Health Insurance Exchange

Quality Improvement Strategy: Technical Guidance and User Guide for the 2020 Plan Year

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Technical Assistance

Technical assistance is available for issuers, Exchanges,[1] and other entities that may have questions related to the quality improvement strategy (QIS) requirements for Qualified Health Plans (QHPs) offered through the Exchanges.

- **QHP issuers:** Please submit questions to the Marketplace Service Desk (MSD) via email to CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Please reference "Marketplace Quality Initiatives (MQI)-QIS" in the subject line.
- **Multi-state Plan (MSP) issuers:** Please submit questions via email to MSPIssuer@OPM.gov and reference "Marketplace Quality Initiatives (MQI)-QIS" in the subject line. For MSP issuers that are also QHP issuers, please copy the MSD (CMS_FEPS@cms.hhs.gov).
- **State-based Exchanges (SBEs):** Please submit questions to your respective State Officers.
- **Federally-facilitated Exchanges (FFEs):** Please submit questions via email to the MSD at CMS_FEPS@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QIS" in the subject line.
- **Other stakeholders:** Please submit questions via email to Marketplace_Quality@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QIS" in the subject line.

Accompanying Documents

The accompanying document, the *2020 QIS Implementation Plan and Progress Report form* (QIS form), is the form for issuers to use to submit a QIS. The document can be found on the Centers for Medicare & Medicaid Services (CMS) Health Insurance MQI website (link in the table below).

Website Links

The following resources provide additional details related to QIS.

Website	Description	Link
CMS MQI website	This website provides resources related to CMS MQI activities, including the Quality Rating System (QRS), the QHP Enrollee Survey, QIS requirements, and patient safety standards. As the central location for QIS resources, this website contains the QIS form and 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 QHP Certification website	This website provides issuers with detailed application instructions, forms—including the QIS form—as well as justifications, supporting documents, frequently asked questions (FAQs), and tools to complete the annual QHP application process.	https://www.qhpcertification.cms.gov/s/QHP

[1] The terms "Exchange" and "Marketplace" are synonymous.

Website	Description	Link
Health Care Payment Learning & Action Network (LAN)	This website provides resources related to increasing the adoption of value-based payments and alternative payment models (APMs). The APM Framework White Paper defines APM categories and subcategories. This resource aligns to Element 16: Current Payment Model(s) Description.	https://hcp-lan.org/
Registration for Technical Assistance Portal (REGTAP)	This website serves as an information hub for CMS technical assistance related to Exchange and Premium Stabilization programs. Registered users can access the library, training resources, and the inquiry tracking and management system. Use keyword search "QIS" to identify any QIS-related resources.	https://REGTAP.info (registration required)
State Exchange Resource Virtual Information System (SERVIS)[2]	This website serves as an information hub for CMS technical assistance related to State-based Exchange (SBE) requirements. Registered State users can access relevant resources organized by the Center for Consumer Information and Insurance Oversight (CCIIO) State Marketplace and Insurance Programs group (SMIPG).	https://servis.cms.gov/ (registration required)

Other Resources

- The final *2020 Letter to Issuers in the Federally-facilitated Exchanges* (Letter to Issuers) provides issuers seeking to offer QHPs, including stand-alone dental plans (SADPs), in the FFEs, whether through the Individual Exchange or the Small Business Health Options Program (SHOP) Exchange, with operational and technical guidance to help them successfully participate in those Exchanges during the 2020 Plan Year.
    - The approach for QHP certification reviews for QIS reporting remains unchanged from the 2018 Letter to Issuers. Please refer to the 2018 Letter to Issuers for more information.
- The Patient Protection and Affordable Care Act; Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016 (Payment Notice) includes implementation requirements for QHP quality improvement strategies beginning with the 2016 Plan Year.

[2] To access any SERVIS links, an issuer must first log in to CMS Enterprise Identity Management (EIDM), then log in to SERVIS and click the link.

1. Document Purpose and Scope

The *Quality Improvement Strategy: Technical Guidance and User Guide for the 2020 Plan Year* (2020 QIS Guidance) 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 2020 Plan Year. This document is organized into two volumes:

- Volume I: QIS Technical Guidance for the 2020 Plan Year; and
- Volume II: QIS User Guide for the 2020 Plan Year.

Issuers should refer to the updated QIS Technical Guidance and User Guide for the 2020 Plan Year on an annual basis, regardless of QIS submission type, as CMS updates both volumes yearly to reflect any relevant changes. Issuers should also adhere to QHP certification processes, which may evolve on an annual basis.

1.1 Section Guide

Volume I: QIS Technical Guidance for the 2020 Plan Year

The QIS Technical Guidance for the 2020 Plan Year (Technical Guidance) provides information on the QIS participation criteria and reporting requirements for all issuers offering or seeking to offer QHP coverage through an Exchange, and on the evaluation methodology for the FFEs, including FFEs where States perform plan management, to review issuers' QIS submissions.

Where applicable, the section descriptions highlight key differences between the QIS Technical Guidance for the 2019 Plan Year, released in May 2018, and this QIS Technical Guidance for the 2020 Plan Year. Throughout this document, unless otherwise noted, references to an FFE (or FFEs) refer to both FFEs and FFEs where the State performs plan management. Similarly, references to an SBE (or SBEs) refer to both SBEs and SBEs on the Federal Platform (SBE-FPs), unless otherwise noted.

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

The Technical Guidance includes the following sections, which provide:

- Background on the QIS,
- An overview of the QIS Technical Guidance,
- The QIS timeline for the 2020 Plan Year,
- Exchange oversight responsibilities,
- The QIS requirements, and
- The QIS evaluation process and methodology.

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

There are several key differences between the 2019 QIS Technical Guidance and the 2020 QIS Technical Guidance. In Section 5.2.1, there is a new sub-section to clarify participation criteria for progress reporting. In Section 5.3, language was added regarding the new Part F *(QIS Modification Summary)* and Part G *(Progress Report Summary)* of the QIS Implementation Plan and Progress Report form (QIS form). In Section 6.2, the scoring methodology was updated to reflect changes made to the QIS form.

Key Differences Between the 2019 QIS Technical Guidance and 2020 QIS Technical Guidance

- Section 5.2.1: Participation Criteria for Progress Reporting– Added sub-section to clarify participation criteria for progress reporting
- Section 5.2.1: QIS Implementation Plan and Progress Report Form – Updated language to reflect revised Parts F (*QIS Modification Summary*) and G (*Progress Report Summary*) in the QIS form.
- Section 6.2: QIS Evaluation Methodology – Updated scoring methodology to reflect QIS form restructuring

Volume II: QIS User Guide for the 2020 Plan Year

The User Guide for the 2020 Plan Year (User Guide) provides issuers offering coverage in an FFE with directions to meet the QIS requirements for the 2020 Plan Year. The User Guide provides procedural, step-by-step instructions for issuers on how to access, complete, and submit QIS Implementation Plan and Progress Report forms to CMS during the 2020 QHP Application Submission and Review Period (QHP Application Period, which applies to the 2020 Plan Year).[4] Where applicable, the section descriptions highlight key differences between the initial version of the QIS User Guide for the 2019 Plan Year, released in May 2018, and this QIS User Guide for the 2020 Plan Year.

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

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

There are several key differences between the 2019 QIS User Guide and the 2020 QIS User Guide. In Section 4.1, the User Guide was updated to include instructions about how to complete Part F *(QIS Modification Summary)*. Section 4.2 was updated to include instructions about how

[4] The 2020 QHP Application Period occurs in the 2019 calendar year.

to complete the revised Progress Report. Appendix G was added, including a table detailing each QIS form element and criteria.

Key Differences Between the 2019 QIS User Guide and 2020 QIS User Guide

- Section 4.1: Part F. QIS Modification Summary – Updated to include instructions on completing Part F (*QIS Modification Summary*)
- Section 4.2: Part G. Progress Report Summary – Updated to include instructions on completing the revised QIS Progress Report
- Appendix G: Elements and Criteria – Added a table detailing the QIS form elements and criteria

Volume I. QIS Technical Guidance for the 2020 Plan Year

1. Background

An issuer participating in an Exchange for two or more consecutive years must implement and report on a quality improvement strategy (QIS), in accordance with section 1311(g) of the Patient Protection and Affordable Care Act, entitled "Rewarding Quality Through Market-Based Incentives."[5] 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 qualified health plans (QHPs) and Multi-state plan (MSP) options through an Exchange, whether through the Individual Exchange or through the Small Business Health Options Program (SHOP) Exchange. Throughout this document, references to "issuers" refer to issuers offering or applying to offer QHPs in an Exchange. The issuer's QIS or strategies must cover all of its QHPs and/or MSP options offered through an Exchange that meet the participation criteria described in Section 5.1 of this Technical Guidance. An issuer has the option of implementing one QIS that covers all eligible health plans and product types or implementing multiple quality improvement strategies to cover all eligible health plans and product types.

All issuers must comply with the following requirements:

(1) Implement a QIS, described as a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.

(2) Implement a QIS that includes at least one of the following:
   i. Activities to improve 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 the Department of Health and Human Services (HHS) in consultation with experts in health care quality and stakeholders.

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

An issuer is encouraged to address health and health care disparities in each QIS. This may be done in one of two ways:

(1) Choosing "Implementation of activities to reduce health and health care disparities" as a topic area addressed by the QIS *or*

(2) Addressing the reduction of health and health care disparities as part of the activities implemented within any other chosen topic area(s).

Disparities can and will vary depending on regional location and enrollee populations. An issuer has the opportunity to submit more than one QIS to meet the needs of its enrollee population (see Section 2 of the Technical Guidance).

(4) Report on progress implementing the QIS to the applicable Exchange on a periodic basis.

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

CMS envisions issuers aligning their quality improvement activities with the quality priorities identified in the Meaningful Measures Framework.[6] The QIS statutory requirements require the use of market-based incentives to improve the quality and value of health care and services, specifically, for Exchange enrollees. Section 1311(g) specifies two market-based incentives types that issuers may include in their quality improvement strategies: (1) increased reimbursement or (2) other incentives. These incentive types are defined below; additional examples are provided in Appendix C.

(1) Increased Reimbursement
- 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).[7]

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

Exhibit 1: Examples of QIS Activities Cited in the Patient Protection and Affordable Care Act[8]

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
Prevent 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

[6] The Meaningful Measures quality priorities can be found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.

[7] Any enrollee financial incentives used as part of an issuer's QIS must comply with other applicable federal and State requirements, including 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), and 45 CFR § 146.121(f)).

[8] 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 Patient Protection and Affordable Care Act.

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

All Exchanges are required[9] to evaluate issuers' QIS submissions, and issuers must submit separate QIS submissions by State. In addition:

- CMS will evaluate the QIS submissions for issuers applying to offer QHPs in an FFE.
- In FFEs where the State performs plan management, issuers applying to offer QHPs will undergo a joint review of their QIS submissions by the State and CMS, with final determination being made by CMS.
- State-based Exchanges (SBEs) will evaluate the QIS submissions of the issuers applying to offer QHPs in their State's Exchange. SBEs, including SBEs on the Federal Platform (SBE-FPs) have the flexibility to establish the timeline, reporting form, validation of data, and other requirements related to annual submission of QIS data by the issuers participating in their respective Exchanges. However, SBEs must comply with the federal minimum reporting requirements.

  For the 2020 QHP Application Period, SBEs must, at a minimum, require issuers to submit QIS information in accordance with the elements and criteria included in the QIS form. SBEs are encouraged to use the reporting manner and frequency requirements established by the FFEs to minimize the burden of reporting. However, SBEs may establish their own reporting forms, evaluation methodologies, and reporting manner and frequency requirements.
- The Office of Personnel Management (OPM) will evaluate QIS submissions for MSP products. If an issuer offers products through the Exchange that are in the form of:
  - Only MSP options, then the issuer must contact OPM at MSPIssuer@opm.gov for specific instructions.
  - Both QHPs and MSP options, then the issuer must send the QIS submission to the applicable Exchange and notify OPM of the action via the MSP Program Application. Once the Exchange approves the QIS submission, the issuer must submit the final QIS submission, along with evidence of such approval to OPM.
  - Issuers offering MSP options should contact OPM at MSPIssuer@opm.gov to confirm the requirements and timing associated with QIS implementation and reporting.

[9] 45 CFR § 155.200(d).

2. Technical Guidance Overview

The goal of QIS implementation is to improve the quality and value of care delivered to Exchange 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 do the following:

- Operationalize the requirements in the statute.[10]
- Align the statutory requirements with other quality improvement programs. As applicable, the QIS will align with the Quality Rating System (QRS), the QHP Enrollee Experience 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-Exchange 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 Exchange population and meets the QIS requirements.
- Allow for flexibility for State implementation, meaning QIS implementation will establish minimum requirements upon which SBE States, if desired, can build additional program requirements in accordance with their local priorities.
- Develop requirements in a public and transparent manner.

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

Issuers have the benefit of two years of experience offering coverage through an Exchange to understand and build quality performance data on their Exchange 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 an Exchange. 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.

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

An issuer that offered an eligible QHP through an Exchange in the 2017 and 2018 Plan Years and continued operating in the Exchange in the 2019 Plan Year must make at least one initial QIS Implementation Plan submission to the applicable Exchanges in calendar year 2019 for the 2020 Plan Year. An issuer that submitted a QIS Implementation Plan or Progress Report in the 2019 Plan Year must submit a QIS Progress Report for the 2020 Plan Year. See Exhibit 2 for examples of the timeline for QIS submissions.

Exhibit 2: QIS Submission Timeline

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

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

The QIS Implementation Plan and Progress Report form (QIS form) is a consolidated form that can be accessed on the Marketplace Quality Initiatives (MQI) website. For the 2020 Plan Year, CMS has updated the QIS form. All issuers that meet the QIS participation criteria, regardless of submission type, must use the updated 2020 QIS form.

The QIS elements and criteria in the 2020 QIS form are described in detail in the QIS User Guide for the 2020 Plan Year. Each element has associated criteria that describe the type of information issuers must provide. A more detailed explanation of the organization of the 2020 QIS form is provided in Section 5.2.1 of this Technical Guidance.

3. QIS Timeline for the 2020 Plan Year

Issuers applying for QHP certification in the FFEs will submit QIS forms during the annual QHP Application Period and should refer to the 2020 Letter to Issuers for final dates for the 2020 QHP Application Period. Issuers operating in SBEs (including SBE-FPs) should refer to their Exchanges regarding specific timeframes, and issuers offering MSP options should refer to OPM.

4. Exchange Oversight Responsibilities

Exchanges are responsible for QHP certification and oversight of compliance with certification standards by QHP issuers operating in their respective Exchanges. All Exchanges are responsible for evaluating issuers' QIS submissions as a condition of QHP certification for the 2020 Plan Year.

4.1 Federally-Facilitated Exchanges

FFE States will follow the QHP Application and Certification Process, which is outlined in the 2020 Letter to Issuers, as it pertains to the QIS requirements.

FFE States performing plan management will receive completed QIS 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). FFE States performing plan management must evaluate the QIS submissions of the issuers offering coverage through the States using the federal QIS evaluation methodology, but issuers should contact the States for additional details. CMS will also review the QIS submissions of issuers offering coverage in FFE States performing plan management.

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 FFE. For example, as part of compliance reviews, issuers may be required to provide a list of Health Insurance Oversight System (HIOS) Standard Component IDs (SCIDs) covered by the QIS to verify that all eligible QHPs are covered. CMS intends to coordinate with State regulators, the applicable State entity for FFE States performing plan management, and SBEs, when appropriate, to avoid duplication of efforts for these compliance reviews.

4.2 State-Based Exchanges

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

SBEs will evaluate the QIS submissions of the issuers applying to offer QHPs in their State's Exchange. SBEs must ensure issuers that meet the QIS participation criteria and operate in their respective Exchanges comply with the federal minimum reporting requirements, which include the QIS requirements outlined in the QIS Technical Guidance and User Guide and the information collected in the QIS form. SBEs are encouraged to use the reporting manner and frequency requirements established by CMS for the FFEs to minimize the burden of reporting. Issuers operating in SBEs should consult these States for information about how to comply with

the States' QIS requirements as SBEs may have established their own reporting manner, frequency requirements, and additional reporting requirements.

4.3 Multi-State Plan Program

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

5. QIS Requirements

This section outlines the requirements for determining which issuers must submit a QIS form to the applicable Exchange. Information on the QIS participation criteria, calculating the minimum enrollment threshold, and the QIS form is provided below.

5.1 Participation Criteria

Issuers applying for QHP certification in the Exchanges for the 2020 Plan Year that meet the QIS participation criteria are expected to submit a QIS form in calendar year 2019 to either: (a) implement a new QIS beginning no later than January 2020 or (b) provide a progress update on an existing QIS.[11]

5.1.1 Participation Criteria for Implementing a QIS

An issuer must implement a new QIS by submitting a QIS form to an Exchange for the 2020 Plan Year if the following conditions apply.

- **An issuer offered coverage through an Exchange in 2017 and 2018.** The QIS reporting requirements apply to issuers that have been operating in an Exchange for two consecutive years and will continue operating in the Exchange in 2019, regardless of whether their QHPs have changed during that time. This phased-in approach gives issuers the necessary time to understand the populations enrolling in a QHP offered through the Exchange and to build quality performance data on their respective QHP enrollees. If an issuer offered coverage in 2018 and 2019 (but not in 2017), the issuer would not need to submit a QIS until calendar year 2020 for the 2021 Plan Year. Additionally, if an issuer is not continuing to offer coverage through an Exchange in the 2020 Plan Year, it does not need to submit a QIS.
- **An issuer provides family and/or adult-only medical coverage.** The QIS (or more than one QIS) should cover all eligible QHPs. Eligible QHPs are QHPs offered through the Exchange at all levels of coverage (Bronze, Silver, Gold, Platinum, and Catastrophic) for the following product types: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS) plans, exclusive provider organizations (EPOs), and indemnity plans. At this time, the QIS requirements do not

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

apply to child-only plans or SADPs. The QIS requirements include QHPs that are compatible with Health Savings Accounts (HSAs) (also known as HSA-eligible plans). The inclusion of HSA-eligible plans is consistent with the QRS requirements and increases QIS participation overall by ensuring issuers that meet the other QIS participation criteria, but offer only HSA-eligible plans, are required to implement a QIS. Issuers are therefore expected to include HSA-eligible plans that meet the other QIS participation criteria in their 2020 Plan Year QIS submissions.

How Many QIS Implementation Plans Should an Issuer Submit?

If an issuer uses the same QIS across multiple Exchanges, it will still need to submit a separate Implementation Plan and Progress Report form to each Exchange in which it offers eligible QHPs.

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

- **An issuer meets the QIS minimum enrollment threshold.** An issuer must submit a QIS if it had more than 500 enrollees within a product type per State as of July 1, 2018.[12, 13] Specifically, for a product type offered through the Exchange that has more than 500 enrollees as of July 1, 2018, all QHPs within that product type must be covered by a QIS. Enrollees who purchased insurance outside the Exchange (off-Exchange) should not be included in the minimum enrollment calculation.

5.2 Calculating the Minimum Enrollment Threshold

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

- Issuers should include only enrollees in QHPs offered through an Exchange (on-Exchange). Enrollees who purchased insurance outside the Exchange (off-Exchange) are not included in the minimum enrollment calculation.
- Issuers should include all enrollees in QHPs that provide family and/or adult-only medical coverage. Enrollees in HSA-eligible plans should also be included in the minimum enrollment calculation. Enrollees in child-only plans or SADPs should not be included in the minimum enrollment calculation.
- If issuers offer QHPs of the same product type in both the Individual Exchange and SHOP Exchange within a State, they must combine the enrollee totals from both the Individual Exchange and SHOP Exchange.

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

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

- If issuers offer both QHP and MSP options of the same product type in the same State through an Exchange, they must combine the enrollee totals from both QHP and MSP products.

Example: A fictional issuer that offered QHPs (all offering family medical coverage) through the Exchanges in 2017 and 2018, and continued offering coverage in 2019, in three States—West Virginia (WV), Maryland (MD), and North Carolina (NC)—has applied for certification of those QHPs in 2019 for the 2020 Plan Year. Exhibit 3 shows the characteristics and enrollment size of the issuer's product types in each State. In accordance with the participation criteria defined above, this issuer must develop and submit a QIS Implementation Plan to the Exchange for only the following States: West Virginia and Maryland. The issuer does not need to submit a QIS Implementation Plan in North Carolina because it did not have sufficient number of enrollees within each product type as of July 1, 2018.

Exhibit 3: Example Issuer Submissions Assessed Against QIS Participation Criteria

Reporting Unit	Number of enrollees in the product type as of July 1, 2018 (total and per Individual Exchange vs. SHOP)	Issuer should submit QIS	All product types and applicable QHPs need to be covered by a QIS
ABC issuer - WV	HMO: 505 (505 individual, 0 SHOP) PPO: 600 (500 individual, 100 SHOP)	Yes	Yes
ABC issuer - MD	HMO: 601 (501 individual, 100 SHOP) PPO: 400 (300 individual, 100 SHOP)	Yes	No – only the HMO and applicable QHPs must be covered by a QIS
ABC issuer – NC	HMO: 300 (200 individual, 100 SHOP) PPO: 400 (300 individual, 100 SHOP)	No	No

5.2.1 Participation Criteria for Progress Reporting

Starting in the 2020 Plan Year, for Progress Report submissions for an existing QIS, CMS will reassess an issuer's product type enrollment after two consecutive QIS Progress Report submissions. As such, an issuer must submit two consecutive years of QIS Progress Reports if they are continuing a QIS, regardless of whether the issuer's product type(s) continues to meet the minimum enrollment threshold, as shown in the table below. An issuer may discontinue QIS Progress Report submissions if a QIS for its product type(s) no longer meets the minimum enrollment threshold prior to the third consecutive year of submitting a QIS Progress Report. If the issuer's product type(s) meets the minimum enrollment threshold for the third consecutive year of submitting a QIS Progress Report, the issuer must submit the Progress Report for an additional two consecutive years. After the submission of those two additional Progress Reports, there would be another reassessment of minimum enrollment size prior to the sixth consecutive year of submission of the QIS Progress Report. This reassessment would continue after each two consecutive years of submission of QIS Progress Reports.

Issuers that continue to meet the QIS participation criteria will be included on the QIS Issuer List and required to continue QIS reporting. These issuers' product type enrollment would then be reevaluated to see if it still meets the minimum enrollment threshold after two more consecutive years of Progress Report submission. Instructions for how to calculate the minimum enrollment threshold is included in Section 5.2.

Exhibit 4: Application of the Minimum Enrollment Threshold to Progress Reporting

Calendar Year of Implementation Plan Submission	Implementation Plan (Plan Year) if Minimum Enrollment Threshold Met	Initial Progress Report (Plan Years)	Calendar Year of Minimum Enrollment Reassessment	Subsequent Progress Report (Plan Years), if Minimum Enrollment Threshold Met[14]
2016	2017	2018 and 2019	2019[15]	2020 and 2021
2017	2018	2019 and 2020	2020	2021 and 2022
2018	2019	2020 and 2021	2021	2022 and 2023
2019	2020	2021 and 2022	2022	2023 and 2024
2020	2021	2022 and 2023	2023	2024 and 2025

5.3 QIS Implementation Plan and Progress Report Form

Issuers applying for QHP certification in FFE States for the 2020 Plan Year and that meet the QIS participation criteria are expected to submit a QIS form in 2019 to either: (a) implement a new QIS beginning no later than January 2020 or (b) provide a progress update on an existing QIS.[16] Issuers may also use the QIS form to modify an existing QIS. This section provides details about the specific elements and criteria that an issuer needs to address when submitting information about its QIS.

5.3.1 QIS Form Purpose and Use

For the 2020 Plan Year, CMS developed an updated QIS form. All issuers, regardless of submission type, must use the updated QIS form.

The goal of the QIS form is to collect information from issuers that demonstrates compliance with section 1311(c)(1)(E) of the Patient Protection and Affordable Care Act. It also facilitates 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 Patient Protection and Affordable Care Act.

Commonly Used QIS Terms

- **QIS requirements:** The information issuers are required to submit for evaluation by an Exchange
- **Elements:** Identifying and descriptive information issuers use to complete the QIS form
- **Criteria:** Descriptions of the type of information issuers must provide and the rules an Exchange uses to evaluate whether an issuer's QIS fulfills the QIS requirements

[14] If an issuer's product type does not meet the minimum enrollment threshold when reassessed, the issuer would no longer be required to report on a QIS. Once the issuer meets all the QIS participation criteria again, the issuer would restart its QIS reporting by submitting at least one QIS Implementation Plan.

[15] In calendar year 2019 (for 2020 Plan Year submission), an issuer would meet the minimum enrollment threshold if it has more than 500 enrollees within a product type per State as of July 1, 2018.

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

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

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

Issuers use the QIS form to submit a QIS Implementation Plan and/or Progress Report to the relevant Exchange. During the 2020 QHP Application Period,[17] issuers that meet the QIS participation criteria, regardless of whether they are submitting an Implementation Plan and/or Progress Report, will indicate in the form which of the following types of information they are submitting:

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

5.3.2 Changing a QIS

Some issuers submitting QIS Progress Reports may choose to change their Implementation Plans from the prior year. Certain changes necessitate issuers' selection of specific QIS submission types, such as "Continuing a QIS with Modifications" and "Discontinuing a QIS Submitted during a Prior QHP Application Period." Exhibit 5 provides information about which QIS submission type issuers should select depending on what they want to change.

Exhibit 5: Changing a QIS

Continuing a QIS with No Modifications	Continuing a QIS with Modifications	Implementing a New QIS after Discontinuing a QIS
▪ Update Issuer Information, ▪ Update Current Payment Model(s) Description, ▪ Update Data Sources, and/or ▪ Update other information not listed in the following columns.	▪ Change QIS goals,[18] ▪ Change QIS activities, ▪ Change QIS measures, ▪ Change performance targets, and/or ▪ Change Product Types.	▪ Change QIS market-based incentive sub-type, ▪ Change QIS topic area, and/or ▪ The QIS results in negative outcomes or unintended consequences.

If making edits based on a previous year's QIS Post-certification Assessment (PCA) report, issuers do not need to select "Continuing a QIS with Modifications" in Element 1, unless the

[17] The 2020 QHP Application Period occurs in the 2019 calendar year.

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

changes are related to goals (Element 19), activities (Element 23), measures and/or performance targets (Element 24), and/or product types (Element 28). Instead, issuers must explain any changes made to address the prior year's Correction Notice from a previous year's QIS in Element 30, Summary of Progress. The different types of QIS submissions are identified and described in Exhibit 6.

Exhibit 6: Type of QIS Submission

Type of QIS Submission	Description of Each Submission Type
New QIS with No Previous QIS Submissions	▪ Select if the issuer did not submit a QIS during the 2019 QHP Application Period and meets the QIS requirements for the 2020 Plan Year specified in Section 5.1.1.
New QIS after Discontinuing a QIS Submitted during a prior QHP Application Period	▪ Select if the issuer: - Changed its Market-Based Incentive sub-type (Element 20), - Changed its Topic Area Selection (Element 21), or - Determines that its QIS resulted in unintended consequences (i.e., negative impact on enrollee population). ▪ If selected, the issuer must discontinue its existing QIS and implement a new QIS.[19]
Discontinuing a QIS Submitted during a prior QHP Application Period	▪ See above, "New QIS after Discontinuing a QIS Submitted during a prior QHP Application Period."
Continuing a QIS with No Modifications	▪ Select if the issuer made no changes to its existing QIS, or if the issuer changed elements and criteria such as: - Updating Issuer Information, - Updating Current Payment Model(s) description, - Updating Data Sources, and/or - Other information not listed in the "Continuing a QIS with Modifications" section below.
Continuing a QIS with Modifications	▪ Select if the issuer changed its: - Product Types (Element 2), - Goals (Element 19), - Activity(ies) that Will Be Conducted to Implement the QIS (Element 23), and/or - Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress (Element 24).

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

5.3.3 QIS Form Structure

The sections of the QIS form and their parts are listed in Exhibit 7.

[19] Issuers may choose to discontinue a QIS for other reasons but are encouraged to leave a QIS in place for at least two years.

Exhibit 7: QIS Form – Sections and Parts

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

Parts A through E of the QIS form comprise the "Implementation Plan" that is referred to throughout the Technical Guidance and User Guide. Parts F and G of the QIS form are the Progress Report section.

Issuers ***must*** complete all required elements included in the QIS form that is being submitted. If an issuer fails to provide responses to any criteria within any of the elements, CMS will ask the issuer to revise and complete the missing information and resubmit the form. CMS will review the information submitted in Parts A, B, C, and D for completeness. By comparison, CMS will review the information submitted in Parts E, F, and G for completeness **and** score these parts (refer to Section 6.3 in this volume for an explanation of QIS scoring).

The User Guide describes the elements found in the QIS form. The list in Appendix G summarizes each element by element number and name, and includes an explanation of each element, the criteria upon which it will be evaluated, whether issuers' responses are subject to character limits, and whether changes to the issuers' responses constitute a modification or require the issuer to discontinue the existing QIS and implement a new one.

6. QIS Evaluation

On an annual basis, issuers must meet the QIS requirements as part of QHP certification. In 2019, issuers submitting a QIS Implementation Plan for the first time will be required to provide information on the following parts of the form as part of their QHP application for the 2020 Plan Year:

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

Issuers that submitted quality improvement strategies as part of their 2019 Plan Year QHP applications are required to report on progress during the 2020 QHP Application Period. These

issuers are required to submit information on the following parts of the form as part of their QHP application for the 2020 Plan Year:

- Part A: QIS Submission Type,
- Part B: Issuer Information,
- Part C: Data Sources Used for Problem Identification and Monitoring Progress,
- Part D: QIS Summary,
- Part E: QIS Requirements,
- Part F: Modification Summary (if applicable), and
- Part G: Progress Report Summary.

6.1 QIS Implementation Plan and Progress Report Completeness Assessment Process

CMS[20] evaluates an issuer's QIS form to determine whether an issuer's QIS meets the applicable requirements, according to the QHP Application and Certification Process review stages and timeline established annually in the Letter to Issuers.

CMS assesses QIS submissions received during the first submission window of the QHP Application Period for completeness. Issuers whose submissions contain blank fields or are missing information receive Correction Notices during the application process indicating which fields were missing information. Issuers that receive such Correction Notices must correct and resubmit their QIS forms during the subsequent submission window within the current QHP Application Period. Issuers that meet the QIS participation criteria, but did not submit at least one QIS as required, also receive Correction Notices. CMS does not notify issuers if their QIS submissions are assessed as complete.

During the PCA Period, CMS evaluates each complete QIS submission to determine whether it meets, meets in the interim, or does not meet the QIS requirements (see Section 6.3.4). CMS scores issuers' submissions during this part of the process as "Meets," "Interim Meets," or "Does Not Meet" the QIS requirements.

6.2 QIS Evaluation Methodology

The QIS Evaluation Methodology reflects how CMS reviews and evaluates an issuer's responses to the elements and criteria of the QIS form. All of the fields in Elements 1–19 in Parts A–D of the QIS form are required; CMS assesses these inputs for completeness but only scores Element 2: Targets All QHPs and Product Types Offered Through an Exchange (Must Pass).

For Parts E, F, and G, CMS uses a "Partial-Credit plus Must-Pass" scoring approach. All "must-pass" elements must have all required criteria complete receive full credit. All non-"must-pass" elements must have at least 50% of the required criteria complete to receive full credit.

[20] 45 CFR § 155.200(d) directs the Exchange to evaluate QIS submissions. For an FFE State, CMS will perform the evaluations; however, for FFEs where the State performs plan management, the submission will be jointly reviewed by CMS and the State, with the final determination being made by CMS. For SBE States (including SBE-FPs), the SBE will perform evaluations. OPM will evaluate QIS submissions for MSP products.

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

6.3 Scoring the QIS Form

CMS scores the QIS form at the element level and only for those elements included in Parts A, E, F (if applicable), and G.

6.3.1 New, Discontinuing, or Continuing QIS Submission (Part A) Scoring

Only Element 2 in Part A is worth 1.00 point and is designated as must-pass. An issuer receives a passing score for Part A if it answers both criteria in Element 2: Targets All QHPs and Product Types Offered Through an Exchange (Must Pass). See Exhibit 8 for details on the scored elements that issuers are required to address in Part A.

Exhibit 8: New, Discontinuing, or Continuing QIS Submission (Part A) 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 2: Targets All QHPs and Product Types Offered Through an Exchange (Must Pass)
Not Scored Elements	▪ Issuer must complete this element if applicable, but it will not be scored.	▪ Element 1: Type of QIS Submission

6.3.2 Implementation Plan (Part E) Scoring

All elements included in Part E are worth 1.00 point, regardless of must-pass designation. An issuer receives 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 scored element not designated as must-pass.

Elements 20–24 are must-pass, and there is no partial credit offered for these five elements. For must-pass elements, an issuer either receives 1.00 point (i.e., 100 percent) for meeting all criteria or receives 0.00 point (i.e., 0 percent) if any criteria are not met. Elements 25 and 26 are also scored, but are not must-pass. Issuers may receive partial credit for these two elements based on the number of criteria they meet. See Exhibit 9 for details on the scored elements that issuers are required to address in Part E.

Exhibit 9: Implementation Plan (Part E) Scored Elements by Type

Element Type	Definition	Individual Elements
Must-Pass Elements	▪ Issuer must meet all criteria within an element to receive 1.00 point. ▪ There is no partial credit; meeting less than all criteria results in receipt of 0.00 point. ▪ Receiving 0.00 point on any must-pass element will result in issuer receiving a correction notification.	▪ Element 20: Market-based Incentive Type ▪ Element 21: Topic Area Selection ▪ 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 within an element are met. ▪ An issuer must receive at least 50% (0.50 point) on each of these elements to receive full credit.	▪ Element 25: Timeline for Implementing the QIS ▪ Element 26: Risk Assessment

CMS scores Element 25 (Timeline for Implementing the QIS) and Element 26 (Risk Assessment), but these elements 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 10 for details.

Exhibit 10: 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

6.3.3 Progress Report (Parts F and G) Scoring

Most elements included in Parts F (if applicable) and G are worth 1.00 point, regardless of must-pass designation. The exception is Element 28, which is required if applicable, but not scored. An issuer will receive a passing score for Parts F (if applicable) and G if it: (1) meets all of the criteria for the predetermined must-pass elements (i.e., receives 1.00 point for each must-pass element); **and** (2) meets the minimum score thresholds of 0.50 point (i.e., 50 percent) for each scored element not designated as must-pass.

Elements 27 (if applicable), 29, and 30 are must-pass, and there is no partial credit offered for these elements. For must-pass elements, an issuer either receives 1.00 point (i.e., 100 percent) for meeting all criteria, or receives 0.00 point (i.e., 0 percent) if any criteria are not met. Elements 31, and 32 are also scored, but are not must-pass. Issuers may receive partial credit for these two elements based on the number of criteria they meet. Element 28 is required (if applicable) and is

not scored. CMS assesses this element for completeness. See Exhibit 11 for details on the elements that issuers are required to address in the Progress Report.

Exhibit 11: Progress Report (Parts F and G) 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 27: Modifying Goals, Activities, and Measures or Associated Performance Targets (if applicable) ▪ Element 29: Analyze Progress Using Baseline Data, as Documented in the Implementation Plan ▪ Element 30: Summary of Progress
Other Scored Elements	▪ Issuer may receive partial credit based on how many criteria within an element are met. ▪ Issuer must receive at least 50% (0.50 point) on each of these elements to receive full credit.	▪ Element 31: Barriers ▪ Element 32: Mitigation Activities
Not Scored Elements	▪ Issuer must complete this element if applicable, but it will not be scored.	▪ Element 28: Modifying Product Types

CMS scores Elements 31 and 32, but these elements 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 12 for details.

Exhibit 12: Scoring Scale for Elements 31 and 32

		100%	80%	50%	20%	0%
Element 31, Barriers (2 criteria)	*# of Criteria Met*	Issuer meets 2 criteria	No scoring available	Issuer meets 1 criterion	No scoring available	Issuer meets no criteria
	Points Awarded	1.00 point awarded	N/A	1.00 point awarded	N/A	0.00 point awarded
Element 32, Mitigation Activities (2 criteria)	*# of Criteria Met*	Issuer meets 2 criteria	No scoring available	Issuer meets 1 criterion	No scoring available	Issuer meets no criteria
	Points Awarded	*1.00 point awarded*	*N/A*	*1.00 point awarded*	*N/A*	*0.00 point awarded*

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

CMS will begin its evaluations of complete QIS submissions after the close of the 2020 QHP Application Period. CMS will communicate evaluation results for QIS submissions for the 2020 Plan Year to issuers during the PCA Period in late fall 2019/early winter 2020.

If an issuer is still missing any critical information following the QHP Application Period or does not receive a score at or above the predetermined minimum evaluation threshold for Part E

(if the issuer submitted an Implementation Plan) or for Parts F (if applicable) and G (if the issuer submitted a Progress Report) after full evaluation, the issuer receives a "Does Not Meet" score and CMS may require the issuer to develop a Work Plan.

An issuer achieves a compliance designation of "Meets" for its QIS Implementation Plan submission if it: (1) successfully completes all fields in Elements 1–19 in Parts A–D, (2) receives a passing score for Element 2, and (3) successfully completes all elements and criteria AND receives a passing score for Part E (see Section 6.3.2).

An issuer achieves a compliance designation of "Interim Meets" for its QIS Implementation Plan submission if a minor data entry error(s) is identified (e.g., the rate provided does not equal the numerator divided by the denominator), preventing the issuer from receiving a passing score for Part E. The data entry error must be minor enough that CMS deems that the intent of the element or criterion is still understood. The "Interim Meets" designation requires issuers to confirm and correct any instances of data entry errors in the QIS Implementation Plan upon submission for the 2021 Plan Year.

An issuer achieves a compliance designation of "Meets" for its QIS Progress Report submission if it successfully completes all fields **and** receives a passing score for Parts F (if applicable) and G.

An issuer achieves a compliance designation of "Interim Meets" for its QIS Progress Report submission if a minor data entry error(s) is identified in Parts F and G. Similar to the Implementation Plan compliance, the data entry error must be minor enough that CMS deems that the intent of the element or criterion is still understood. The "Interim Meets" designation requires issuers to confirm and correct any instances of data entry errors in the QIS Progress Report upon submission for the 2021 Plan Year.

Based on the results captured in the QIS evaluation, CMS assigns an overall outcome of "Meets," "Interim Meets," or "Does Not Meet" to each issuer's QIS submission(s). Issuers do not receive numerical scores; however, issuers are notified if their QIS submissions were found incomplete (e.g., missing critical information), contain data entry errors, or were found deficient.

At this time, CMS does not penalize issuers if they do not achieve the performance targets set out in their QIS Implementation Plans; however, these issuers are required to track progress and make adjustments, as appropriate.[21]

6.3.5 QIS Results Communication

CMS assesses QIS submissions for completeness upon receipt during the QHP Application Period. As noted above, in the case of blank fields or missing data in the initial submission, issuers receive Correction Notices following each review period during the QHP Application Period to inform them that corrections are required for the parts of the QIS submission that were incomplete or missing. Once a submission is deemed complete, CMS conducts a full evaluation to determine if the QIS meets the QIS requirements. CMS communicates potential concerns and recommended actions resulting from evaluation to issuers during the PCA Period in the late

[21] 80 Fed. Reg. 10848 (Feb. 27, 2015).

fall/early winter timeframe via PCA Reports, following the close of the QHP Application Period and after QHP Certification.

If a submission receives an "Interim Meets" designation for the QIS Implementation Plan submission and/or the QIS Progress Report submission, the issuer must confirm receipt of the feedback and correct any instances of data entry errors in the relevant QIS submission for the 2021 Plan Year. An issuer may not receive an "Interim Meets" designation on the same type of error two years in a row. If an issuer makes the same type of error two years in a row, the issuer receives a "Does Not Meet" designation and must correct the error during the PCA Period for the 2021 Plan Year.

If an issuer receives a "Does Not Meet" designation or their submission is incomplete, it must confirm receipt of the feedback and correct all potential concerns during the PCA Period for the 2020 Plan Year. Additionally, an issuer may be required to develop a Work Plan.

CMS does not notify issuers if their QIS submissions successfully receive an overall outcome of "Meets."

As part of the annual QHP Application and Certification Process, an issuer must attest to complying with each Exchange certification standard.[22] CMS relies on that statement to affirm issuers' commitment to submit complete and accurate data.

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

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

Volume II. QIS User Guide for the 2020 Plan Year

1. User Guide Introduction

This User Guide provides instructions for issuers about compliance with quality improvement strategy (QIS) requirements. It describes differences in the submission process for issuers operating in a Federally-facilitated Exchange (FFE) State versus those that operate in FFEs where the State performs plan management. An issuer operating in the latter works directly with the State in which it is offering qualified health plans (QHPs) through the Exchange to submit its QIS.

Issuers that meet the QIS participation criteria operating in an FFE should review the QIS materials, prior to beginning their 2020 QHP Applications.[23] Issuers should also review the 2020 Letter to Issuers for additional guidance specific to the 2020 Plan Year.

1.1 Access the QIS Materials on the MQI Webpage

The QIS materials specific to each plan year will be accessible via the Marketplace Quality Initiatives (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[24] quality initiatives, such as the Quality Rating System (QRS)[25] and QHP Enrollee Satisfaction 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 **QIS Data Collection** page on 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): https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Improvement-Strategy/QIS-Data-Collection.html.

Step 2: Select each QIS-related document and click on the file name to view it.

Step 3: Under the "File" tab, select "Print" or "Save," as desired.

The QIS materials specific to each plan year will also be accessible via the CMS QHP Certification website prior to the start of the applicable QHP Application Period. The QHP Certification website houses instructions and forms for issuers to complete the annual QHP Application to be certified by an FFE.

[23] The 2020 QHP Application Period occurs in calendar year 2019.

[24] The terms "Exchange" and "Marketplace" are synonymous.

[25] 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 issuer reporting requirements. QRS develops public-facing QHP ratings based on relative quality and price, while QIS requires issuers to implement quality improvement strategies that include market-based incentives to cover all of their eligible QHPs as a condition of the QHP certification in the Exchange.

1.2 Prepare to Complete the Implementation Plan and Progress Report Form

For the 2020 Plan Year, CMS developed an updated QIS Implementation Plan and Progress Report form (QIS form). Issuers participating in an FFE that meets the QIS participation criteria, regardless of submission type must use the updated QIS form.

After reviewing the Technical Guidance and User Guide, issuers must complete the applicable sections of the QIS form (Parts A–E for the Implementation Plan and Parts A–G for the Progress Report) by following these instructions:

Step 1: Click on the PDF file titled, "QIS Implementation Plan and Progress Report" and confirm that "2020 Plan Year" appears in the header on the first page.

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

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

Step 4: Begin populating or updating the QIS Submission Type, Background Information, and the QIS Implementation Plan and/or the QIS Progress Report sections, as applicable, by following the instructions provided in Volume II, Sections 2, 3, 4, and 5 below.

Issuers are responsible for maintaining records that provide the detail required by the Exchanges and that may be necessary to demonstrate compliance with applicable Exchange requirements as part of an audit, compliance review, or other monitoring effort.[26] Issuers may not upload additional materials beyond the form itself via the System for Electronic Rate Filing and Forms (SERFF) or Health Insurance Oversight System (HIOS), and CMS will not accept them as part of the QIS submission.

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

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

TIP: For assistance accessing the QIS form online, please contact the Marketplace Service Desk (MSD) at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

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

[26] See 45 CFR § 156.705.

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

An issuer must complete Parts A–C of the QIS form for each QIS submission. An issuer must submit the form to each Exchange in which the QHP associated with the QIS is offered. Parts A–C consist of the following two sections of the QIS form:

- **Type of QIS Submission**
  - New, Discontinuing, or Continuing QIS (Part A)
  - Targets All QHPs and Product Types Offered Through an Exchange
- **Background Information**
  - Issuer Information (Part B)
  - Data Sources used for Problem Identification and Monitoring Progress (Part C)

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

TIP: Submissions will be blinded prior to full evaluation. To facilitate timely review, issuers should not include any identifying information (e.g., issuer name, State, any proprietary products) in their responses to the elements and criteria in the QIS form, except in Part B.

The subsections below provide instructions on how to complete each section. They also provide information about the elements and criteria, the level of detail expected in issuers' responses, and applicable character limits. Issuers must use the space provided in the QIS form to provide their responses; inclusion of additional attachments and/or supporting documentation will not be accepted. The form allows issuers to copy and paste language from other documents (e.g., Microsoft Word® documents) into the response fields, as long as the pasted text does not exceed the field's character limits.

TIP: The character limits specified include spaces and punctuation.

2.1 Part A. New, Discontinuing, or Continuing a QIS Submission

Part A of the QIS form asks issuers to identify what type of QIS submission they are making. During the 2020 QHP Application Period, an issuer may use the QIS form to submit a new QIS, implement a new QIS after discontinuing an existing QIS, discontinue a QIS, continue a QIS without modifications, or continue a QIS with modifications.[27] Part A is designed to guide issuers to complete the correct parts of the QIS form, depending on the type of QIS submission they are making. Issuers are also prompted at the end of the Implementation Plan section to

[27] Appendix B defines these QIS submission types and indicates which sections of the QIS form issuers must complete depending on the applicable scenario.

complete or skip the remaining parts of the QIS form depending on the type of QIS submission they chose in Element 1.

Follow the steps below to complete Part A. New, Discontinuing, or Continuing QIS Submission:

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., implementing a new QIS with no previous QIS submission, implementing a new QIS after discontinuing a QIS submitted during a prior QHP Application Period, discontinuing a QIS submitted during a prior QHP Application Period, continuing a QIS with no modifications, or continuing a QIS with modifications).

An issuer that did not submit a QIS during the 2019 QHP Application Period and newly meets the QIS participation criteria for the 2020 Plan Year must select "New QIS with No Previous QIS Submission." [28] An issuer that submitted a QIS during the 2019 QHP Application Period must select from the other submission type options and complete the required sections of the form. If an issuer wants to discontinue its existing QIS and submit a new QIS, it must complete two forms: one to report progress and discontinue its QIS, and one to submit its new QIS. See Appendix B for additional information on which QIS submission type to select.

The required sections of the QIS form are determined by the type of QIS submission as specified in Part A.

Step 2: Identify whether the QIS applies to all eligible QHPs the issuer offers or is seeking to offer through the Exchange by checking the appropriate box in Element 2.

Indicate the number of forms that will be submitted using the space provided (e.g., this is form 1 of 2).

To complete Criterion 2a, check the box for "All QHPs" if the QIS applies to all eligible QHPs included in the current year's QHP Application. Check the box for "Subset of QHPs" if the QIS covers only some of the eligible QHPs offered by the issuer through the Exchange.

TIP: Eligible QHPs are health plans within a product type that meets the minimum enrollment threshold (i.e., the product type had more than 500 on-Exchange enrollees per State as of July 1, 2018). QHPs within product types that do not meet the minimum enrollment threshold (i.e., non-eligible QHPs) are not required to be covered by a QIS. For more information about QHP eligibility with respect to an issuer's QIS, refer to Section Volume I.5.2 of the Technical Guidance.

TIP: If this QIS covers only a subset of the issuer's eligible QHPs offered through the Exchange, an issuer must submit additional QIS forms so each eligible QHP offered by the issuer through an Exchange is associated with a QIS.

[28] A "new QIS" is defined as either a QIS that has not been previously submitted to an Exchange OR a QIS that differs from an issuer's prior QIS due to changes in market-based incentive, topic area, or other aspects.

TIP: An issuer that previously covered all eligible QHPs with a single QIS may choose to cover a subset of QHPs with its existing QIS in subsequent years, but must submit an additional QIS form(s) to cover its remaining eligible QHPs. Similarly, an issuer that previously covered subsets of its eligible QHPs with different quality improvement strategies may discontinue one or more of its strategies by submitting QIS forms to close them out. The issuer must also ensure all eligible QHPs are covered by an existing or new QIS.

To complete Criterion 2b, check the appropriate box(es) to indicate the product type(s) (e.g., health maintenance organization [HMO], point of service [POS]) to which the QIS applies for the 2020 Plan Year.

TIP: If you are adding or removing product types to an existing QIS, you will specify that information in Element 28. **Only provide the product type(es) that apply to the 2020 Plan Year QIS in Criterion 2b.**

2.2 Part B. Issuer Information

Part B of the QIS form collects identifying information about the issuer (e.g., issuer legal name, company legal name, HIOS Issuer ID, issuer State, QIS contact information, date issuer began offering coverage through the Exchanges, information about the issuer's current payment models). CMS requires responses to all Part B elements, but will not score them. There are no associated criteria requested in Part B.

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

Step 1: Type the issuer's legal name into the space provided for Element 3.

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 3–6 (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 QHP Application for the 2020 Plan Year.

TIP: If you previously completed Elements 3–16 as part of your Implementation Plan and are now submitting a Progress Report for your existing QIS, review your prior years' responses to these elements and make any necessary updates. It is important to make sure your responses to these elements are current. Changes to these elements do not warrant selection of "Continuing a QIS with Modifications" in Element 1.

Step 2: Type the legal name of the issuer's parent company into the space provided for Element 4.

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 are the same.

Step 3: Enter the issuer's HIOS Issuer ID in the space provided for Element 5.

The HIOS Issuer ID is a five-digit numeric identifier that is assigned to each issuer during HIOS registration.[29]

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

Step 4: In Element 6, name the State in which the issuer is domiciled.

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

Step 5: Identify and provide contact information for the issuer's QIS primary point of contact (POC) in Elements 7–10.

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 QIS form 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 11–14.

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

Step 7: Enter the date the issuer began offering coverage through the Exchange in the space provided for Element 15.

The date entered should specify when the issuer began offering coverage through the Exchange by following this format: MM/DD/YYYY. For example, an issuer might indicate that it began offering coverage through the Exchange on 01/01/2014.

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

Step 8: Select one or more of the categories of payment models listed in Element 16.

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

The information provided in Element 16 will help CMS gauge progress toward meeting value-based payment goals.[30] Exhibit 13 provides a description of each of the four categories.

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

[30] https://hcp-lan.org/apm-refresh-white-paper/

Exhibit 13: Examples of Payment Models by Category[31]

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

Enter the percentage of payments (i.e., the percentage of payment dollars) to providers in the space provided for each of the payment model types selected. Please confirm that the total percentage of payments across all four payment model type categories equals approximately 100 percent.

TIP: Round percentages to the nearest whole number (e.g., 2). Do not enter decimal places (e.g., 1.73), fractions (e.g., 1 ¾) or percent signs (e.g., %).

TIP: To calculate the percentage of payments, use the calculation methodologies defined in the Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs (APM Measurement Effort) Final Paper: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

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

Part C of the QIS form collects information about the data sources the issuer used to inform the development and implementation of its QIS. The information requested in this element is used to understand how an issuer identified the goals and developed the rationale for its QIS. An issuer must provide a response to this element, but CMS will not score the response. **Changes to this element do not warrant selection of "Continuing a QIS with Modifications" in Element 1**. Follow this step to complete Part C in the Background Information section of the QIS form:

Step 1: Indicate the data sources that were used to identify the problem or topic area that the QIS aims to address by checking the appropriate box(es) in Element 17.

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 (including the QHP Enrollee Experience Survey); plan data, such as complaint, appeals, and customer service records; registries; U.S. Census data; the Area Health Resource File (AHRF),[32] all-payer claims data; State health department population data; and/or regional collaborative health data.

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

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

Check one or more boxes to indicate which of the data sources listed in Element 17 the issuer 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) you used to identify the problem(s) and to monitor its QIS progress.

TIP: If you previously completed Element 17 as part of your Implementation Plan and are now submitting a Progress Report for your existing QIS, review your prior submission and make any necessary updates to your data sources. It is important to make sure your response to this element is current. Changes to this element do not warrant selection of "Continuing a QIS with Modifications" in Element 1.

3. Complete the QIS Implementation Plan (Part D. QIS Summary and Part E. QIS Requirements)

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

- **QIS Implementation Plan Section**
  - Part D: QIS Summary
  - Part E: QIS Requirements

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

TIP: Submissions will be blinded prior to full evaluation. To facilitate timely review, issuers should not include any identifying information (e.g., issuer name, State, any proprietary products) in their responses to the elements and criteria in the QIS form, except in Part B. Issuer Information.

The subsections below provide instructions on how to complete each part of the Implementation Plan. Refer to Appendix G for an element by element summary.

TIP: Prior to submitting your Implementation Plan to CMS, use the QIS form Pre-Submission Checklist provided in Appendix D to confirm you have provided responses to all required[33] elements—including must-pass elements—and criteria, and to guide you through the submission process.

[33] For example, if you do not select "Other Market-based Incentives" in Element 20, you do not need to provide a description in the text box.

3.1 Part D. QIS Summary

Part D of the QIS form collects information that summarizes the issuer's QIS (e.g., QIS title and description). Responses to both elements in Part D are required but will not be scored. There are no associated criteria requested in Part D.

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

Step 1: Provide a name for the QIS in the space provided for Element 18.

The QIS title provided in Element 18 should be brief, but descriptive.

Step 2: Provide a brief summary description of the QIS in the spaces provided for Element 19.

The QIS description is a snapshot of some of the QIS elements covered in more detail in Part E of the Implementation Plan Section. The QIS description should specify the market-based incentive type(s) (e.g., provider, enrollee) and the QIS topic area (e.g., improve health outcomes, prevent hospital readmissions). These two pieces of information should be derived from the issuer's responses to Elements 20 and 21, respectively, in Implementation Plan Part E.

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

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

Indicate if this QIS is one that the issuer currently has in place for an Exchange product line and/or for other product lines (e.g., Medicaid, commercial). Issuers may use existing strategies that are employed in non-Exchange product lines if the existing strategy is relevant to their Exchange population and meets the QIS requirements.[34] 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.

Step 3: Describe the overall goal(s) of the QIS (no more than two goals).

The QIS description should specify the overall goal or goals (no more than two) of the QIS—drawing a clear link between the goal(s) and the topic area(s) selected in Element 21, as well as the measures identified in Element 24 in QIS Implementation Plan Part E. If the goal(s) were modified, include the modified goals in Element 19 and describe the modifications in Part F, QIS Modification Summary: Criterion 27a.

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

TIP: Since the QIS description (Element 19) closely relates to your responses to elements and criteria in Part E (e.g., Elements 20 and 21), double check the consistency, as well as the completeness, of your responses to each element and criteria throughout the Implementation Plan prior to submission.

3.2 Part E. QIS Requirements

Part E of the QIS form collects detailed information about the QIS for evaluation.

TIP: Responses are required for all Part E elements and criteria. Five of the seven 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.

The section below describes the elements and criteria issuers must populate in Part E in the Implementation Plan Section of the QIS form. 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 that its submission is missing information via a Correction Notice. The Correction Notice will specify which element(s) and/or criteria need to be revised and resubmitted. Follow these steps to complete Part E. QIS Requirements in the Implementation Plan Section of the QIS form:

Step 1: Select at least one of the market-based incentive types listed in must-pass Element 20.

To complete Element 20, select the box(es) for the market-based incentive sub-type(s) (e.g., increased reimbursement, bonus payment, premium credit, co-insurance reduction[35]) the QIS includes. An issuer may choose to implement a provider market-based incentive, an enrollee market-based incentive, or both.

TIP: An issuer that previously submitted an Implementation Plan and is completing a Progress Report on an existing QIS should NOT change its market-based incentive sub-type selections in Element 20. If an issuer changes its market-based incentive sub-type, it must discontinue its previous QIS and submit a new Implementation Plan.

If "In-kind incentives," "Other provider market-based incentives," and/or "Other enrollee market-based incentives" are selected as a market-based incentive sub-type, include a brief description in the corresponding space(s) provided.

TIP: Refer to Appendix C for additional information to complete Element 20.

[35] 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); and 45 CFR § 146.121(f)).

Step 2: Select at least one of the topic areas listed in must-pass Element 21.

To complete Element 21, check the box(es) for at least one topic area the QIS addresses, as defined in the Patient Protection and Affordable Care Act.[36] Issuers may select more than one topic to address with a single QIS.

TIP: An issuer that previously submitted an Implementation Plan and is completing a Progress Report for an existing QIS should NOT change its topic area selections in Element 21. If an issuer changes its topic area selections, it must discontinue its previous QIS and submit a new Implementation Plan.

Step 3: Enter a rationale for the QIS in the space provided for must-pass Element 22. The rationale should include both a description of the issuer's current[37] QHP enrollee population and how the QIS will address the needs of the current population.

Step 4: 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 (i.e., a-d)

The activities listed should relate to the goal(s) of the QIS (consistent with the goals identified in Element 19) and should advance the QIS as it relates to: (1) the market-based incentive chosen in Element 20, (2) the topic area(s) chosen in Element 21, 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 assessment 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. If the activity(ies) was modified, please include the modified activity(ies) in Element 23 and describe the modifications in Part F, QIS Modification Summary: Criterion 27b. 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 21, but relevant activities are included in the context of another topic area in the issuer's QIS, describe how implementation activities relate to health and health care disparities. If health and health care disparities are not addressed

[36] Patient Protection and Affordable Care Act, section 1311(g)(1).

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

in the QIS, or if health and health care disparities is one of the topic areas selected in Element 21, check "Not Applicable."

Step 5: 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 19 (if JavaScript is enabled, the goals should auto-populate from Element 19. If the goals do not auto-populate, copy and paste the goals from Element 19 to Element 24). For each goal, identify at least one (but no more than two) primary measures that are used to track progress against the goal by providing the measure name in Criteria 24a, 24f, 24k, and 24p.

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

If an issuer modified the measures or associated performance targets, please include the modified measures and/or performance targets in Element 24 and describe the modifications in Part F, QIS Modification Summary: Criterion 27c. *Note: Issuers may only modify their performance target if the target was met or is no longer feasible or accurate.*

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

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

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

For Criteria 24a, 24f, 24k, and 24p, issuers must provide a narrative description of the measure, including a clear description of the measure numerator and denominator. Next, specify whether the issuer is using a National Quality Forum (NQF)-endorsed measure by checking "Yes" or "No." If yes, provide the NQF ID in the space provided and indicate whether the issuer modified the NQF-endorsed measure specifications.

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

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

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

For Criteria 24b, 24g, 24l, and 24q, issuers must provide a narrative description of how each measure supports tracking performance related to the corresponding QIS goal. Issuers must also use this space to provide additional detail on what the performance target (Criteria 24e, 24j, 24o, and 24t) represents.

For Criteria 24c, 24h, 24m, and 24r, issuers must provide the baseline assessment results by calculating the rate (a numerical value) and providing the associated numerator and denominator, if applicable. If the measure is not a rate, but another data point, enter the number in the space provided.

- **TIP:** Baseline data is the initial collection of data that serves as a basis for comparison with the subsequently acquired data. For QIS, issuers should use the data from their initial QIS Implementation Plan if they have not modified their measures. Baseline assessment results should measure an issuer's performance before implementation of the QIS.
- **TIP:** If an issuer is continuing a QIS with no modifications, the baseline assessment results reported in Element 24 should remain constant from Element 24 in the prior year's QIS submission, and should match the baseline assessment results reported in Element 29 of the current QIS submission.
- **TIP:** If an issuer is continuing a QIS with modifications and is modifying its measures, the baseline assessment results reported in Element 24 should reflect the modified measures. The baseline assessment results reported in Element 29 should match the results reported in Element 24 of the prior year's Implementation Plan. In this case, the baseline assessment results in Elements 24 and 29 of the current QIS submission will likely not match.
- **TIP:** Check for data entry errors. Ensure that the rate provided is equivalent to the numerical value created when the numerator is divided by the denominator.

For Criteria 24d, 24i, 24n, and 24s, specify the baseline performance period (e.g., measurement year) covered by the baseline data assessment.

- **TIP:** If an issuer is continuing a QIS with no modifications, the baseline performance period reported in Element 24 should remain constant from Element 24 in the prior year's QIS submission and should match the baseline performance period reported in Element 29 of the current QIS submission.
- **TIP:** If an issuer is continuing a QIS with modifications and is modifying its measures, the baseline performance period reported in Element 24 should reflect the baseline performance period for the modified measures. The baseline performance period reported in Element 29 should match the baseline performance period reporting in Element 24 of the prior year's Implementation Plan. In this case, the baseline performance period in Elements 24 and 29 of the current QIS submission may not match.

To complete Criteria 24e, 24j, 24o, and 24t, issuers must provide the performance target for each specified measure. New for the 2020 Plan Year, if an issuer meets its performance target, it may

modify its target by "Continuing a QIS with Modifications," instead of "Discontinuing a QIS" as required in prior plan years.

TIP: At this time, 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: If an issuer is continuing a QIS with modifications and is modifying its performance targets, the performance targets reported in Element 24 should reflect the modified performance targets.

Step 6: Provide a timeline for implementing the QIS in the space provided in scored Element 25. Be sure to address all of the specified criteria.

The timeline should include the QIS initiation/start date in Criterion 25a. Enter the date using the following format: MM/YYYY. The QIS initiation/start date should be the first month of the plan year in which the issuer **first** began implementing the QIS for the Exchange product types and health plans specified in Element 2.

For example, an issuer that submitted its initial QIS Implementation Plan during the 2018 QHP Application Period (calendar year 2017) and its initial QIS Progress Report during the 2019 QHP Application Period (calendar year 2018) should list its QIS initiation/start date as 01/2018 or earlier for its continued QIS submissions. An issuer submitting a new QIS Implementation Plan for the first time during the 2020 QHP Application Period (calendar year 2019), should list its QIS initiation/start date as 01/2020 or earlier.

TIP: Issuers submitting a continued QIS submission (with or without modifications) for the 2020 QHP Application Period must list the QIS initiation/start date as 01/2019 or earlier. Issuers submitting a new QIS Implementation Plan for the 2020 QHP Application Period must list the QIS initiation/start date as 01/2020 or earlier.

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

The dates and milestones provided for those criteria must correspond to the activities described in Element 23. Issuers will not be penalized if they need to adjust their timelines or redefine their milestones as they move forward with implementation. However, the issuer's QIS initiation/start date in Criterion 25a should remain the same from the prior year's submission when continuing a QIS. Changes to this element do not warrant the selection of "Continuing a QIS with Modifications" in Element 1.

Step 7: Provide a risk assessment that describes known or anticipated barriers and mitigation activities in the space provided in scored Element 26. Be sure to address both of the specified criteria.

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

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

Step 8: If applicable, provide any additional information on the QIS Implementation Plan that reviewers may find useful in the text box. This field will not be scored.

Step 9: Confirm which required parts of the form must be completed using the resource at the bottom of page 18 of the QIS form.

Exhibit 14: Resource for Determining Which Required Parts of the Form Must Be Completed

If "New QIS with No Previous QIS submission," STOP HERE.
If "New QIS after Discontinuing," STOP HERE.
If "Discontinuing a QIS," SKIP to page 22 (Part G. Progress Report Summary).
If "Continuing a QIS with Modifications," continue to next page 21 (Part F. Modification Summary).
If "Continuing a QIS with No Modifications," SKIP to page 22 (Part G. Progress Report Summary).

Step 10: Save the completed QIS Implementation Plan after verifying responses have been provided to address all of the required elements and criteria.

Review the form to make sure responses have been provided for all required elements and criteria. CMS will notify issuers that leave required elements blank and/or do not meet the evaluation threshold for each element of these deficiencies and instruct these issuers to correct and resubmit their Implementation Plans during the QHP Application Period.

Save the completed QIS Implementation Plan as a PDF file. The file name should follow this naming convention: [5-digit 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: [5-digit HIOS Issuer ID]-[Issuer Name]-QIS-[#]. For example, if an issuer submits two Implementation Plans, the first file should be named "12345- Issuer ABC-QIS-1" and the second file should be named "12345- Issuer ABC-QIS-2." All QIS Implementation Plans must follow these naming conventions when submitted.

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

4. Complete the QIS Progress Report Section (Part F. QIS Modification Summary and Part G. Progress Report Summary)

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

Issuers that submitted an Implementation Plan or Progress Report for the 2019 Plan Year are required to report on activities conducted to implement the QIS by submitting the applicable

section(s) of the Progress Report using the 2020 Plan Year QIS form. Issuers submitting a QIS for the first time during the 2020 QHP Application Period are not required to submit a Progress Report until the 2021 QHP Application Period.

To complete the Progress Report, issuers must:

- Complete the **QIS Submission Type** section (Part A);
- Confirm the **Issuer Information** section (Part B) and **Data Sources** section (Part C) are accurate or include updates from the prior year, if necessary;
- Complete the **Implementation Plan Section** (Parts D and E) with the prior year's QIS submission information if continuing the QIS with no modifications, or with new information in Part E, where applicable, if continuing the QIS with modifications; and
- Complete the **Progress Report Section** (Parts F [if issuer selected "Continuing a QIS with Modifications" in Element 1] and G).

4.1 Part F. QIS Modification Summary

If an issuer modified its goals, activities, measures (including performance targets) and/or product types from the prior year's QIS submission, the issuer must select "Continuing a QIS with Modifications" in Element 1. This section describes the Progress Report Section elements and criteria that issuers must complete in Part F of the QIS if they selected "Continuing a QIS with Modifications" in Element 1.

Issuers that are continuing a QIS with no modifications or are discontinuing a QIS should leave Part F blank and skip to Part G of the QIS form detailed in Section 4 of the User Guide.

Follow these steps to complete Part F. QIS Modification Summary in the Progress Report Section of the QIS form, if applicable:

Step 1: Indicate what type of modification(s) the issuer is making to the goals, activities, and measures in its QIS and provide a rationale for the modification(s) to complete must-pass Element 27. Be sure to address all of the specified criteria.

To complete Criterion 27a, select the box(es) to indicate which goal(s) were modified from the prior year's QIS submission. Describe modifications to the goal(s) in the space provided, if applicable. If no goals were modified, leave this criterion blank.

To complete Criterion 27b, indicate which activity(ies) were modified from the prior year's QIS submission. If the issuer selects "Yes" in Criterion 27b, please describe modifications to the QIS activities.

To complete Criterion 27c, select the box(es) to indicate which measure(s) or associated performance target(s) were modified from the prior year's QIS submission. Describe modifications to the measure(s) or associated performance target(s) in the space provided, if applicable. If no measures or associated performance targets were modified, leave this criterion blank.

Step 2: Indicate whether issuer added or removed any product type(s) from the QIS to complete Element 28.

Select "Add" or "Remove" for each of the product types added to or removed from the 2020 Plan Year QIS originally listed in Criterion 2c of the Implementation Plan Section of the QIS form. If there were no additions or removals, leave Element 28 blank.

4.2 Part G. Progress Report Summary

Step 1: If an issuer selected "Discontinuing a QIS," "Continuing a QIS with Modifications," or "Continuing a QIS with No Modifications" in Element 1, restate the goals and baseline data provided in Elements 19 and 24 of the prior year's QIS submission.

Analyze progress by providing follow-up results and indicating whether the performance target in Element 24 was met in must-pass Element 29. Be sure to address all five of the specified criteria.

In the space provided, restate the goals and baseline data provided in Elements 19 and 24.

TIP: If the issuer is modifying its goals and/or measures for the 2020 Plan Year (i.e., selected "Continuing a QIS with Modifications" in Element 1 and filled out Part F. Modification Summary), the issuer's response in Element 29 should reflect progress made **prior to modification(s)** on the original goals and/or measures.

For example, if an issuer submitted a QIS Implementation Plan during the 2019 QHP Application Period and chooses to modify the measures in Element 24 of its QIS Implementation Plan during the 2020 QHP Application Period, the Progress Report submitted by the issuer during the 2020 QHP Application Period should reflect progress made against the measures **originally specified** in its 2019 QIS Implementation Plan (as opposed to its newly modified measures). Then, if, an issuer continues its QIS with no modifications for the 2021 Plan Year, the issuer should report progress made on its modified goals and/or measures (as specified in the 2020 QIS submission) in Element 29 of the 2021 QIS submission.

To complete Criteria 29a, 29f, 29l, and 29q, specify the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment as indicated in Element 24 of your prior year's QIS submission. Enter the response in MM/YYYY format.

TIP: If an issuer selected "Continuing a QIS with No Modifications" in Element 1, the **baseline performance period** reported in Element 29 should match the **baseline performance period** reported in Element 24.

TIP: If an issuer selected "Discontinuing a QIS" or "Continuing a QIS with Modifications" in Element 1, the **baseline performance period** reported in Element 29 should reflect the **baseline performance period** reported in Element 24 in the prior year's QIS submission.

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

To complete Criteria 29c, 29h, 29m, and 29r, provide the measure name as indicated in Element 24 of your prior year's QIS submission . Note the tips above about matching goals and measures.

To complete Criteria 29d, 29i, 29n, and 29s, restate the baseline assessment results provided in Element 24 of your prior year's QIS submission, including the rate (a numerical value) and associated numerator and denominator, if applicable. If the measure is not a rate, but another data point, enter the number in the space provided.

- **TIP:** Baseline assessment results reported in Element 29 should measure an issuer's performance before implementation of the QIS. Baseline data is the initial collection of data that serves as a basis for comparison with the subsequently acquired data. For QIS, issuers should use the data from their initial QIS Implementation Plan if they have not modified their measures.

- **TIP:** If an issuer is continuing a QIS with no modifications, the **baseline assessment results** reported in Element 29 should match the **baseline assessment results** reported in Element 24.

- **TIP:** If an issuer is continuing a QIS with modifications and is modifying its measures, the **baseline assessment results** reported in Element 29 should match the **baseline assessment results** reported in Element 24 of the prior year's Implementation Plan.

- **TIP:** Check for data entry errors. Ensure that the rate provided is equivalent to the numerical value created when the numerator is divided by the denominator.

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

- **TIP:** Baseline assessment results and follow-up results should be distinct; issuers should not restate the baseline assessment results provided in Element 24 in Criteria 29e, 29j, 29o, and 29t.

- **TIP:** Check for data entry errors. Ensure that the rate provided is equivalent to the numerical value created when the numerator is divided by the denominator.

- **TIP:** Issuers will not be penalized if they do not achieve performance target(s); however, issuers may revise their performance target(s) if the original performance target(s), as specified in Element 24 of the prior year's QIS Implementation submission, is met, or is no longer feasible or accurate. New for the 2020 Plan Year, issuers may modify their performance targets after they have met the initial target. Issuers should include the modified targets in Element 24 and should report on progress made toward their original target in Element 29.

Step 2: In Element 30, provide a summary of progress toward achieving the performance target(s) documented in Element 24 of your prior year's QIS Implementation Plan. Include a description of the activity(ies) leading to the outcome in must-pass Element 30.

Indicate why progress was or was not made toward achieving the performance target(s) documented in Element 24 of your prior year's QIS Implementation Plan. Include a description of activities that led to the outcome. If the issuer selected "Continuing with Modifications" in Element 1 and the modification(s) were described in Part F. QIS Modification Summary, specify whether the information included in the summary of progress provided in Element 30 affected the decision to modify the QIS.

If the issuer selected "Discontinuing a QIS" in Element 1, provide the rationale for discontinuing the QIS.

Provide information about changes made to the QIS based on potential concerns and recommended actions from the issuer's PCA Report from the previous year, if applicable.

Step 3: In Element 31, indicate whether the issuer faced any barriers implementing its QIS and/or any problems meeting the timelines specified in Criterion 25b of your prior year's QIS Implementation Plan submission. Be sure to address both of the specified criteria.

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

To complete Criterion 31b, indicate whether there were any problems meeting the timelines specified in Criterion 25b of your prior year's QIS submission. If "Yes" is selected, describe the problems in meeting timelines.

Step 4: In Element 32, describe any mitigation activities implemented to address the barriers and/or challenges meeting timelines that were specified in Element 31, if applicable. Describe the results of the mitigation activities.

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

Step 5: If applicable, provide any additional information on the QIS Progress Report that reviewers may find useful in the text box. This field will not be scored.

5. Submit the QIS Form

Issuers will submit their completed QIS forms, along with all other QHP certification documentation,[38] during the annual QHP Application Period. For the 2020 QHP Application Period, the QHP Application submission window for the FFEs is specified in the 2020 Letter to Issuers. For the 2020 Plan Year, the QIS form will be submitted through the accreditation module.

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

Issuers submitting quality improvement strategies for QHPs offered through an FFE will submit their QIS form(s) through HIOS.[39] Once issuers have typed responses for each applicable element and criteria into the QIS 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 FFE for evaluation.

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

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

5.1 Submit via HIOS

Issuers in FFEs where the State does not perform plan management should follow these steps to submit their completed Implementation Plan and Progress Report form(s) via HIOS:

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

Step 2: Enter the user's Enterprise Identity Management System credentials (i.e., user name and password) to access HIOS.[40]

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

[38] 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.

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

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

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

Step 5: Upload the completed Implementation Plan and Progress Report form to HIOS.

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

Issuers must label their submissions according to the aforementioned naming convention: [5-digit HIOS Issuer ID]-[Issuer Name]-QIS, for single submissions; and [5-digit HIOS Issuer ID]-[Issuer Name]-QIS-[#], for multiple submissions.

TIP: For help accessing HIOS, or for technical assistance related to QIS form submission in HIOS, please contact the Marketplace Service Desk (MSD) Desk at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

5.2 Submit via SERFF

Issuers submitting quality improvement strategies for QHPs offered in FFEs where the State performs plan management follow a slightly different submission process. These issuers submit their QIS forms through SERFF. Once submitted, these issuers' QIS forms are transmitted to the State and the FFEs for joint evaluation.

Issuers operating in FFEs where the State performs plan management should follow these steps to submit their completed QIS forms to the Exchange 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 form (in Adobe Acrobat PDF format) to SERFF.

Issuers must label their submissions according to the aforementioned naming conventions: [5-digit HIOS Issuer ID]-[Issuer Name]-QIS, for single submissions; and [5-digit 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. Direct questions about SERFF to the SERFF Help Desk at 1-816-783-8990 or via email at serffhelp@naic.org.

6. Address Incomplete or Deficient QIS Submissions

CMS 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 CMS determines that their submissions are incomplete and/or do not meet the QIS requirements.[41]

6.1 Addressing Deficiencies during the Current QHP Application Period

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

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

The Correction Notice will specify any QIS form that is missing information, submitted in the incorrect format, missing required parts, or not submitted at all.

Step 2: Open the local copy of the issuer's saved QIS form.

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

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

The issuer should provide responses or make corrections to the elements and criteria CMS indicated were missing information. The new responses should address the identified deficiencies by providing additional information or including missing information as directed by the Correction Notice.

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

Step 4: Save a local copy of the revised QIS form.

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

Step 5: Upload the revised QIS form to HIOS or SERFF (as appropriate).

Follow the steps provided in Section 5 above, to submit the revised form to CMS and the State (if applicable). Issuers operating in FFEs where the State performs plan management should

[41] Issuers offering coverage in FFEs where the State performs plan management should contact the applicable State regulator(s) for additional details on the State process for evaluating QIS submissions. Issuers offering coverage in SBEs (including SBE-FPs) should contact the applicable Exchange for details on the process for evaluating QIS submissions. Issuers offering MSP products in FFEs should contact OPM for additional details on its process for evaluating QIS submissions.

submit via SERFF; for all other FFE States, issuers should submit via HIOS. For MSP products, issuers should follow the guidance provided by OPM.

6.2 Addressing Potential Concerns after the QHP Application Period

CMS begins evaluations of complete QIS submissions after the close of the 2020 QHP Application Period. CMS will communicate full evaluation results for QIS submissions for the 2020 Plan Year to issuers in late fall 2019/early winter 2020.

If an issuer is still missing critical information or does not receive a score at or above the predetermined minimum evaluation threshold for Part E (if the issuer submitted an Implementation Plan) or Parts F and G (if the issuer submitted a Progress Report) after full evaluation, the issuer receives a "Does Not Meet" score and CMS may require the issuer to develop a Work Plan. Issuers that receive a "Does Not Meet" score will be required to correct and resubmit their QIS during the PCA Period.

An issuer achieves a compliance designation "Interim Meets" for its QIS submission if it does not receive a score at or above the predetermined minimum evaluation threshold due to minor data entry errors in Part E (if the issuer submitted an Implementation Plan only) or Parts F and G (if the issuer submitted an Implementation Plan and Progress Report) after full evaluation. Issuers that receive an "Interim Meets" score are required to correct and submit their QIS during the **next QHP Application Period.** An issuer may not receive an "Interim Meets" designation on the same type of error two years in a row. If an issuer makes the same type of error two years in a row, the issuer will receive a "Does Not Meet" designation and must correct the error during the PCA Period for the 2020 Plan Year.

An issuer achieves a compliance designation of "Meets" for its QIS Implementation Plan submission if it: (1) successfully completes all fields in Elements 1–19 in Parts A–D, (2) receives a passing score for Element 2, and (3) successfully completes all elements and criteria AND receives a passing score for Part E (see Section Volume I.6.3.2of the Technical Guidance).

An issuer achieves a compliance designation of "Meets" for its QIS Progress Report submission if it: successfully completes all fields **and** receives a passing score for Parts F (if applicable) and G. Issuers that receive a "Meets" score will receive no communications regarding QIS during the PCA Period.

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)
Exchange 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
Exchange 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 Patient Protection and 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 Patient Protection and Affordable Care Act consistent with the standards of section 1311(g) of the Patient Protection and 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 Patient Protection and Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Patient Protection and 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

Topic	Provisions	Citation
Exchange 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 Patient Protection and 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 Patient Protection and Affordable Care Act, for each QHP offered in an Exchange, consistent with the guidelines developed by HHS under section 1311(g) of the Patient Protection and 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 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 Part A (QIS Submission Type) of the QIS form. Issuers that meet the QIS participation criteria must complete Part A of the QIS form annually, in addition to any other required sections.

Scenarios for Form Completion Based on Type of QIS Submission

Type of QIS Submission	Issuer and Prior QIS Submission History	QIS Implementation Plan and Progress Report Sections To Be Completed
New QIS[42] with No Previous QIS Submission	▪ The issuer has offered QHPs through an Exchange for at least two consecutive years, AND ▪ Has not previously submitted a QIS Implementation Plan[43]	▪ 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 ▪ 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
Discontinuing a QIS Submitted during a prior Qualified Health Plan (QHP) Application Period	▪ The issuer has previously submitted a QIS Implementation Plan, AND ▪ The issuer intends to discontinue its existing QIS to implement a new QIS (i.e., one with a different market-based incentive and/or topic area than its previous QIS).	▪ Complete two forms ▪ Complete one to close out the discontinued QIS: - Complete the Background Information section (Parts B and C) - Complete the QIS Implementation Plan Section (Parts D and E) - Complete the QIS Progress Report Section (Parts F and G), AND ▪ Complete a new/separate form to submit the new QIS: See "New QIS after Discontinuing…" above.

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

[43] 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 form. If a subset of an issuer's QHPs is covered by a different QIS, then the issuer may have previously submitted a QIS for those plans but may still select "New QIS with No Previous QIS Submission" as long as the current QIS addresses an entirely different subset of QHPs from what was previously submitted. If an issuer submitted a QIS, then was no longer required to submit a QIS, and now meets the QIS requirements again, it should select "New QIS with No Previous Submission" in Element 1.

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 a QIS Implementation Plan, AND ▪ Will continue its existing QIS without any changes to its goals, measures, activities, and/or product types.	▪ 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, ▪ SKIP the QIS Modification Summary (Part F), AND ▪ Complete the QIS Progress Report Summary (Part G) ▪ Note: Parts D and E should remain unchanged. Those sections were 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 that do not meet the definition of a new QIS (i.e., the issuer changed its goals, activities, measures, performance targets, and/or product types). *Note: Other types of changes do not necessitate the selection of "Continuing a QIS with Modifications." However, if the issuer would like to change is market-based incentive or selected topic areas, 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) ▪ Complete the QIS Modifications Summary (Part F) as needed based on modifications, AND ▪ Complete the QIS Progress Report Summary (Part G)

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 20 in the QIS form.

Examples and Definitions of Market-Based Incentives for Providers

Provider Market-based Incentive Examples	Market-based Incentive Type Definition
Increased Reimbursement	Providers receive a higher payment based on whether they meet certain quality performance targets. If providers meet performance targets, they receive the maximum eligible payment, but if they do not meet all of the performance targets, they receive only a portion of the maximum payment they are eligible to receive.
Bonus Payments	An additional incentive payment (beyond regular FFS payments) to providers, contingent on meeting certain measure-based performance targets.
In-kind Incentives	In-kind incentives do not use a direct financial payment. In-kind incentives are the provision of non-financial resources for the purpose of supporting quality improvement. These incentives may include, but are not limited to, in-office nurses or physician extenders, staffing support to conduct care coordination, technical support for data collection,[44] and/or health IT implementation.

Examples and Definitions of Market-Based Incentives for Exchange 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.

[44] For technical support to qualify as an in-kind incentive, it must include not only data collection/sharing, but also include resources like people or systems/infrastructure (e.g., Electronic Medical Records [EMRs,] computers, phone banks) to support both collection and use of the data.

Appendix D. QIS Implementation Plan and Progress Report Form Pre-Submission Checklist

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

QIS IMPLEMENTATION PLAN AND PROGRESS REPORT FORM PRE-SUBMISSION CHECKLIST

A. PREPARATION

- ☐ Review the applicable regulations, the entire 2020 QIS Technical Guidance and User Guide, as well as the relevant sections of the 2020 Letter to Issuers.
- ☐ Print or save each QIS-related document listed on the QHP Application website.
- ☐ Download and save a local copy of the fillable PDF of the QIS Implementation Plan and Progress Report.

B. COMPLETE THE IMPLEMENTATION PLAN

- ☐ Enable JavaScript in the fillable PDF form before you enter your QIS information.
- ☐ Complete the QIS Submission Type section (Part A) by checking the applicable Type of QIS Submission
- ☐ Complete all elements in Part B: Issuer Information, in the Background Information section.
- ☐ In Elements 3-6 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 required elements—including must-pass elements—and criteria in all parts of the form, either by providing QIS information or by selecting "Not Applicable."
- ☐ Confirm that you were consistent in your answers across all elements and criteria.

C. COMPLETE THE PROGRESS REPORT (IF NECESSARY)

- ☐ Complete applicable elements and criteria in Part F: Modification Summary, if necessary
- ☐ Complete all of the required elements and criteria in Part G: Progress Report Summary, in the QIS Progress Report Section.
- ☐ Confirm that you have provided responses for all required elements—including must-pass elements—and criteria in all parts of the form, either by providing QIS information or by selecting "Not Applicable."
- ☐ Confirm that you were consistent in your answers across all elements and criteria.

D. SUBMIT THE FORM

- ☐ Save a local copy of the form using the appropriate file naming convention either [5-digit HIOS Issuer ID]- [Issuer Legal Name]- QIS or [5-digit HIOS Issuer ID]- [Issuer Legal Name]-QIS-[#]. Do not password protect or flatten the completed fillable PDF form.
- ☐ Upload the completed copy of the QIS form to HIOS or SERFF, as appropriate, for submission to the FFEs. For MSP products, issuers should follow the guidance provided by OPM. For coverage offered through an SBE, issuers should follow the guidance provided by the applicable Exchange.
- ☐ Share your QIS submission with staff who are responsible for the QIS, so they may refer to it throughout the year as needed and access it during the next QHP Application Period.
- ☐ Verify that each applicable QHP offered by the issuer through an Exchange is covered by a QIS; submit additional QIS forms as necessary.

Appendix E. Glossary

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

Term	Definition
Areas Health Resources Files (AHRF)	The AHRF are Health Resources and Service Administration (HRSA) databases that provide a comprehensive set of county, State, and national data. The data offer a broad range of health resources and socioeconomic indicators that impact demand for health care.
baseline data	Baseline data is the initial collection of data which serves as a basis for comparison with the subsequently acquired data.
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.[45]
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.[46]
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.[47]
criteria	Criteria describe the type of information issuers must provide and are the rules that an Exchange will use to evaluate whether an issuer's QIS fulfills the QIS requirements.
element	Identifying and descriptive information that issuers will use to complete the QIS Implementation Plan and QIS Progress Report. Each element has associated criteria that describe the type of information issuers must provide.
exclusive provider organization (EPO)	A type of health insurance product that usually limits coverage to care from providers, or groups of providers, that have contracts with the health insurance issuer to be part of a network of participating providers. EPO enrollees will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.
Federally-facilitated Exchanges (FFE) or Federally-facilitated Marketplaces (FFM)	The Exchange models operated by HHS for individual and small group market coverage.
Health Insurance Exchange (Exchange) or Health Insurance Marketplace (Marketplace)	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 Exchange is operated by the State. In others, it is operated by the federal government.
Health Insurance Oversight System (HIOS)	A data submission tool that allows CMS to collect data from States and individual and small group market issuers, which will be aggregated with other data sources and made public on a consumer-facing website. The initial mechanism for the States and issuers to submit their data is through the use of the HIOS form.
health maintenance organization (HMO)	A type of health insurance product that usually limits coverage to care from providers that work for or contract with the HMO and generally will not cover out-of-network care, except in an emergency.

[45] Patient Protection and Affordable Care Act. http://housedocs.house.gov/energycommerce/ppacacon.pdf

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

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

Term	Definition
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 Patient Protection and 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.[48]
Medicare Shared Savings Program	CMS has established a Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by: ▪ Promoting accountability for the care of Medicare FFS beneficiaries ▪ Requiring coordinated care for all services provided under Medicare FFS ▪ Encouraging investment in infrastructure and redesigned care processes The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Participation in an ACO is purely voluntary.[49]
Multi-State Plan (MSP)	A Multi-State Plan is a private health insurance plan offered through the Exchanges under contract with the Office of Personnel Management. MSP options are recognized as QHPs, per 45 CFR § 155.1010, and therefore are subject to the same federal quality reporting requirements. When describing requirements for "QHP issuers" within this document, it is assumed the same requirements apply to issuers offering MSP options, unless otherwise noted. OPM will provide any additional guidance to MSP issuers.
National Quality Forum (NQF)	NQF is an organization that—as part of its mission—uses a multi-stakeholder process to evaluate quality measures for endorsement. All NQF-endorsed measures are given an ID number. A list of endorsed measures can be found in NQF's Quality Positioning System (http://www.qualityforum.org/QPS/QPSTool.aspx).
Office of Personnel Management (OPM)	OPM administers the Federal Employees Health Benefits (FEHB) Program. The Patient Protection and Affordable Care Act directs OPM to contract with private health insurers in each state to offer high-quality, affordable health insurance options (Multi-State Plan options) through the Multi-State Plan Program to drive competition and choice in the Exchanges.
payment structure	Provider payments or enrollee benefits used by health plans to improve quality and reduce costs by incentivizing providers and enrollees toward high-value care, rather than volume-driven care.[50]

[48] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf

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

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

Term	Definition
physician value-based payment modifier	Section 3007 of the Patient Protection and 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.[51]
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.
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 form	The QIS Implementation Plan and Progress Report form is a form issuers use for annual reporting to the applicable Exchange. 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 Exchange 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 the 2017 QHP Application Period will complete the QIS Progress Report Section of the form annually to communicate their quality improvement strategies' progress to the applicable Exchange.

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

Term	Definition
QIS requirements	The statutory requirements, according to section 1311(g) and accompanying federal regulations, including: (1) implementation of a quality improvement strategy described as a payment structure that provides increased reimbursement or other incentives for: (2) addressing at least one of the five topic areas listed in section 1311(g); (3) complying with guidelines established by the Secretary of HHS in consultation with experts in health care quality and stakeholders; and (4) reporting strategy progress to the applicable Exchange on a periodic basis.
QIS scoring methodology	The criteria used to systematically determine a strategy's merit, using criteria governed by a set of standards.
QHP Application and Certification Process	The process by which issuers apply for QHP certification, and through which the applicable Exchange reviews applications and makes QHP certification determinations.
QHP Application Submission and Review Period (QHP Application Period)	The specific timeframe in which an issuer submits its QIS to the applicable Exchange for evaluation and review, and the Exchange 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 Patient Protection and Affordable Care Act and supporting regulation, issued or recognized by the applicable Exchange through which such plan is offered.[52]
Qualified Health Plan issuer (QHP issuer)	A health insurance issuer that offers a QHP in accordance with a certification from an Exchange, as defined by 45 CFR § 155.20. Each QHP issuer is defined by a separate federal HIOS Issuer ID. Each QHP issuer is defined by a State geographic unit.[53] 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 Patient Protection and Affordable Care Act is implemented by an issuer to satisfy the related statutory certification requirement to participate in Exchanges.
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 Exchanges.
State-based Exchange (SBE) or State-based Exchange	An Exchange model in which a State operates its own Health Insurance Exchange, SM for both the individual and small group markets. A State-based Exchange is responsible for certifying issuers, overseeing issuer compliance with federal Exchange quality standards as a condition of certification.
State-based Exchange on the Federal Platform (SBE-FP)	An Exchange model in which a State operates its own Health Insurance Exchange SM, for both the individual and small group markets, but relies on the federal platform to perform certain eligibility and enrollment functions. An SBE-FP is responsible for certifying issuers, overseeing issuer compliance with federal Exchange quality standards as a condition of certification.
States performing plan management	FFEs where the State performs plan management for QHPs offered through the Exchange. Consumers in these States apply for and enroll in coverage through the FFEs.
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).

[52] Exchange and Insurance Market Standards for 2015 and Beyond Final Rule. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketstandards-5-16-2014.html

[53] Ibid.

Term	Definition
topic areas	The specific areas for quality improvement cited in Section 1311(g) of the Patient Protection and Affordable Care Act. They include health outcomes, readmissions, patient safety, wellness and health promotion, and disparities.
Work Plan	A detailed plan developed by an issuer that provides a resolution for any identified errors with the issuer's QIS submission. An issuer's Work Plan is generally submitted to the Exchange for evaluation following the QHP Application Submission and Review Period.

Appendix F. Acronym List

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

Acronym	Complete Term or Name
CCIIO	Center for Consumer Information & Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
FFE	Federally-facilitated Exchange
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HSA	Health Savings Account
MQI	Marketplace Quality Initiatives
MSD	Marketplace Service Desk
MSP	Multi-state Plan
NQF	National Quality Forum
OPM	U.S. Office of Personnel Management
POC	Point of Contact
QHP	Qualified Health Plan
QIS	Quality Improvement Strategy
QRS	Quality Rating System
SADP	Stand Alone Dental Plan
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program

Appendix G. Elements and Criteria

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
Part A					
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	Not Applicable
2	**Targets All QHPs and Product Types Offered Through an Exchange** (Must Pass)	Please indicate the number of forms that will be submitted using the space provided (e.g., this is form 1 of 2). 2a – Indicate if this QIS is applicable to all eligible QHPs you offer or are applying to offer through the Exchanges, or to a subset of eligible QHPs. If "Subset of QHPs" was selected above, an additional QIS form (Background Information and Implementation Plan) must be submitted for eligible QHPs not covered by this QIS. 2b – Select the relevant product types to which the QIS applies. Check all that apply. To update a prior QIS submission by adding or removing Product Types, use Element 28.	This element will be scored; Element 2 is a must-pass element.	None	Yes, issuer must select "Continuing a QIS with Modifications" if changing its product type(s). If no changes to product type(s), issuer may select "Continuing a QIS with No Modifications."
Part B					
3	**Issuer Legal Name**	None	This element is required but will not be scored.	None	Not Applicable
4	**Company Legal Name**	None	This element is required but will not be scored.	None	Not Applicable

[54] This column indicates whether a change to a given element/criterion from a previous QIS requires selecting "Continuing a QIS with Modifications" or "New QIS after Discontinuing a QIS Submitted during a prior QHP Application Period" in Element 1.

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
5	**HIOS Issuer ID**	None	This element is required but will not be scored.	None	Not Applicable
6	**Issuer State**	None	This element is required but will not be scored.	None	Not Applicable
7	**QIS Primary Contact's Name**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
8	**QIS Primary Contact's Title**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
9	**QIS Primary Contact's Phone**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
10	**QIS Primary Contact's Email**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
11	**QIS Secondary Contact's Name**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
12	**QIS Secondary Contact's Title**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
13	**QIS Secondary Contact's Phone**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
14	**QIS Secondary Contact's Email**	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
15	**Date Issuer Began Offering Coverage Through the Exchange**	None	This element is required but will not be scored.	None	Not Applicable
16	**Current Payment Model(s) Description** Select the category(ies) of payment models that are used by the issuer across its Exchange product line. Provide the percentage of payments tied to quality and value for each payment model(s) selected.	None	This element is required but will not be scored.	None	No, issuer may select "Continuing a QIS with No Modifications."
Part C					
17	**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	No, issuer may select "Continuing a QIS with No Modifications."
Part D					
18	**QIS Title** Provide a short title for the QIS.	None	This element is required but will not be scored.	200 characters	No, issuer may select "Continuing a QIS with No Modifications."

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
19	**QIS Description** Provide a brief summary description of the QIS. The description must include the market-based incentive type and topic area (see Elements 20 and 21). 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 Exchange product line and/or for other product lines? If "Yes" was checked for either/both of the above, please describe the State initiative and/or current issuer strategy. Describe the overall goal(s) of the QIS (no more than two). (Note: The topic area(s) selected in Element 21 and the measures described in Element 24 should be linked to these goals). (Note: If you modified the Goals, describe the modifications in Part F, QIS Modification Summary: Criterion 27a, and include the modified goals here in Element 19).	None	This element is required but will not be scored.	1,000 characters for the brief summary description, 1,000 characters for a description of initiatives, and 500 characters per goal	Yes, issuer must select "Continuing a QIS with Modifications" if changing its goals. If no changes to goals, issuer may select "Continuing a QIS with No Modifications."

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
Part E					
20	**Market-based Incentive Type(s)** (Must Pass) 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.	None	This element will be scored; Element 20 is a must-pass element.	None	Yes, issuer must select "New QIS after Discontinuing a QIS Submitted during a prior QHP Application Period" and submit two forms: A Progress Report to close out its current QIS and a new Implementation Plan.
21	**Topic Area Selection** (Must Pass) Select the topic area(s) this QIS addresses, as defined in the Patient Protection and Affordable Care Act. Check each topic area that applies.	None	This element will be scored; Element 21 is a must-pass element.	None	Yes, issuer must select "New QIS after Discontinuing a QIS Submitted during a prior QHP Application Period" and submit two forms: A Progress Report to close out its current QIS and a new Implementation Plan.
22	**Rationale for QIS** (Must Pass) 22 – Provide a rationale for the QIS that describes the issuer's current QHP enrollee population and how the QIS will address the needs of the current QHP enrollee population(s).	None	This element will be scored; Element 22 is a must-pass element.	1,500 characters per criterion	No, issuer may select "Continuing a QIS with No Modifications."

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
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. If the activity(es) were modified, please include the modified activity(es) here, and describe the modifications in Part F, QIS Modification Summary: Criterion 27b. 23b – Describe how the activities relate to the selected market-based incentive (see Element 20). 23c – Describe how the activities relate to the topic area(s) selected (see Element 21). 23d – If the issuer did not choose health and health care disparities as a topic area in Element 21, but the QIS does include activities related to addressing health and health care disparities, describe the activities below. If (1) health and health care disparities is one of the topic areas selected in Element 21; OR (2) health and health care disparities are not addressed in this QIS, check "Not Applicable."	This element will be scored; Element 23 is a must-pass element.	1,500 characters per criterion	Yes, issuer must select "Continuing a QIS with Modifications."

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
24	**Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress** (Must Pass) Restate the goal(s) identified in the QIS description (see Element 19). 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. **Note:** If you modified the measures and/or associated performance targets, describe the modifications in Part F, QIS Modification Summary: Criterion 27c, and include the modified measures and/or associated performance targets here in Element 24. Restate the goal(s) identified in the QIS description.	24a, 24f, 24k, 24p –Name of the measure; narrative description of the measure numerator and denominator; whether the measure is National Quality Forum (NQF)-endorsed; NQF ID if applicable (NQF-endorsed measures are not required); if NQF-endorsed, whether the measure specifications were modified; 24b, 24g, 24l, 24q– Describe how the measure supports the tracking of performance related to the goal. 24c, 24h, 24m, 24r– Baseline Assessment. Provide the baseline results by calculating the rate and providing the associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided. 24d, 24i, 24n, 24s– Performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment. 24e, 24j, 24o, 24t – Provide numerical value performance target for the measure.	This element will be scored; Element 24 is a must-pass element.	500 characters per goal; 500 characters per measure description; 1,000 characters per description of how the measure supports tracking of goals	Yes, issuer must select "Continuing a QIS with Modifications."
25	**Timeline for Implementing the QIS**	25a – The QIS initiation/start date. 25b – Describe the milestone(s) and provide the date(s) for each milestone (e.g., when activities described in Element 23 will be implemented). At least one milestone is required.	This element will be scored. Both criteria must be completed.	100-character limit per milestone in 25b	No, issuer may select "Continuing a QIS with No Modifications."
26	**Risk Assessment**	26a – List all known or anticipated barriers in implementing QIS activities. If no barriers were identified, please describe how you assessed risk. 26b – Describe the mitigation activities that will be incorporated to address each barrier identified in Criterion 26a.	This element will be scored. Both criteria must be completed.	1,500-character limit per criterion	No, issuer may select "Continuing a QIS with No Modifications."

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
Part F					
27	**Modifying Goals, Activities, and Measures** (Must Pass) (if applicable) If "Continuing a QIS with Modifications" was selected in Part A, Element 1, please indicate what type of modification(s) the issuer is making to its QIS and provide a rationale for the modification(s). Note that modifications only apply to elements in Part D (Implementation Plan).	27a – Which Goals, if any, are modified from the prior year's QIS submission. Check all that apply. Describe Modifications to Goals. 27b – Are Activities modified from the prior year's QIS submission? Describe Modifications to Activities. 27c – Which Measures, if any, are modified from the prior year's QIS submission. Check all that apply. Describe Modifications to Measures.	This element will be scored; Element 27 is a must-pass element.	500 characters per criterion	Not Applicable
28	**Modifying Product Types**	Are the product types modified from the prior year's QIS submission? Indicate whether the issuer is adding or removing any product types to the QIS originally listed in Criterion 2c. Select all that apply.	This element is required (if applicable) but will not be scored.	None	Not Applicable

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
Part G					
29	**Analyze Progress Using Baseline Data, as Documented in the Implementation Plan** (Must Pass) Restate the goals identified in the prior year's Implementation Plan. For each goal, restate the measure(s) identified in the prior year's Implementation Plan, and complete the fields below. (Note: The Goals and Measures identified in this section (Part G: Progress Report Summary) are the Goals and Measures from the prior year's Implementation Plan against which progress is measured (i.e., the Goal(s) and/or Measure(s) as stated before modifications were made, where applicable).	29a, 29f, 29k, 29p – Baseline performance period (e.g., the month and year when data collection began and ended covered by the baseline data assessment. 29b, 29g, 29l, 29q – Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress update data assessment. 29c, 29h, 29m, 29r – Measure name. 29d, 29i, 29n, 29s – Restate the baseline results from Element 24 of your prior year's QIS submission, including the rate and associated numerator and denominator, if applicable. If the measure is not a rate but another data point, enter the number in the space provided for numerator and enter "1" in the space for denominator. 29e, 29j, 29o, 29t– Provide the follow-up results by calculating the rate and providing the associated numerator and denominator. If the measure is not a rate, but another data point, enter the number in the space provided. Was the performance target provided in Element 24 achieved?	This element will be scored; Element 29 is a must-pass element.	500 characters per criterion	Not Applicable

Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Modification or Discontinuation Selection in Element 1[54]
30	**Summary of Progress** (Must Pass) 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, and if applicable, indicated whether the information provided here affects the decision to modify or change the QIS (Part F). If the issuer selected "New QIS after Discontinuing a QIS Submitted during a prior QHP Application Period" in Element 1, provide the rationale for discontinuing the QIS. If applicable, provide information about changes made based on Correction Notices from a previous year.		This element will be scored; Element 30 is a must-pass element.	3,000 characters	Not Applicable
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 challenges.	This element will be scored. Both criteria must be completed.	1,500 characters per criterion	Not Applicable
32	**Mitigation Activities**	32a – If "Yes" was selected in Criterion 31a, describe the mitigation activities implemented to address each barrier. Also, describe the result(s) of the mitigation activities. If "No" was selected in 31a, check "Not Applicable." 32b – If "Yes" was selected in Criterion 31b, describe the mitigation activities implemented to address each problem in meeting the timeline. Also, describe the result(s) of the mitigation activities. If "No" was selected in Criterion 31b, check "Not Applicable."	This element will be scored. Both criteria must be completed.	1,500 characters per criterion	Not Applicable