Note that modifications only apply to elements in Part D (Implementation Plan). If no modifications are being made, check Not Applicable. 28b – Provide a justification and brief description of the modification(s) selected in Criterion 28a. If "Continuing a QIS with Modifications" was NOT selected in Element 1, check "Not Applicable."
29	**Analyze Progress Using Baseline Data, as Documented in the Implementation Plan (Must Pass)** Restate the goals identified in the Implementation Plan (see Elements 18 and 24). For each goal, restate the measure(s) identified in Element 24). For each measure identified, provide the criteria at right.	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, 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. 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.
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 criterion 28a, indicate whether the information provided here affects the decision to modify or change the QIS.

Element #	Element Name	Criteria
31	**Barriers**	31a – Were barriers encountered in implementing the QIS? If "Yes," describe the barriers. 31b – Were there problems meeting timelines as indicated in Element 25? If "Yes," describe the problems in meeting timelines.
32	**Mitigation Activities**	32a – If "Yes" was selected in 31a or 31b, describe the mitigation activities implemented to address each barrier or problem in meeting the timeline. Also, describe the result(s) of the mitigation activities. If "No" was selected in 31a and 31b, select "Not Applicable."

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

Future versions of this User Guide will also provide specific instructions about how to complete the QIS Implementation Plan and Progress Report form for scenarios that will arise during the 2018 QHP Application Period and beyond (e.g., submitting a QIS with modifications, submitting a new QIS while discontinuing a previous QIS). See Appendix B for an overview of the scenarios an issuer may encounter in future years related to the completion of the QIS Implementation Plan and Progress Report form.

Appendices

Appendix A. 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. All issuers must complete the QIS Submission Type section (Part A) of the form annually, in additional to any other required sections.

Scenarios for Form Completion Based on Type of QIS Submission

Type of QIS Submission	Issuer and Prior QIS Submission History	QIS Implementation Plan and Progress Report Sections to be Completed
New QIS[36] with No Previous QIS Submission	• The issuer has offered QHPs through a Marketplace for at least two consecutive years, AND • Has not previously submitted a QIS Implementation Plan[37]	• Complete the Background Information section (Parts B and C), AND • Complete the QIS Implementation Plan Section (Parts D and E)
New QIS after Discontinuing a QIS Submitted during a Prior QHP Application Period	• The issuer has previously submitted a QIS Implementation Plan and a QIS Progress Report based upon that Plan, AND • The issuer intends to discontinue its previous strategy to implement a new QIS (i.e., one with a different market-based incentive and/or topic area than its previous QIS)	▪ Complete two forms; one to close out the discontinued QIS: – Complete the Background Information section (Parts B and C) – Complete the QIS Implementation Plan Section (Parts D and E) – Complete the QIS Progress Report Section (Part F), AND ▪ Complete a new/separate form to submit the new QIS: – Complete the Background Information section (Parts B and C) – Complete the QIS Implementation Plan Section (Parts D and E) section

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

[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 a different subset of QHP entirely from what was previously submitted.

Type of QIS Submission	Issuer and Prior QIS Submission History	QIS Implementation Plan and Progress Report Sections to be Completed
Continuing a QIS with No Modifications	• The issuer previously submitted an QIS Implementation Plan and will continue without any changes	• Update the Background Information section (Parts B and C) as needed, AND, • Confirm the QIS Implementation Plan Section (Parts D and E) is completed with the prior year's information, AND • Complete the QIS Progress Report Section (Part F) • Note: Parts D and E should remain unchanged. Those sections will have been populated during the previous QHP Application Period.
Continuing a QIS with Modifications	• The issuer previously submitted a QIS Implementation Plan, AND • Made changes to the QIS related to 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, AND • Update the QIS Implementation Plan Section (Parts D and E) as needed based on modifications, AND • Complete the QIS Progress Report Section (Part F)

Appendix 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 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 Pre-Submission Checklist

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

QIS IMPLEMENTATION PLAN PRE-SUBMISSION CHECKLIST

A. PREPARATION

- ☐ Review the entire 2017 QIS Technical Guidance and User Guide, as well as the relevant sections of the 2017 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 FORM

- ☐ Enable JavaScript in the fillable PDF form before you enter your QIS information.
- ☐ Complete the QIS Submission Type section (Part A) by checking "New QIS with No Previous QIS Submission."
- ☐ Complete all elements in Part B: Issuer Information, in the Background Information section.
- ☐ In Elements 2-5 in Part B, use the same information that was included elsewhere in the QHP Application templates.
- ☐ Complete Part C: Data Sources Used for Problem Identification and Monitoring Progress, in the Background Information section.
- ☐ Complete all of the elements and criteria in Part D: QIS Summary, in the QIS Implementation Plan Section.
- ☐ Complete all of the elements and criteria in Part E: QIS Requirements, in the QIS Implementation Plan Section.
- ☐ Confirm that you have provided responses for all elements—including must-pass elements—and criteria in all parts 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. SUBMIT THE FORM

- ☐ Save a local copy of the form using the appropriate file naming convention.
- ☐ Upload the completed copy of the QIS Implementation Plan and Progress Report form to HIOS or SERFF, as appropriate.
- ☐ Share your QIS submission with the issuer's staff who are responsible for the QIS, so they may refer to it throughout the year as needed and access it during the next QHP Application Period.
- ☐ Verify that each applicable QHP offered by the issuer 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 and 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 which 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.
evaluation tool	Tool used to provide issuers with the evaluation results of their QIS Implementation Plan and subsequent QIS Progress Reports. The evaluation tool lists the QIS criteria with options to score as "meets," "does not meet," or "not applicable."
Exclusive Provider Organization (EPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO enrollees will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.

[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
Federally-facilitated Marketplaces (FFM) or Federally-facilitated Exchanges (FFE)	The Marketplace models operated by HHS for individual and small group market coverage.
Health Insurance Marketplace (Marketplace) or Health Insurance Exchange (Exchange)	A resource in each state where qualified individuals, families, and small businesses can learn about their health insurance options; compare QHPs based on quality, costs, benefits, and other important features; choose a QHP; and enroll in coverage. In some states, the Marketplace is operated by the state. In others, it is operated by the federal government.
Health Insurance Oversight System (HIOS)	A data submission tool that allows CMS to collect data from states and individual and small group market 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 who work for or contract with the HMO and generally will not cover out-of-network care, except in an emergency.
hospital value-based purchasing program	Hospital Value-Based Purchasing is part of the Centers for Medicare & Medicaid Services' long-standing effort to link Medicare's payment system to a value-based system to improve health care quality, including the quality of care provided in the inpatient hospital setting. The program attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country. Participating hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide. Congress authorized Inpatient Hospital VBP in Section 3001(a) of the Affordable Care Act. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting (IQR) Program, which was authorized by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[42]
Medicare Shared Savings Program	The Centers for Medicare & Medicaid Services has established a Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by: ▪ Promoting accountability for the care of Medicare FFS beneficiaries ▪ Requiring coordinated care for all services provided under Medicare FFS ▪ Encouraging investment in infrastructure and redesigned care processes The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Participation in an ACO is purely voluntary.[43]
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).

[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]
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.
provider	A provider is an organization, institution, or individual that is a supplier of medical services.

[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
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 Marketplace. The form is comprised of four sections: QIS Submission Type, Background Information, QIS Implementation Plan Section, and QIS Progress Report Section. Issuers will complete the QIS Implementation Plan Section of the form, along with the QIS Submission Type and Background Information sections, to describe their quality improvement strategies and submit them to the Marketplace beginning with the 2017 QHP Application Period. Taken together, these three sections of the form are called the Implementation Plan, and are referred to as such throughout this User Guide. Beginning with the 2018 QHP Application Period, issuers that submitted QIS Implementation Plans in 2017 QHP Application Period will complete the QIS Progress Report Section of the form annually to communicate their quality improvement strategies' progress to the Marketplace.
QIS requirements	The statutory requirements, according to section 1311(g) and subsequent federal regulations, including: (1) implementation of a quality improvement strategy described as a payment structure that provides increased reimbursement or other incentives for: (2) addressing at least one of the five topic areas listed in section 1311(g); (3) complying with guidelines established by the Secretary of HHS in consultation with experts in health care quality and stakeholders; and (4) reporting strategy progress to the applicable Marketplace on a periodic basis.
QIS scoring methodology	The criteria used to systematically determine a strategy's merit, using criteria governed by a set of standards.
QHP Application and Certification Process	The process by which issuers apply for QHP certification, and through which the Marketplace reviews applications and makes QHP certification determinations.
QHP Application Submission and Review Period (QHP Application Period)	The specific timeframe in which an issuer submits its QIS to the Marketplace for evaluation and review, and the Marketplace notifies issuers if their QIS submissions have been approved. The period typically takes place from mid-March to mid-September.
Qualified Health Plan (QHP)	A QHP is a health insurance plan that has in effect a certification that it meets the standards established by the Affordable Care Act and supporting regulation, issued or recognized by each Marketplace through which such plan is offered.[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 Health Insurance Oversight (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 statutory requirements to participate in Marketplaces.
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.

[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
State-based Marketplace (SBM) or State-based Exchange	A Marketplace model in which a state operates its own Health Insurance Marketplace, for both the individual and small group markets. An SBM is responsible for certifying issuers, overseeing issuer compliance with federal Marketplace quality standards as a condition of certification, and, starting with the open enrollment period that begins in the fall of 2016, displaying quality rating information on the SBM website for consumer access.
States performing plan management functions in an FFM	Includes FFM states where the states perform plan management functions. 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 during the QHP Application Period. An issuer's Work Plan is submitted to the Marketplace for evaluation following the QHP Application Submission and Review Period.

Appendix F. Acronym List

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

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