

Health Insurance Exchange

Quality Improvement Strategy: Technical Guidance and User Guide for the 2022 Plan Year

April 2021

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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1. Technical Assistance Available to Issuers

Technical assistance is available for issuers, Health Insurance Exchanges (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.
- **State-based Exchanges (SBEs):** Please submit questions to your respective State Officers.
- **Federally-facilitated Exchanges (FFE)s:** 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 documents, the 2022 QIS Implementation Plan form and Progress Report form (QIS forms), are the forms for issuers to use to submit a QIS as part of their QHP application. These documents 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 Experience Survey (QHP Enrollee Survey), QIS requirements, and patient safety standards. As the central location for QIS resources, this website contains the QIS forms and instructional documents regarding QIS implementation and reporting, including this document.	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/About-MQI-Landing-Page
CMS QHP Certification website	This website provides issuers with detailed application instructions, forms—including the QIS forms—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. Marketplace is commonly used in consumer-facing communications.

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 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 [2022 Letter to Issuers in the Federally-facilitated Exchange](#) (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), with operational and technical guidance to help them successfully participate in those Exchanges during the 2022 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.

2. Document Purpose and Scope

The *Quality Improvement Strategy: Technical Guidance and User Guide for the 2022 Plan Year* (2022 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 2022 Plan Year. This document is organized into two volumes:

- [Volume I: QIS Technical Guidance for the 2022 Plan Year](#) (QIS Technical Guidance); and
- [Volume II: QIS User Guide for the 2022 Plan Year](#) (QIS User Guide).

Issuers should refer to the updated QIS Technical Guidance and the QIS User Guide for the upcoming plan year on an annual basis, regardless of QIS submission type, as CMS updates both volumes yearly, as may be necessary, to reflect any relevant changes. Issuers should also adhere to the CCIIO QHP certification processes (reflected in the [Letter to Issuers](#)), which may evolve on an annual basis.

2.1 Section Guide

Volume I: QIS Technical Guidance for the 2022 Plan Year

The QIS 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 2022 Plan Year, and the previous versions of the guidance. Due to the suspension of quality data collection for the 2021 Plan Year,³ the 2021 QIS Technical Guidance was never published. As such, the last published Technical Guidance was the Plan Year 2020 Technical Guidance, released in April 2019.

This guidance will address substantive changes to the QIS forms for the 2022 Plan Year, as well as policy changes that were implemented in 2020. 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.

³ In April 2020, CMS released the COVID-19 Marketplace Quality Initiatives Memo announcing that CMS was exercising enforcement discretion to adopt a temporary policy of relaxed enforcement and directing all eligible QHP issuers to discontinue the collection of clinical quality measure data and survey measure data that would normally be reported between May and June 2020 given the challenges healthcare providers have been facing responding to the Coronavirus Disease 2019 (COVID-19) virus. This enforcement discretion policy extended to reporting of QIS data, such that issuers eligible to submit QIS submissions were no longer required to make such submissions for the Plan Year 2021 QHP certification period for participation in the FFEs. This memo is available at: <https://www.cms.gov/files/document/covid-qrs-and-marketplace-quality-initiatives-memo-final.pdf>.

The requirements outlined in this document are based on statute and CMS regulations, including the Patient Protection and Affordable Care Act (PPACA) and the HHS Notice of Benefit and Payment Parameters for 2016 Final Rule.⁴

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 2022 Plan Year,
- Exchange oversight responsibilities,
- The QIS requirements, and
- The QIS evaluation process and methodology.

The most significant change for the 2022 Plan Year is the separation of the QIS Implementation Plan and Progress Report form into three separate components: the Implementation Plan form, the Progress Report form, and the Modification Summary Supplement. The QIS Technical Guidance and the QIS User Guide have been updated to reflect the new form structure, and the following sections have been updated to describe the impacts of this change.

Note: The Modification Summary Supplement will not be available until the 2023 Plan Year. See Section 5.3 for more detailed information.

In addition to the separation of the QIS Implementation Plan and Progress Report form into three separate components, there are several key differences between the 2022 QIS Technical Guidance and the 2020 QIS Technical Guidance, as described in the table below.

Key Differences Between the 2020 QIS Technical Guidance and 2022 QIS Technical Guidance

- **Section 2** – Added a new issuer verification step for the QIS Issuer List.
- **Section 5.2.1: Participation Criteria for Progress Reporting** – Added information to clarify the minimum enrollment threshold.
- **Section 6: QIS Evaluation** – The “Interim Meets” scoring designation will not be available for issuers for the 2022 Plan Year as CMS wants to ensure all issuers have a complete submission on the new separate forms by the end of the evaluation period.

Volume II: QIS User Guide for the 2022 Plan Year

The QIS User Guide for the 2022 Plan Year (QIS User Guide) provides issuers offering coverage in an FFE with directions to meet the QIS requirements for the 2022 Plan Year. The User Guide

⁴ 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).

provides procedural, step-by-step instructions for issuers on how to access, complete, and submit the QIS Implementation Plan and the QIS Progress Report forms to CMS during the 2022 QHP Application Submission and Review Period (QHP Application Period, which applies to the 2022 Plan Year).⁵ Where applicable, this section descriptions highlight key differences between the 2020 QIS User Guide, released in April 2019, and this 2022 QIS User Guide.

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

There are several key differences between the 2020 QIS User Guide and the 2022 QIS User Guide, as described in the table below. As noted above, the most significant change for the 2022 Plan Year is the separation of the QIS forms into three separate components: the Implementation Plan form, the Progress Report form, and the Modification Summary Supplement.

Key Differences Between the 2022 QIS User Guide and the 2020 QIS User Guide

Updates to the 2022 Plan Year User Guide:

- **Section 3.1: Part D. QIS Summary** – Updated to reflect addition of a separate Element 20 in the Implementation Plan for QIS goals.
- **Section 3.2: Part E. QIS Requirements** – Updated to provide flexibility to use an applicable data point other than a calculated rate.
- **Section 4: Part C. Progress Report Summary** – Updated to provide flexibility to use an applicable data point other than a calculated rate.
- **Section 4: Part C. Progress Report Summary** – Updated to break Element 17 in the Progress Report into three separate parts.

2020 Plan Year User Guide Content Removed for 2022 Plan Year:

- **Section 4.1: Part F. Modification Summary** – This section of the 2020 Plan Year User Guide was removed for 2022 Plan Year to reflect that the Modification Summary Supplement is no longer a section in the Progress Report, but is now a standalone form.

⁵ The 2022 QHP Application Period occurs in calendar year 2021.

Volume I. QIS Technical Guidance for the 2022 Plan Year

1. Background

An issuer participating in an Exchange for two or more consecutive years must implement and report on a QIS, in accordance with section 1311(g) of the PPACA, entitled “Rewarding Quality Through Market-Based Incentives.”⁶ A QIS should incentivize quality by tying payments to measures of performance when providers meet specific quality indicators or enrollees make certain choices or exhibit behaviors associated with improved health.

The QIS requirements apply to all issuers offering QHPs options through an Exchange, whether through the Individual Exchange or through the SHOP. 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 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 one⁷ 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 QIS User Guide, established by HHS in consultation with experts in health care quality and stakeholders.

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

 **How Can an Issuer Indicate the Intent to Address Health and Health Care Disparities in its QIS?**

An issuer is encouraged to address health and health care disparities in each QIS.

This may be done in one of two ways:

- (1) Choosing “Implementation of activities to reduce health and health care disparities” as a topic area addressed by the QIS *or*
- (2) Addressing the reduction of health and health care disparities as part of the activities implemented within any other chosen topic area(s).

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

⁶ Section 1311(c)(1)(E) of the Patient Protection and Affordable Care Act, 45 CFR §§ 156.200(b) and 156.1130.

⁷ At this time, issuers are only required to address one of the listed topic areas. See the 2016 Payment Notice Final Rule, 80 FR 10749 at 10844 -10848 (February 27, 2015).

CMS envisions issuers aligning its quality improvement activities with the quality priorities identified in the Meaningful Measures Framework.⁸ 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 E.

(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).⁹

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. While incentives may be monetary in nature, they are not required to be. The incentive must provide an additional value to the recipient, whether that be through an additional service or financial resource. See Exhibit 1 for examples of activities cited in the PPACA that may be included in issuers’ quality improvement strategies.

Exhibit 1: Examples of QIS Activities Cited in the Patient Protection and Affordable Care Act¹⁰

QIS Topic Area	Examples of QIS Activities
Improve Health Outcomes	<ul style="list-style-type: none"> ▪ Quality reporting ▪ Effective case management ▪ Care coordination ▪ Chronic disease management ▪ Medication and care compliance initiatives

⁸ 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>.

⁹ 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).

¹⁰ 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 PPACA.

QIS Topic Area	Examples of QIS Activities
Prevent Hospital Readmissions	<ul style="list-style-type: none"> ▪ Comprehensive program for hospital discharge that includes: <ul style="list-style-type: none"> – Patient-centered education and counseling – Comprehensive discharge planning – Post discharge reinforcement by an appropriate health care professional
Improve Patient Safety and Reduce Medical Errors	<ul style="list-style-type: none"> ▪ Appropriate use of best clinical practices ▪ Evidence-based medicine ▪ Health information technology
Implement Wellness and Health Promotion Activities	<ul style="list-style-type: none"> ▪ Smoking cessation ▪ Weight management ▪ Stress management ▪ Healthy lifestyle support ▪ Diabetes prevention
Reduce Health and Health Care Disparities	<ul style="list-style-type: none"> ▪ Language services ▪ Community outreach ▪ Cultural competency trainings

All Exchanges are required¹¹ to evaluate issuers' QIS submissions, and issuers must submit separate QIS submissions by state. In addition, this review process includes the following activities:

- 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.
- SBEs will evaluate the QIS submissions of the issuers applying to offer QHPs in their state's Exchange. SBEs 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 2022 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 forms. 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.

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.¹²

¹¹ 45 CFR § 155.200(d).

¹² Section 1311(c)(1)(E) of the PPACA, 45 CFR §§ 156.200(b) and 156.1130.

- Align the statutory requirements with other quality improvement programs. As applicable, the QIS will align with the QRS, the QHP Enrollee 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 flexibility 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 PPACA 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.

An issuer that offered an eligible QHP through an Exchange in the 2019 and 2020 Plan Years and continued operating in the Exchange in the 2021 Plan Year must make at least one initial QIS Implementation Plan submission to the applicable Exchanges in calendar year 2021 for the 2022 Plan Year.

The Implementation Plan submitted for the 2022 Plan Year may use data from the original baseline submitted for the QIS, regardless of what year it was originally submitted. This Implementation Plan will be maintained by CMS as a baseline Implementation Plan against which future Progress Reports will be compared.

An issuer that submitted a QIS Implementation Plan or Progress Report in the 2020 Plan Year must submit a QIS Progress Report for the 2022 Plan Year.

With the suspension of quality data collection for the 2021 Plan Year, CMS decided that issuers that would have been required to submit their second year of progress reporting in calendar year 2020 (for the 2021 Plan Year), but have subsequently fallen below the minimum enrollment threshold of 500 enrollees for a plan type, would still be required to submit their second year of progress reporting in calendar year 2021 (for the 2022 Plan Year).

This approach allows submissions from a more inclusive group of issuers; therefore, it minimizes the amount of data lost due to the interruptions caused by the COVID-19 pandemic. This approach also allows for collecting the largest amount of data while still mitigating data reporting burden for QIS issuers. Additionally, this option is consistent to the requirement of two years of reporting progress, regardless of minimum enrollment threshold as defined in this QIS Technical Guidance.

Each year, CMS posts the QIS Issuer List for the upcoming plan year on the CMS MQI website. The QIS Issuer List identifies issuers that meet the QIS participation criteria for the upcoming plan year and that are consequently required to submit at least one QIS Implementation Plan form and/or Progress Report form as part of their QHP applications to either: (a) implement a new QIS beginning no later than January of the following year, or (b) report progress on an existing QIS. The QIS Issuer List identifies issuers operating in FFEs that meet the QIS participation criteria. Issuers operating in SBEs are not included on the QIS Issuer List and should contact their Exchange for participation and submission requirements.

New for the 2022 Plan Year, CMS will give issuers an opportunity to review the QIS Issuer List and provide any updates to CMS before the Issuer List is finalized and posted.

1. CMS will provide a draft QIS Issuer List in the spring of 2021.
2. FFE issuers will be informed via MQI email and newsletter eblasts when the draft QIS Issuer List is available on the MQI website.
3. Issuers will be able to review the draft Issuer List to verify their information and communicate any discrepancies to CMS by emailing CMS_FEPS@cms.hhs.gov with “QIS Issuer List” in the subject line.

The QIS forms can be accessed via the [MQI website](#). All issuers that meet the QIS participation criteria, regardless of submission type, must use the updated 2022 QIS forms.

The QIS elements and criteria in the 2022 QIS forms are described in detail in the [QIS User Guide for the 2022 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 2022 QIS forms is provided in Section 5.2.1 of this Technical Guidance.

3. QIS Timeline for the 2022 Plan Year

Issuers applying for QHP certification in the FFEs will submit QIS forms during the annual QHP Application Period for the 2022 Plan Year and should refer to the CMS final bulletin titled [Qualified Health Plan \(QHP\) Data Submission and Certification Timeline for Plan Year 2022](#) for the finalized QHP data submission and certification timeline. Issuers operating in SBEs should refer to their Exchanges regarding specific timeframes for the 2022 Plan Year.

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 2022 Plan Year.

4.1 Federally-facilitated Exchanges

FFE states will follow the QHP certification process, which is outlined in the [2022 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 Rates and Forms 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 their quality improvement strategies to verify that all eligible QHPs are covered. CMS intends to coordinate with state regulators, the applicable state entities 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. FFE standards provide the minimum requirements as a foundation for SBEs. SBEs that establish and implement such standards and other requirements 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 QIS User Guide, and the information collected in the QIS forms. 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.

5. QIS Requirements

This section outlines the requirements for determining which issuers will be included on the QIS Issuer List and, consequently, must submit an Implementation Plan and/or Progress Report form to the applicable Exchange (see Section 5.3 for additional QIS forms submission guidance for the 2022 Plan Year). Information on the QIS participation criteria, calculating the minimum enrollment threshold, and the QIS forms is provided below.

5.1 Participation Criteria

Issuers applying for QHP certification in the Exchanges for the 2022 Plan Year that meet the QIS participation criteria are expected to submit a QIS form in calendar year 2021 to either: (a) implement a new QIS beginning no later than January 2022 or (b) provide a progress update on an existing QIS.¹³

5.1.1 Participation Criteria for Implementing a QIS

An issuer must implement a new QIS by submitting an Implementation Plan form to an Exchange for the 2022 Plan Year if the following conditions apply:

- **An issuer offered coverage through an Exchange in 2019 and 2020.** 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 2022, 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 2020 and 2021 (but not in 2019), the issuer would not need to submit a QIS until calendar year 2022 for the 2023 Plan Year.
 - If an issuer is not continuing to offer coverage through an Exchange in the 2022 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

¹³ 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.

the following product types: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS) plans, exclusive provider organizations (EPOs), and indemnity plans. At this time, the QIS requirements do not apply to child-only plans or SADPs. The QIS requirements 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 2022 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 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.**¹⁴ Issuers that had more than 500 enrollees within a product type per state as of July 1 of the prior year meet the minimum enrollment threshold. Issuers that change product types will continue to meet the minimum enrollment threshold when an issuer: (a) crosswalks enrollees from the old product type to a different one, and (b) still has more than 500 enrollees in the new product type. Issuers that meet these requirements will be required to submit a QIS that covers all eligible QHPs within that product type. 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.

¹⁴ As noted previously in this Guidance, with the suspension of quality data collection for the 2021 Plan Year, CMS decided that issuers that would have been required to submit their second year of progress reporting in calendar year 2020 (for the 2021 Plan Year), but have subsequently fallen below the minimum enrollment threshold of 500 enrollees for a plan type, would still be required to submit their second year of progress reporting in calendar year 2021 (for the 2022 Plan Year). See *supra* note 3.

- If issuers offer QHPs of the same product type in both the Individual Exchange and SHOP within a state, they must combine the enrollee totals from both the Individual Exchange and SHOP Exchange.

Example: A fictional issuer that offered QHPs (all offering family medical coverage) through the Exchanges in 2019 and 2020, and continued offering coverage in 2021, in three states—West Virginia (WV), Maryland (MD), and North Carolina (NC)—has applied for certification of those QHPs in 2021 for the 2022 Plan Year. Exhibit 2 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, 2020.

Exhibit 2: Example Issuer Submissions Assessed Against QIS Participation Criteria

Reporting Unit	Number of Enrollees in the Product Type as of July 1, 2020 (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

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 it is continuing a QIS, regardless of whether the issuer’s product type(s) continues to meet the minimum enrollment threshold, as shown in Exhibit 3 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 these issuers still meets the minimum enrollment threshold after two more consecutive years of Progress Report submission. Instructions for how to calculate the minimum enrollment threshold are provided in Section 5.2.

Exhibit 3: 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 Is Met ¹⁵
2017	2018	2019 and 2020	2020 ¹⁶	2022 and 2023
2018	2019	2020 and 2022	2022	2023 and 2024
2019	2020	2022 and 2023	2023	2024 and 2025
2020 ¹⁷	2021	2022 and 2023	2023	2024 and 2025
2021	2022	2023 and 2024	2024	2025 and 2026


5.3 QIS Implementation Plan and Progress Report Forms

Issuers applying for QHP certification in FFE states for the 2022 Plan Year and that meet the QIS participation criteria are expected to submit a QIS form in 2021 to either: (a) implement a new QIS beginning no later than January 2022 or (b) provide a progress update on an existing QIS.¹⁸

For the 2022 Plan Year, CMS separated the QIS form into component parts: the Implementation Plan form and the Progress Report form. Issuers submitting a new QIS will complete the Implementation Plan form only, while issuers continuing a QIS will also complete and submit the Progress Report form.

All issuers will be required to complete the Implementation Plan form for the 2022 Plan Year to establish a baseline Implementation Plan under the new forms. This Implementation Plan will then be kept on file, and issuers will not need to resubmit the Implementation Plan portion as they have in the past.

Since all issuers will submit the Implementation Plan form for the 2022 Plan Year, they should incorporate any modifications directly into the Implementation Plan. Beginning with the 2023 Plan Year, issuers making modifications will reflect those changes in the Modification Summary Supplement (Modification Summary).

 **Modification Summary Supplement**

- A third form, the Modification Summary, will be introduced during calendar year 2022 for the Plan Year 2023 QHP Application Period. That will be the first year that issuers will be able to make modifications using the new separated QIS forms.

¹⁵ 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 for that product. 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 for that product.

¹⁶ In calendar year 2021 (for 2022 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, 2020.

¹⁷ There were no QIS submissions in calendar year 2020 for the 2021 Plan Year due to the suspension of data collection for the 2021 Plan Year. See supra note 3.

¹⁸ Issuers are permitted to use a strategy they are already implementing for the Exchange or another product line, as long as the strategy meets the QIS elements and criteria and is relevant to the issuer’s Exchange population.

5.3.1 QIS Forms Purpose and Use

For the 2022 Plan Year, CMS made significant updates to the structure of the QIS form through the separation into component parts, as well as updated language in specific elements and criteria to clarify instructions for issuers. Overall, however, the data requested from issuers remains the same. All issuers, regardless of submission type, must use the updated QIS forms.

The goal of the QIS forms is to collect information from issuers that demonstrates compliance with section 1311(c)(1)(E) of the PPACA. 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 PPACA.

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

The QIS forms provide 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 forms to submit a QIS Implementation Plan and/or Progress Report to the relevant Exchange. CMS has updated the submission type options to reflect the new separate forms and submission scenarios. During the 2022 QHP Application Period,¹⁹ 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:

- Implementation Plan form options:
 - Baseline Implementation Plan (for the 2022 Plan Year only) for a continuing QIS
 - New QIS After Discontinuing a QIS Submitted During a Prior Qualified Health Plan (QHP) Application Period
 - New QIS with No Previous QIS Submission
- Progress Report form options:
 - Progress Report
 - Progress Report Closeout form



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 forms
- **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

¹⁹ The 2022 QHP Application Period occurs in calendar year 2021.

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 can be made year over year, while some changes necessitate completion of the Modification Summary or even require issuers to discontinue the QIS and implement a new QIS. Exhibit 4 provides information about the implications of changing various components of the QIS.

Note that for the 2022 Plan Year, all changes should be reflected in the issuer’s baseline Implementation Plan, as the Modification Summary will not be made available to issuers until the 2023 Plan Year.

Exhibit 4: Impacts of Changing Elements of a QIS

No Implications	Implementing a New QIS after Discontinuing a QIS	Completion of Modification Summary Supplement (for use starting in the 2023 Plan Year) ²⁰
<ul style="list-style-type: none"> ▪ Update Issuer Information, ▪ Update Current Payment Model(s) Description, ▪ Update Data Sources, and/or ▪ Update other information not listed in the following columns. 	<ul style="list-style-type: none"> ▪ Change QIS market-based incentive sub-type, ▪ Change QIS topic area, and/or ▪ The QIS results in negative outcomes or unintended consequences. 	<ul style="list-style-type: none"> ▪ Change QIS goals,²¹ ▪ Change QIS activities, ▪ Change QIS measures, ▪ Change performance targets, and/or ▪ Change Product Types.

The different types of QIS submissions are identified and described in Exhibit 5.

Exhibit 5: Type of QIS Submission

Type of QIS Submission	Description of Each Submission Type
Implementation Plans	
New QIS after Discontinuing a QIS Submitted During a Prior QHP Application Period	<ul style="list-style-type: none"> ▪ Select if the issuer: <ul style="list-style-type: none"> – 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 (e.g., negative impact on enrollee population). ▪ If selected, the issuer must discontinue its existing QIS by submitting a Progress Report Closeout Form and implementing a new QIS.²²
Baseline Implementation Plan (only for 2022 Plan Year) for a Continuing QIS	<ul style="list-style-type: none"> ▪ Select if the issuer is continuing a current QIS (with or without modifications) and describe the QIS that will be in place for the 2022 Plan Year. Any modifications made to the QIS from the previous year should be included in this new Implementation Plan form as the new baseline data. These issuers should also report on progress achieved on the QIS during the previous year by submitting a separate QIS Progress Report form.

²⁰ The Modification Summary will not be available until calendar year 2022 for the 2023 Plan Year. Issuers should incorporate modifications to these elements for the 2022 Plan Year directly into the baseline Implementation Plan form. Certain details on the Modification Summary are included here for information and planning purposes.

²¹ In Part D of the QIS Implementation Plan form, an issuer must summarize the overall goal or goals (no more than two) of its 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.

²² Issuers may choose to discontinue a QIS for other reasons, but are encouraged to leave a QIS in place for at least two years.

Type of QIS Submission	Description of Each Submission Type
New QIS with No Previous QIS Submissions	<ul style="list-style-type: none"> ▪ Select if the issuer did not submit a QIS during the 2020 QHP Application Period and meets the QIS requirements for the 2022 Plan Year specified in Section 5.1.1.
Progress Reports	
Progress Report	<ul style="list-style-type: none"> ▪ Select if the issuer is continuing its current QIS (with or without modifications) and should report progress on its prior year's QIS (i.e., the 2020 Plan Year Implementation Plan form), or if the issuer changed elements and criteria like: <ul style="list-style-type: none"> - Updates to Issuer Information, - Updates to Current Payment Model(s) description, - Updates to Data Sources, - Edits made in response to the prior year's Post-certification Assessment (PCA) Notice not affecting Goals, Activities, Performance Targets or Measures,²³ and/or - Other information not listed in the "Continuing a QIS with Modifications" section below.
Progress Report Closeout Form	<ul style="list-style-type: none"> ▪ Select if the issuer: <ul style="list-style-type: none"> - Changed its Market-Based Incentive sub-type, - Changed its Topic Area Selection, or - Determines that its QIS resulted in unintended consequences (e.g., negative impact on enrollee population). ▪ If selected, the issuer must discontinue its existing QIS and implement a new QIS.²⁴
Modification Summary Supplement (for use starting in the 2023 Plan Year)	<ul style="list-style-type: none"> ▪ <i>Select if the issuer changed its:</i> <ul style="list-style-type: none"> - <i>Product Types,</i> - <i>Goals,</i> - <i>Activity(ies) that Will Be Conducted to Implement the QIS, and/or</i> <ul style="list-style-type: none"> ▪ <i>Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress</i> ▪ <i>These issuers should also complete the Progress Report form.</i>

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.

²³ Changes made in response to the prior year's PCA Notice (not affecting Goals, Activities Performance Targets or Measures) do NOT warrant a modification to the QIS. Instead, in Element 17, Summary of Progress, issuers must explain any changes made to address the prior year's PCA Notice(s) that influenced the decision to modify the QIS. Element 17 has been separated into criteria 17a, 17b and 17c to make it easier for issuers to address the three parts of this question, as applicable. See Section 4.1: Part C. Progress Report Summary, Step 2 for more information.

²⁴ Issuers may choose to discontinue a QIS for other reasons, but are encouraged to leave a QIS in place for at least two years.

5.3.3 QIS Forms Structure

The sections of the QIS forms and their parts are listed in Exhibit 6.²⁵

Exhibit 6: QIS Forms – Sections and Parts

QIS Implementation Plan Form	QIS Progress Report Form
QIS Submission Type Section	QIS Submission Type Section
<ul style="list-style-type: none"> ▪ Part A: New QIS Submission 	<ul style="list-style-type: none"> ▪ Part A: Progress Report or Closeout QIS Submission
Background Information Section	Background Information Section
<ul style="list-style-type: none"> ▪ Part B: Issuer Information ▪ Part C: Data Sources Used for Problem Identification and Monitoring Progress 	<ul style="list-style-type: none"> ▪ Part B: Issuer Information
QIS Implementation Plan Section	QIS Progress Report Section
<ul style="list-style-type: none"> ▪ Part D: QIS Summary ▪ Part E: QIS Requirements 	<ul style="list-style-type: none"> ▪ Part C: Progress Report Summary

For the 2022 Plan Year, all issuers will complete all sections in the Implementation Plan form. Issuers that are continuing an existing QIS will also complete and submit a Progress Report form.

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 of the Implementation Plan form, A and B of the Progress Report form, and Part A of the Modification Summary (for use starting in the 2023 Plan Year) for completeness, but will not score these parts. Furthermore, CMS will review the information submitted in Part E of the Implementation Plan form and Part C of the Progress Report form for completeness **and** score these parts. (Refer to Section 6.3 for an explanation of QIS scoring.)

The QIS User Guide describes the elements found in each of the QIS forms. The list in Appendix C 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 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 the QHP certification process. In 2021, issuers submitting a QIS Implementation Plan for the first time will be required to provide information on the entire Implementation Plan form as part of their QHP application for the 2022 Plan Year, which includes the following sections:

²⁵ Note that the Modification Summary is not described here as that form will not be available for the 2022 Plan Year. Details will be added for the 2023 Plan Year.

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

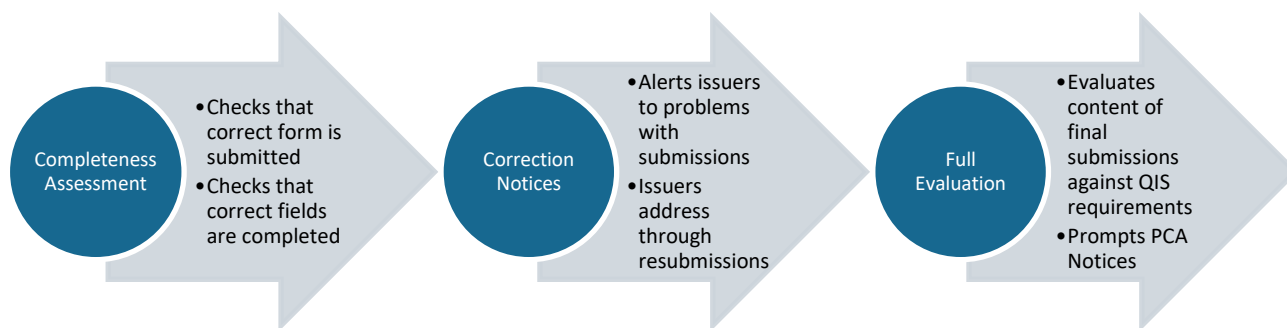
Issuers that submitted quality improvement strategies as part of their 2020 Plan Year QHP applications are required to report on progress during the 2022 QHP Application Period. These issuers will complete an Implementation Plan form (as listed above) to establish a baseline Implementation Plan with the new forms. As part of their QHP application for the 2022 Plan Year, these issuers are also required to submit information on the Progress Report form, which includes the following sections:

- Part A: Progress Report or Closeout QIS Submission,
- Part B: Issuer Information, and
- Part C: QIS Progress Report Summary.

6.1 QIS Implementation Plan and Progress Report Completeness Assessment Process

CMS²⁶ evaluates each issuer’s QIS submission to determine whether the issuer’s QIS meets the applicable requirements, according to the QHP Application and Certification Process review stages and the applicable timeline.²⁷ Exhibit 7 provides a high level overview of the reviews QIS submissions will undergo.

Exhibit 7: Completeness Assessment and Evaluation Process



CMS assesses the completeness of QIS submissions received during the QHP Application Period. Following the initial submission window, issuers whose submissions contain blank fields or are missing information receive Correction Notices during the application process indicating

²⁶ 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, the SBE will perform evaluations.

²⁷ See Plan Year 2022 QHP Data Submission Key Dates Timeline (February 26, 2021) available at: <https://www.cms.gov/files/document/py2022-qhp-data-submission-and-certification-timeline-bulletin.pdf>

which fields were missing information. Issuers that meet the QIS participation criteria, but did not submit at least one QIS as required, also receive Correction Notices. Issuers that receive Correction Notices must correct and resubmit their QIS form(s) during the subsequent submission window within the current QHP Application Period. CMS does not notify issuers if their QIS submissions are assessed as complete.

During the subsequent PCA Period, CMS evaluates each complete QIS submission to determine whether it meets or does not meet the QIS requirements (see Section 6.3.3). CMS scores issuers' submissions during this part of the process as "Meets," or "Does Not Meet" the QIS requirements. **CMS will not offer the "Interim Meets" designation for the 2022 Plan Year in an effort to ensure all issuers have complete submissions on the new forms.** Issuers will be expected to make corrections to the form(s) through resubmissions and the PCA Period.

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 forms. All of the fields in Elements 1–20 in Parts A–D of the Implementation Plan form and Elements 1–15 in Parts A–B in the Progress Report form;²⁸ CMS assesses these inputs for completeness.

For Part E of the Implementation Plan form and Part C of the Progress Report form, CMS uses a "Partial-Credit plus Must-Pass" scoring approach. All must-pass elements must have all required criteria completed for an issuer to receive full credit. All non-must-pass elements must have at least 50 percent of the required criteria completed for an issuer to receive full credit.

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

6.3 Scoring the QIS Submission

CMS scores the QIS submission(s) at the element level and only for those elements included in Part E of the Implementation Plan and Part C of the Progress Report Summary.

6.3.1 Implementation Plan Form (Part E) Scoring

All elements included in Part E of the Implementation Plan form 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 must-pass elements (i.e., receives 1.00 point for each must-pass element), **and** (2) meets the minimum score threshold of 0.50 point (i.e., 50 percent) for each scored element not designated as must-pass.

Elements 21–25 and 27 of the Implementation Plan form are must-pass, and there is no partial credit offered for these six elements. For must-pass elements, an issuer either receives 1.00 point (i.e., 100 percent) for meeting all criteria or receives 0.00 points (i.e., 0 percent) if any criteria are not met.

²⁸ Evaluation and scoring information on the Modification Summary Supplement will be included in the 2023 QIS Technical Guidance, as the Modification Summary Supplement will not be available to issuers for the 2022 Plan Year.

Element 26 is also scored, but is not must-pass. Issuers may receive partial credit for this element based on the number of criteria they meet. See Exhibit 8 below for details on the scored elements that issuers are required to address in Part E of the Implementation Plan form.

Exhibit 8: Implementation Plan (Part E) Scored Elements by Type

Element Type	Definition	Individual Elements
Must-Pass Elements	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Element 21: Market-based Incentive Type(s) ▪ Element 22: Topic Area Selection ▪ Element 23: Rationale for QIS ▪ Element 24: Activity(ies) that Will Be Conducted to Implement the QIS ▪ Element 25: Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress ▪ Element 27: Risk Assessment
Other Scored Elements	<ul style="list-style-type: none"> ▪ Issuer may receive partial credit based on how many criteria within an element are met. ▪ An issuer must receive at least 50 percent (0.50 point) on the element to receive full credit. 	<ul style="list-style-type: none"> ▪ Element 26: Timeline for Implementing the QIS

CMS scores Element 26 (Timeline for Implementing the QIS), but this element is not must-pass. This element 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 full credit (i.e., 100 percent or 1.00 point) for meeting both criteria. See Exhibit 9 for details.

Exhibit 9: Scoring Scale for Element 26

		100%	50%	0%
<i>Element 26, Timeline for Implementing the QIS (2 criteria)</i>	<i># of Criteria Met</i>	Issuer meets 2 criteria	Issuer meets 1 criterion	Issuer meets no criteria
	<i>Points Awarded</i>	1.00 point awarded	1.00 point awarded	0.00 point awarded

6.3.2 Progress Report Form (Part C) Scoring

All elements included in Part C of the Progress Report form are worth 1.00 point, regardless of must-pass designation. An issuer will receive a passing score for Part C if it: (1) meets all of the criteria for the 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 16 and 17 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 points (i.e., 0 percent) if any criteria are not met. Element 18 is scored, but is not must-pass. Issuers may receive partial credit for this element based on the number of criteria they meet. See Exhibit 10 for details on the elements that issuers are required to address in the Progress Report.

Exhibit 10: Progress Report Form (Part C) Scored Elements by Type

Element Type	Definition	Individual Elements
Must-Pass Elements	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Element 16: Analyze Progress Using Baseline Data, as Documented in the Implementation Plan ▪ Element 17: Summary of Progress
Other Scored Elements	<ul style="list-style-type: none"> ▪ Issuer may receive partial credit based on how many criteria within an element are met. ▪ Issuer must receive at least 50 percent (0.50 point) on each of these elements to receive full credit. 	<ul style="list-style-type: none"> ▪ Element 18: Barriers and Mitigation Activities

CMS scores Element 18, but this element is not must-pass. This element 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 full credit (i.e., 100 percent or 1.00 point) for meeting both criteria. See Exhibit 11 for details.

Exhibit 11: Scoring Scale for Element 18

		100%	50%	0%
<i>Element 18, Barriers and Mitigation Activities (2 criteria)</i>	<i># of Criteria Met</i>	Issuer meets 2 criteria	Issuer meets 1 criterion	Issuer meets no criteria
	<i>Points Awarded</i>	1.00 point awarded	1.00 point awarded	0.00 point awarded

6.3.3 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 2022 QHP Application Period (in calendar year 2021). CMS will communicate evaluation results for QIS submissions for the 2022 Plan Year to issuers during the PCA Period in the late fall of 2021/early winter of 2022.

Based on the results captured in the QIS evaluation, CMS assigns an overall outcome of “Meets” or “Does Not Meet” to each issuer’s QIS submission(s). Exhibit 12 summarizes these scoring designations. Issuers do not receive numerical scores; however, issuers are notified if their QIS submissions were found incomplete (e.g., missing critical information) 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.²⁹

²⁹ 80 Fed. Reg. 10848 (February 27, 2015).

Exhibit 12: Scoring Designations

Score	Conditions
Meets:	<ul style="list-style-type: none"> An issuer receives a scoring designation of “Meets” for its QIS Implementation Plan form if it: (1) successfully completes all fields in Elements 1–20 in Parts A–D, and (2) successfully completes all elements and criteria AND receives a passing score for Elements 21–27 in Part E (see Section 6.3.1). An issuer receives a scoring designation of “Meets” for its QIS Progress Report form if it: (1) successfully completes all fields in Elements 1–15 in Parts A–B, and (2) successfully completes all elements and criteria AND receives a passing score for Elements 16–18 in Parts C.
Does Not Meet:	<ul style="list-style-type: none"> An issuer receives a “Does Not Meet” scoring designation if it is still missing any critical information in its QIS Implementation Plan and/or Progress Report forms following the QHP Application Period or does not receive a score at or above the predetermined minimum evaluation threshold for Part E of the Implementation Plan form or for Part C of the Progress Report form after full evaluation. CMS will require the issuer to correct and resubmit its QIS form(s) during the PCA Period for the 2022 Plan Year. Additionally, such issuers may be required to develop a Work Plan.³⁰ An issuer receives a “Does Not Meet” scoring designation if it makes the same type of error two years in a row in its QIS Implementation Plan and/or Progress Report. CMS will require an issuer who received an “<i>Interim Meets</i>” designation for a 2020 QIS submission and does not correct the noted errors in its 2022 QIS submission, to correct and resubmit its QIS submission during the PCA Period for the 2022 Plan Year. Additionally, such issuers may be required to develop a Work Plan.

6.3.4 QIS Results Communication

CMS assesses QIS submissions for completeness as they are received 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 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 whether 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 fall/early winter timeframe via PCA Notices, following the close of the QHP Application Period and after completion of the QHP certification process. Exhibit 13 below describes the different CMS QIS results communications following its assignment of scores to issuer QIS submissions.

As part of the FFE’s annual QHP application and certification process, an issuer must attest to complying with each Exchange certification standard.³¹ 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.

³⁰ The Work Plan may be required as part of CCIIO’s QHP compliance reviews.

³¹ 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.”

Exhibit 13: CMS QIS Results Communication

Score	Conditions
Meets:	<ul style="list-style-type: none"><li data-bbox="418 273 1425 323">▪ CMS does not notify issuers if their QIS submissions receive an overall outcome of “Meets.”
Does Not Meet:	<ul style="list-style-type: none"><li data-bbox="418 327 1425 432">▪ If an issuer receives a “Does Not Meet” designation or its submission is incomplete, the issuer must confirm receipt of the feedback and correct all potential concerns during the PCA Period for the 2022 Plan Year. Additionally, these issuers may be required to develop a Work Plan.

Volume II. QIS User Guide for the 2022 Plan Year

1. User Guide Introduction

This QIS User Guide provides instructions for issuers about compliance with QIS requirements. It describes differences in the submission process for issuers operating in an FFE state versus those that operate in FFEs where the state performs plan management. An issuer operating in the latter type of Exchange works directly with the state in which it is offering 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 2022 QHP applications.³² Issuers should also review the [2022 Letter to Issuers](#) for additional guidance specific to the 2022 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 [MQI website](#) prior to the start of the QHP Application Period. The MQI website is an online resource for issuers that houses information about ongoing Marketplace quality initiatives, such as the QRS³³ and QHP Enrollee Survey.

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

Step 1: Click on this link to open the [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.

1.2 Prepare to Complete the Implementation Plan and Progress Report Forms

For the 2022 Plan Year, CMS developed separate QIS Implementation Plan and Progress Report forms (QIS forms). Issuers participating in an FFE that meet the QIS participation criteria, regardless of submission type must use the updated QIS forms.





³² The 2022 QHP Application Period occurs in calendar year 2021.

³³ 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 an Exchange.

After reviewing the Technical Guidance and User Guide, all issuers must complete the Implementation Plan form for the 2022 Plan Year to establish a baseline, and issuers continuing a QIS must complete the Progress Report form in addition to the Implementation Plan form by following these instructions:

- Step 1: Click on the PDF file(s) titled “QIS Implementation Plan” and “QIS Progress Report” (if applicable) and confirm that “2022 Plan Year” appears in the header on the first page.**
- Step 2: Download the file(s) by selecting “Save As” on the “File” tab.**
- Step 3: Save a local copy with JavaScript® enabled to an easily accessible folder.**
- Step 4: Begin populating the QIS Implementation Plan form and the QIS Progress Report form (if 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.³⁴ Issuers may not upload additional materials beyond the form itself via SERFF or HIOS, and CMS will not accept them as part of the QIS submission.

-  **TIP:** The QIS forms are fillable PDF documents that are available only electronically; issuers may not request hard copies by mail.
-  **TIP:** To view and save the forms, download and install Adobe Acrobat Reader®, a free electronic file reader that is available [online](#). To complete the forms, follow the prompts to enable JavaScript.
-  **TIP:** For assistance accessing the QIS forms 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 QIS User Guide so it can be viewed side-by-side with the forms and referred to it as often as necessary. Save the forms regularly as responses are entered.


³⁴ See 45 CFR § 156.705.


2. Complete Introductory Sections of the QIS Implementation Plan and Progress Report Forms

All issuers must complete Parts A–C of the QIS Implementation Plan form and Parts A and B of the Progress Report form (as applicable) 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 and B consist of the following two sections of the QIS forms:

- **Part A: QIS Submission Type**
 - Type of QIS Submission (Implementation Plan form): (baseline Implementation Plan, New after Discontinuing or New with No Previous Submission)
 - Type of QIS Submission (Progress Report form): Progress Report or Progress Report Closeout form
 - Targets All QHPs and Product Types Offered Through an Exchange (found in Implementation Plan only)
- **Part B: Background Information**
 - Issuer Information
 - Current Payment Model(s) Descriptions


In the Implementation Plan form, issuers must also complete **Part C: Data Sources Used for Goal Identification and Monitoring Progress**.

 **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 form, element(s) and/or criteria are missing information.

 **TIP:** Submissions will be blinded and redacted to remove any identifying information 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 forms, except in Part B: Issuer Information.

The subsections below provide instructions on how to complete each section. These subsections 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 forms to provide their responses; inclusion of additional attachments and/or supporting documentation will not be accepted. The forms allow 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 QIS Submission Type

Part A of the QIS forms ask issuers to identify what type of QIS submission they are making. During the 2022 QHP application period, all issuers will complete the QIS Implementation Plan form and may use this form to submit a baseline Implementation Plan, a new QIS with no

previous QIS submission, or implement a new QIS after discontinuing an existing QIS.³⁵ 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.

Follow the steps below to select the appropriate QIS submission type in Part A:

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


Select the option that describes what type of QIS submission the issuer is making (i.e., implementing a New QIS with No Previous QIS Submission, Implementing a New QIS after Discontinuing a QIS Submitted During a Prior QHP Application Period, or baseline Implementation Plan).


An issuer that did not submit a QIS during the 2020 QHP Application Period and newly meets the QIS participation criteria for the 2022 Plan Year must select “New QIS with No Previous QIS Submission.”³⁶ An issuer that submitted a QIS during the 2020 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 BD 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 (Implementation Plan only).

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, 2020). 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 QIS³⁷. For more information about QHP eligibility with respect to an issuer’s QIS, refer to Section 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.


³⁵ Appendix D defines these QIS submission types and indicates which sections of the QIS form issuers must complete depending on the applicable scenario.

³⁶ 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.

³⁷ See supra note 14.

 **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) (i.e., health maintenance organization [HMO], point of service [POS]) to which the QIS applies for the 2022 Plan Year.

 **TIP:** If an issuer is adding or removing product types to an existing QIS, the issuer should reflect that here. For Plan Year 2022, all modifications should be incorporated into the baseline Implementation Plan.³⁸


2.2 Part B. Issuer Information


Part B of both the Implementation Plan form and the Progress Report form collects identifying information about the issuer (e.g., issuer legal name, company legal name, HIOS Issuer ID, issuer state, QIS contact information, date issuer began offering coverage through the 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 in both forms:³⁹

Step 1: Type the issuer’s legal name into the space provided for Element 3 (PR 2).

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

 **TIP:** The information provided in the issuer’s responses to Elements 3–6 (PR 2-5) (i.e., the legal names of the issuer and the issuer’s parent company, the issuer’s HIOS Issuer ID, and the state in which the issuer is located) should match the information provided on the application templates completed as part of the issuer’s QHP Application for the 2022 Plan Year.

 **TIP:** If the issuer previously completed Elements 3–16 (2-15) as part of its Implementation Plan and is now submitting a Progress Report for its existing QIS, the issuer should review its prior years’ responses to these elements and make any necessary updates. It is important that the issuer confirms the responses to these elements are current. Changes to these elements do not warrant selection of “Continuing a QIS with Modifications” in Element 1.

³⁸ As noted above, beginning with the 2023 Plan Year, issuers making modifications will reflect those changes in the new separate Modification Summary form.


³⁹ Element numbers vary between the Implementation Plan and Progress Report form. For clarity, “(PR #)” has been added after each Implementation Plan element reference to indicate the corresponding element in the Progress Report form.

Step 2: Type the legal name of the issuer’s parent company into the space provided for Element 4 (PR 3).

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

Step 3: Enter the issuer’s HIOS Issuer ID in the space provided for Element 5 (PR 4).

Enter the HIOS Issuer ID, which is a five-digit numeric identifier that is assigned to each issuer during HIOS registration.⁴⁰

 **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 (PR 5), 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 (PR 6-9).


Provide the first and last name, title, phone number, and email address of the issuer’s staff member who is responsible for filling out the QIS form(s) 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 (PR 10-13).

Provide the first and last name, title, phone number, and email address of a second staff member who is responsible for filling out the QIS form(s) 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 (PR 14).

Enter a date that specifies 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 (PR 15).

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


⁴⁰ The HIOS Issuer ID and the HIOS Plan ID (also known as an 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.

The information provided in Element 16 (PR 15) will help CMS gauge progress toward meeting value-based payment goals.⁴¹ Exhibit 14 provides a description of each of the four categories.

Exhibit 14: Examples of Payment Models by Category⁴²

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 (FFS) – 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 (APMs) 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. These can be estimated percentage breakdowns. 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 ³/₄) or percent signs (e.g., %).

 **TIP:** To calculate the percentage of payments, use the calculation methodologies defined in the APM Framework: <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 Implementation Plan 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. Follow this step to complete Part C in the Background Information section of the QIS Implementation Plan 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 Survey); plan data, such as complaint, appeals, and customer service records; registries; U.S. Census data; the Area Health Resource File (AHRF),⁴³ all-payer claims data; state health department population data; and/or regional collaborative health data.


⁴¹ <https://hcp-lan.org/apm-refresh-white-paper/>


⁴² Categories of payment models are defined in the *APM Framework* <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

⁴³ 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 their data source description.


 **TIP:** If the issuer checks the box for “Census data,” it should make sure to specify which type of Census data (e.g., tract, ZIP Code, block) was used to identify the problem(s) and to monitor its QIS progress.

 **TIP:** If the issuer previously completed Element 17 as part of its Implementation Plan and is now submitting a Progress Report for its existing QIS, the issuer should review its prior submission and make any necessary updates to its data sources. It is important to make sure the 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)

For the 2022 Plan Year, each eligible 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, regardless of whether the issuer has reported on the QIS in prior years. This submission will establish a baseline Implementation Plan on the new separate forms for all issuers. In addition to Parts A-C described in the previous section, an Implementation Plan consists of the following sections:

- **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.

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

 **TIP:** Prior to submitting the Implementation Plan to CMS, an issuer should use the QIS form Pre-Submission Checklist provided in Appendix B to confirm it has provided responses to all required⁴⁴ elements—including must-pass elements—and criteria. This checklist also helps guide issuers through the submission process.

⁴⁴ For example, if an issuer does not select “Other Market-based Incentives” in Element 21, the issuer does not need to provide a description in the text box.

3.1 Part D. QIS Summary

Part D of the QIS Implementation Plan form collects information that summarizes the issuer's QIS (i.e., 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 form:

Step 1: Provide a title 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 form. 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 21 and 22, respectively, in Part E of the Implementation Plan form.

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.⁴⁵ 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 the issuer checks "Yes" for the mandatory state initiative question or the currently existing strategy question, it should describe the initiative(s) in the space provided.

Step 3: Describe the QIS.

The QIS description should provide a brief summary of the strategy and must address the market-based incentive type (identified in Element 21) and topic area selected (Element 22).

 **TIP:** Since the QIS description (Element 19) closely relates to the issuer's responses to elements and criteria in Part E (i.e., Elements 21 and 22), double check the consistency, as well as the completeness, of these responses to each element and criteria throughout the Implementation Plan prior to submission.

⁴⁵ For a detailed discussion of the QIS requirements, please refer to Volume I, Section 5: QIS Requirements.


Step 4: Describe the overall goal(s) of the QIS (no more than two goals).

Element 20 should cover the overall goal(s), 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 25. If the goal(s) were modified, only the updated goals should be addressed directly in Element 20.

Issuers must address at least one, but no more than two goals in support of their QIS.

3.2 Part E. QIS Requirements


Part E of the Implementation Plan 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 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 the Part E. QIS Requirements in the Implementation Plan form:


Step 1: Select at least one of the market-based incentive types listed in must-pass Element 21.

To complete Element 21, select the box(es) for the market-based incentive sub-type(s) (e.g., increased reimbursement, bonus payment, premium credit, co-insurance reduction⁴⁶) 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 21. If an issuer changes its market-based incentive sub-type, it must discontinue its previous QIS and submit a new Implementation Plan.

 **TIP:** Incentives do not necessarily need to be monetary in nature, but must create some added value that would otherwise not be received (e.g., additional service, premium credit).


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 E for additional information to complete Element 21.

⁴⁶ 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 22.

To complete Element 22, check the box(es) for at least one topic area the QIS addresses, as defined in the PPACA.⁴⁷ 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 22. 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 23. The rationale should include both a description of the issuer’s current⁴⁸ 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 24. 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 20) and should advance the QIS as it relates to: (1) the market-based incentive chosen in Element 21, (2) the topic area(s) chosen in Element 22, 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 24a, list the activities that will be implemented to achieve the identified goals. If the activity(ies) was modified, please include only the modified activity(ies) in Element 24.

To complete Criterion 24b, describe how the QIS activities relate to the selected market-based incentive.

To complete Criterion 24c, describe how the activities relate to the selected topic area(s).

To complete Criterion 24d, check the first box and move to Element 25 if health and health care disparities is one of the topic areas selected in Element 22. If health and health care disparities is NOT one of the topic areas selected AND they are not addressed in the QIS, select the second box and move to Element 25. If “Implementation of activities to reduce health and health care disparities” is not selected as a topic area in Element 22, but relevant activities are included in

⁴⁷ Patient Protection and Affordable Care Act, section 1311(g)(1).


⁴⁸ In this context, “current” refers to the QHP enrollee population over the past two years.

the context of another topic area in the issuer's QIS, describe how implementation activities relate to health and health care disparities in the text field.


Step 5: Name goal(s), measure(s), and performance targets to monitor QIS progress in the spaces provided in must-pass Element 25. Be sure to address all of the specified criteria.


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 25a, 25f, 25k, and 25p.

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 16 of the Progress Report form. Issuers will also have the opportunity to provide a narrative description of progress made against those measures in Element 17 of the Progress Report.


 **TIP:** Issuers may include any concerns regarding impacts of COVID-19 on progress made against measures in Element 17.


If an issuer modified the measures or associated performance targets, the issuer should include only the modified measures and/or performance targets directly in Element 25. *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 25 of the Implementation Plan.

For Criteria 25a, 25f, 25k, and 25p, issuers must provide a narrative description of the measure, including a clear description of the measure numerator and denominator. Next, the issuer should specify whether it is using a National Quality Forum (NQF)-endorsed measure by checking “Yes” or “No.” If it selects “Yes,” the issuer should 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 25. 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 25b, 25g, 25l, and 25q, 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 25e, 25j, 25o, and 25t) represents.


For Criteria 25c, 25h, 25m, and 25r, issuers must provide the baseline assessment results by either calculating the rate or determining the applicable data point. If the measure is a rate, the numerator and denominator provided should calculate to the numerical value provided. If the measure is not a rate, enter the applicable data point as a numerical value 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. Any modified measures should be reflected directly in the 2022 Plan Year Implementation Plan form. 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 25 should remain constant from the prior year’s QIS submission, and should match the baseline assessment results reported in Element 16 of the Progress Report.
-  **TIP:** If an issuer is continuing a QIS with modifications and is modifying its measures, the baseline assessment results reported in Element 24 of the Progress Report should reflect the modified measures (which should be directly incorporated into the baseline Implementation Plan). The baseline assessment results reported in Element 16 of the Progress Report 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 Element 29 of the Progress Report of the current QIS submission may 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 25d, 25i, 25n, and 25s, the issuer should 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 25 should remain constant from Element 25 in the prior year’s QIS submission and should match the baseline performance period reported in Element 16 of the Progress Report 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 25 should reflect the baseline performance period for the modified measures. The baseline performance period reported in Element 16 of the Progress Report should match the baseline performance period reporting in Element 25 of the prior year’s Implementation Plan. In this case, the baseline performance period in Elements 25 and Element 16 of the Progress Report of the current QIS submission may not match.

To complete Criteria 25e, 25j, 25o, and 25t, provide the performance target for each specified measure. If an issuer meets its performance target, it may modify its target by “Continuing a QIS with Modifications,” instead of “Discontinuing a QIS,” as was 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:** Performance targets should be numerical values (e.g., target of 90 percent) and NOT percentage changes (e.g., improvement of 10 percent).

 **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 26. Be sure to address all of the specified criteria.

The timeline should include the QIS initiation/start date in Criterion 26a. 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 2019 QHP Application Period (calendar year 2018) and its initial QIS Progress Report during the 2020 QHP Application Period (calendar year 2019) should list its QIS initiation/start date as 01/2019 or earlier for its continued QIS submissions. An issuer submitting a new QIS Implementation Plan for the first time during the 2022 QHP Application Period (calendar year 2021) should list its QIS initiation/start date as 01/2022 or earlier.

 **TIP:** Issuers submitting a continued QIS submission for the 2022 QHP Application Period must list the QIS initiation/start date as 01/2021 or earlier.

For Criterion 26b, 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 26a.

The dates and milestones provided for those criteria must correspond to the activities described in Element 24. 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 26a should remain the same from the prior year's submission when continuing a QIS.

Step 7: Provide a risk assessment that describes known or anticipated barriers and mitigation activities in the space provided in scored Element 27. Be sure to address both of the specified criteria.

Describe all known or anticipated barriers to implementing QIS activities in Criterion 27a. If no barriers were identified, describe how the issuer assessed risk in the next box.

To complete Criterion 27b, describe the mitigation activities the issuer will incorporate into the QIS (if needed) for each barrier identified in Criterion 27b. 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 *Optional* text box. This field will not be scored.

Step 9: 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_[IP or PR]**. For example, a file named “12345_Issuer ABC_QIS” adheres to the appropriate naming convention.

If an issuer submits more than one QIS form, the file name for each form should also contain a numerical identifier: **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP or PR]_[#]**. For example, if an issuer submits two QIS Implementation Plan forms, the first file should be named “12345_Issuer ABC_QIS_IP_1” and the second file should be named “12345_Issuer ABC_QIS_IP_2.” All QIS forms must follow these naming conventions when submitted.

 **TIP:** Issuers should keep a local copy of the completed Implementation Plan form and make it available to any staff who may be responsible for QIS implementation and reporting. The issuer should refer to its completed Implementation Plan each year to facilitate any corrective actions the issuer may need to take based on the QIS evaluation results, and to help complete the Progress Report in future years.

4. Complete the QIS Progress Report Form

In each subsequent year following the submission of a QIS Implementation Plan, an issuer must submit a Progress Report form 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 2020 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 2022 Plan Year Progress Report form. Issuers submitting a QIS for the first time during the 2022 QHP Application Period are not required to submit a Progress Report until the 2023 QHP Application Period.

To complete the Progress Report, issuers must perform all of the following activities:

- Complete the **QIS Submission Type** section (Part A);
- Confirm the **Issuer Information** section (Part B) is accurate or include updates from the prior year, if necessary; and
- Complete the **Progress Report Section** (Part C).

4.1 Part C. Progress Report Summary

Step 1: If an issuer selected “Progress Report” or “Progress Report Closeout Form” in Element 1, the issuer should restate the goals and baseline data provided in Elements 20 and 25 of the QIS Implementation Plan form.


The issuer should analyze progress by providing follow-up results and indicating whether the performance target in Element 25 of the Implementation Plan was met in must-pass Element 16. Be sure to address all five of the specified criteria.


In the space provided, restate the goals and baseline data provided in Elements 20 and 25 of the Implementation Plan form.


Element 16 should reflect progress made on the **original** goals and/or measures, even if modifications were made and incorporated into the baseline Implementation Plan form. For example, if an issuer submitted a QIS Implementation Plan during the 2020 QHP Application Period and chooses to modify the measures in Element 25 of its QIS Implementation Plan during the 2022 QHP Application Period, the Progress Report submitted by the issuer during the 2022 QHP Application Period should reflect progress made against the measures **originally specified** in its 2020 QIS Implementation Plan (as opposed to its newly modified measures, which will now be reflected in the 2022 Plan Year baseline Implementation Plan). Then, if, an issuer continues its QIS with no modifications for the 2023 Plan Year, the issuer should report progress made on its modified goals and/or measures (as specified in the 2022 QIS submission).


To complete Criteria 16a, 16h, 16o, and 16v, provide the measure name as indicated in Element 25 of the issuer’s Implementation Plan.

To complete Criteria 16b, 16i, 16p, and 16w, restate the baseline assessment results by either calculating the rate or determining the applicable data point. If the measure is a rate, the numerator and denominator provided should calculate to the numerical value provided. If the measure is not a rate, enter the applicable data point as a numerical value in the space provided.

 **TIP:** Baseline assessment results reported in Element 16 should measure an issuer’s performance before implementation of the QIS. Baseline data comprise 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 16 should match the **baseline assessment results** reported in Element 25 of both the prior year’s⁴⁹ and the baseline Implementation Plan.

 **TIP:** If an issuer is continuing a QIS with modifications and is modifying its measures, the **baseline assessment results** reported in Element 16 should match the **baseline assessment results** reported in Element 25 of the prior year’s Implementation Plan.


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


⁴⁹ With the suspension of data collection for the 2021 Plan Year (see supra note 3), this may be the 2020 Plan Year submission.


To complete Criteria 16c, 16i, 16q, and 16x, 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 25 of its QIS Implementation Plan. Enter the response in MM/YYYY format.


 **TIP:** If an issuer selected “Baseline Implementation Plan in Element 1, the **baseline performance period** reported in Element 16 should match the **baseline performance period** reported in Element 25 of the Implementation Plan.

To complete Criteria 16d, 16j, 16r, and 16y, 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.

 **TIP:** Baseline assessment results and follow-up results should be distinct; issuers should not restate the baseline assessment results provided in Element 25 of the Implementation Plan in Criteria 16d, 16j, 16r, and 16y.

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

 **TIP:** Issuers will not be penalized at this time if they do not achieve performance target(s); however, issuers may modify 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. Issuers should include the modified targets in Element 25 of the Implementation Plan and should report on progress made toward their original target in Element 16.

 **TIP:** Due to the timing and availability of certain measure data (e.g., Healthcare Effectiveness Data and Information Set® [HEDIS®] measure rates), issuers may not have all the final data needed to complete their QIS submissions by the first QHP submission deadline. Issuers may submit their QIS with preliminary data in the measure fields and an appropriate explanation in the optional field at the end of the form. The issuers may then finalize their submission with updated data and resubmit before the close of the final QHP submission window. This process will ensure these issuers’ submissions pass an initial completeness check for these criteria and avoid unnecessary deficiency notices, while allowing for issuers to update their submissions with final HEDIS measure rates when available.

To complete Criteria 16e, 16l, 16s, and 16z, 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 16f, 16m, 16t and 16aa, restate the performance target for the measure. This should be a numerical value and NOT a percentage change.

To complete Criteria 16g, 16n, 16u and 16bb, indicate whether the original performance target specified in Element 25 of the Implementation Plan was achieved by selecting “Yes” or “No.”

Step 2: In Element 17, provide a summary of progress toward achieving the performance target(s) documented in Element 25 of the issuer’s prior year’s QIS Implementation Plan. Include a description of the activity(ies) leading to the outcome in must-pass Element 17.

In Element 17, indicate why progress was or was not made toward achieving the performance target(s) documented in Element 25 of the prior year’s QIS Implementation Plan. Include a description of activities that led to the outcome.

Issuers should complete 17b ONLY if the issuer selected “Progress Report Closeout form” as their submission type in Element 1. They should provide the rationale for discontinuing the QIS.

Issuers should complete 17c if the issuer received an “Interim Meets” determination during the previous PCA Period and was instructed to address a deficiency or error in their 2022 Plan Year submission. Issuers should provide information about changes made to the QIS to address these concerns, and specify which elements/criteria to which they apply.


If the scenarios described in 17b and/or 17c do not apply, issuers should leave these fields blank; however, but all issuers must complete 17a.

Step 3: In Element 18, indicate whether the issuer faced any barriers implementing its QIS, the mitigation activities implemented to address these barriers and/or any problems meeting the timelines specified in Criterion 26b of the prior year’s QIS Implementation Plan submission. Be sure to address both of the specified criteria.

To complete Criterion 18a, indicate whether any barriers were encountered in implementing the QIS. If “Yes” is selected, describe the barriers encountered while implementing the QIS and the mitigation activities implemented to address **each** barrier.

To complete Criterion 18b, indicate whether there were any problems meeting the timelines specified in Criterion 26b of the QIS Implementation Plan submission. If “Yes” is selected, describe the problems in meeting timelines and the mitigation activities implemented to address **each** of the problems meeting timelines.

Step 4: 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.


 **TIP:** Issuers may include any concerns regarding impacts of COVID-19 on progress made against measures in this optional field.


5. Submit the QIS Form(s)

Issuers will submit their completed QIS forms, along with all other QHP certification documentation,⁵⁰ during the annual QHP Application Period. For the 2022 QHP Application Period, the QHP Application submission window for the FFEs is specified in the [Qualified Health Plan \(QHP\) Data Submission and Certification Timeline for Plan Year 2022](#). For the 2022 Plan Year, the QIS forms will be submitted through the accreditation module.

⁵⁰ The complete set of QHP Application instructions, templates and materials is available at: <https://www.qhpcertification.cms.gov/s/Home>.

- 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 should contact their Exchanges for specific instructions on QHP Application submission details, including QIS submission requirements.

 **TIP:** Before an issuer submits the QIS forms, it should use the checklist provided in Appendix D to confirm its QIS forms' completeness, and verify that the 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 via 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 that submit password protected QIS forms will be asked to remove password protection and resubmit.

5.1 Submit via HIOS

As noted above, issuers submitting quality improvement strategies for QHPs offered through an FFE will submit their QIS form(s) through HIOS.⁵¹ Once issuers have typed responses for each applicable element and criteria into the QIS form(s) and saved a local copy of the completed form(s), they will need to upload the document(s) to HIOS along with their other QHP Application materials to transmit it to the relevant FFE for evaluation.

Issuers operating 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 EIDM credentials (i.e., user name and password) to access HIOS.⁵²

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

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


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

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

⁵¹ 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 QIS User Guide for further details.

⁵² To gain access to HIOS, all issuers must register in the CMS 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.

Issuers must label their submissions according to the aforementioned naming convention: **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP or PR]**, for single submissions; and **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP or PR]_[#]**, 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_[IP or PR]**, for single submissions; and **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP or PR]_[#]**, 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.⁵³

⁵³ 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 should contact the applicable Exchange for details on the process for evaluating QIS submissions.

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 forms to HIOS or SERFF (as appropriate).

Follow the steps provided in Section 5 above to submit the revised forms to CMS and the state (if applicable). Issuers operating in FFEs where the state performs plan management should submit via SERFF; for all other FFE states, issuers should submit via HIOS.

6.2 Addressing Potential Concerns After the QHP Application Period

CMS begins evaluations of complete QIS submissions after the close of the 2022 QHP Application Period. CMS will communicate full evaluation results for QIS submissions for the 2022 Plan Year to issuers in the late fall of 2021/early winter of 2022.

Appendices

Appendix A. Excerpts of Relevant Statutory and Regulatory Citations

Exhibit 15: 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	<p>(c) RESPONSIBILITIES OF THE SECRETARY.—</p> <p>(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—</p> <p>(E) implement a quality improvement strategy described in subsection (g)(1).</p>	Section 1311(c)(1)(E)
Exchange standards for quality improvement strategies	<p>(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES —</p> <p>(1) STRATEGY DESCRIBED — A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(D) the implementation of wellness and health promotion activities; and</p> <p>(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.</p> <p>(2) GUIDELINES — The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).</p> <p>(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).</p>	Section 1311(g)

Exhibit 16: 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	<p>(d) <i>Quality activities.</i> 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.</p>	45 CFR § 155.200(d) Functions of an Exchange

Exhibit 17: 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	<p>(a) <i>General requirement.</i> 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.</p> <p>(b) <i>QHP issuer requirement.</i> A QHP issuer must—</p> <p>(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;</p> <p>(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.</p>	45 CFR § 156.200(a), (b)(5), (h) QHP issuer participation standards
Exchange QHP certification standards	<p>a) <i>Definition.</i> 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.</p> <p>(b) <i>General requirement.</i> 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.</p> <p>(c) <i>General certification criteria.</i> The Exchange may certify a health plan as a QHP in the Exchange if—</p> <p>(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</p> <p>(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—</p> <p>(i) On the basis that such plan is a fee-for-service plan;</p> <p>(ii) Through the imposition of premium price controls; or</p> <p>(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.</p>	45 CFR § 155.1000, Certification standards for QHPs

Exhibit 18: 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
<p>Quality improvement strategy standards</p>	<p><i>(a) General requirement.</i> 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.</p> <p><i>(b) Data requirement.</i> 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.</p> <p><i>(c) Timeline.</i> 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.</p>	<p>45 CFR § 156.1130(a)-(c), Quality Improvement Strategy</p>

Appendix B. QIS Implementation Plan and Progress Report Forms Pre-Submission Checklist

The checklist shown as Exhibit 19 is intended to help issuers verify the completeness of their QIS forms, confirm that their responses address all of the elements and criteria—especially the must-pass elements—and guide them through the QIS submission process.

Exhibit 19: QIS Implementation Plan and Progress Report Form Pre Submission Checklist

QIS IMPLEMENTATION PLAN AND PROGRESS REPORT FORM PRE-SUBMISSION CHECKLIST

A. PREPARATION

- Review the applicable regulations, the entire 2022 QIS Technical Guidance and QIS User Guide, as well as the relevant sections of the 2022 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 form and QIS Progress Report form (if applicable).

B. COMPLETE THE IMPLEMENTATION PLAN FORM

- 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 form.
- Complete all of the elements and criteria in Part E: QIS Requirements, in the QIS Implementation Plan form.
- 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 FORM (IF NECESSARY)

- Enable JavaScript in the fillable PDF form before you enter your QIS information.
- Complete Part A: QIS Submission Type 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 of Part B, use the same information that was included elsewhere in the QHP Application templates.
- Complete all of the required elements and criteria in Part C: Progress Report Summary.

- 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” in elements or criteria where this is an option
- Confirm that you were consistent in your answers across all elements and criteria.

D. SUBMIT THE FORM(S)

- Save a local copy of the form(s) 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(s) to HIOS or SERFF, as appropriate, for submission to the FFEs. 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 reference 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 C. Elements and Criteria

Exhibit 20: QIS Implementation Plan Elements and Criteria

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires 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	2a – Indicate if this QIS is applicable to all eligible QHPs the issuer offers or is applying to offer through the Exchanges, or to a subset of eligible QHPs. If “Subset of QHPs” is selected, an additional QIS Implementation Plan(s) (Parts D and E of this form) 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.	This element is required but will not be scored.	None	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”
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 “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS” or “New QIS After Discontinuing a QIS Submitted During a Prior Qualified Health Plan (QHP) Application Period” in Element 1. Issuers with no previous QIS submission must select “New QIS with No Previous QIS Submission” in Element 1. A “new” QIS is defined as a QIS that has not been previously submitted to an Exchange.

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1⁵⁴
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	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
8	QIS Primary Contact's Title	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
9	QIS Primary Contact's Phone	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
10	QIS Primary Contact's Email	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1⁵⁴
11	QIS Secondary Contact's Name	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
12	QIS Secondary Contact's Title	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
13	QIS Secondary Contact's Phone	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
14	QIS Secondary Contact's Email	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
15	Date Issuer Began Offering Coverage Through the Exchange	None	This element is required but will not be scored.	None	Not Applicable

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1⁵⁴
16	<p>Current Payment Model(s) Description Select the category(ies) of payment models that are used by the issuer across the applicable Exchange product line. Provide the percentage of payments in each payment model category used by the issuer across the applicable Exchange product line. The total percentage of payments across all four payment model types should equal approximately 100 percent. These percentages can be estimates and do not need to be exact figures. Issuers may update this information from year to year, as needed.</p>	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”
Part C					
17	<p>Data Sources Indicate the data sources used for identifying QHP enrollee population needs and supporting the QIS rationale (see Element 23). Check all that apply.</p>	None	This element is required but will not be scored.	100 characters if “Other” is selected.	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”
Part D					
18	<p>QIS Title Provide a short title for the QIS.</p>	None	This element is required but will not be scored.	200 characters	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1 ⁵⁴
19	<p>QIS Description</p> <p>Provide a brief summary description of the QIS. The description must include the market-based incentive type(s) and topic area(s) (see Elements 21 and 22). Is the QIS described above part of a mandatory state initiative?</p> <p>Is the QIS submission a strategy that the issuer currently has in place for its Exchange product line and/or for other product lines?</p> <p>If "Yes" was checked for either/both of the above, please describe the state initiative and/or current issuer strategy.</p>	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.	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
20	<p>QIS Goals</p> <p>Describe the overall goal(s) of the QIS (no more than two). The topic area(s) selected in Element 22 and the measure(s) described in Element 25 should be linked to these goals.</p>	None	This element is required but will not be scored.	500 characters per text box	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element ¹⁵⁴
Part E					
21	Market-based Incentive Type(s) Select the sub-type of market-based incentive(s) the QIS includes. Check all that apply. If either “In-kind incentives,” “Other provider market-based incentives,” or “Other enrollee market-based incentives” is selected, provide a brief description in the space provided.	None	This element will be scored; Element 21 is a must-pass element.	500 characters per text box	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	Topic Area Selection 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 22 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.
23	Rationale for QIS 23 – Provide (1) a rationale for the QIS that describes the issuer’s current QHP enrollee population(s) and (2) how the QIS will address the needs of the current QHP enrollee population(s).	None	This element will be scored; Element 23 is a must-pass element.	1,500 characters	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element ¹⁵⁴
24	Activity(ies) That Will Be Conducted to Implement the QIS	<p>24a – List the activities that will be implemented to achieve the identified goals in Element 20.</p> <p>24b – Describe how the activities listed in Criterion 24a relate to the market-based incentive(s) selected in Element 21.</p> <p>24c – Describe how the activities listed in Criterion 24a relate to the selected topic area(s) selected in Element 22.</p> <p>24d – If the issuer did not choose health and health care disparities as a topic area in Element 22, but the QIS includes activities related to addressing health and health care disparities, describe such activities below. If (1) health and health care disparities is one of the topic areas selected in Element 22; OR (2) health and health care disparities are not addressed in this QIS, select the check box.</p>	This element will be scored; Element 24 is a must-pass element.	1,500 characters per criterion	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”

QIS Implementation Plan					
Element #	(if applicable)	Criteria	Scoring	Character Limit	1 ⁵⁴
25	<p>Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress</p> <p>For each goal, identify at least one (but no more than two) primary measure(s) used to track progress toward meeting the goal. For each measure identified, address the criteria in the criteria column to the right.</p>	<p>25a, 25f, 25k, 25p – 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.</p> <p>25b, 25g, 25l, 25q – Describe how the measure supports the tracking of performance related to the goal.</p> <p>25c, 25h, 25m, 25r – Baseline Assessment. Provide the baseline results by calculating the rate or providing the applicable data point. If the measure is a rate, provide the associated numerator and denominator and the calculated rate. Note: The numerator and denominator should calculate to the rate provided. If the measure is not a rate but another data point, enter the applicable number in the space provided.</p> <p>25d, 25i, 25n, 25s – Provide the baseline performance period (i.e., month and year when data collection began and ended) covered by the baseline data assessment provided in Criterion 25c.</p> <p>25e, 25j, 25o, 25t – Provide the numerical value performance target for this measure (i.e., the target rate or data point the QIS intends to achieve). Note: This entry should NOT be a percentage change but a numerical value.</p>	<p>This element will be scored; Element 25 is a must-pass element.</p>	<p>500 characters per measure description; 1,000 characters per description of how the measure supports tracking of goals</p>	<p>Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”</p>

QIS Implementation Plan					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element ¹⁵⁴
26	Timeline for Implementing the QIS	26a – QIS initiation/start date. 26b – Describe the milestone(s) and provide the date(s) for each milestone (i.e., when activities described in Element 24 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 26b	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”
27	Risk Assessment	27a – List all known or anticipated barriers to implementing QIS Activities. If no barriers were identified, describe how you assessed risk in the box below. If barriers were identified above, this box should be left blank. 27b – Describe the mitigation activities that will be incorporated to address each barrier identified in Criterion 27a. If there were no barriers identified, this box should be left blank.	This element will be scored. Element 27 is a must-pass element.	750-character limit per text box in 27a; 1,500 character limit for 27b	Regardless of changes, issuer must select “Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS.”

Exhibit 21: QIS Progress Report Elements and Criteria

QIS Progress Report					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1⁵⁵
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
Part B					
2	Issuer Legal Name	None	This element is required but will not be scored.	None	Not Applicable
3	Company Legal Name	None	This element is required but will not be scored.	None	Not Applicable
4	HIOS Issuer ID	None	This element is required but will not be scored.	None	Not Applicable
5	Issuer State	None	This element is required but will not be scored.	None	Not Applicable
6	QIS Primary Contact's Name	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."

⁵⁵ This column indicates whether a change to a given element/criterion from a previous QIS requires selecting "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS" or "New QIS after Discontinuing a QIS Submitted during a Prior Qualified Health Plan (QHP) Application Period" in Element 1.

QIS Progress Report					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1⁵⁵
7	QIS Primary Contact's Title	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
8	QIS Primary Contact's Phone	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
9	QIS Primary Contact's Email	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
10	QIS Secondary Contact's Name	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
11	QIS Secondary Contact's Title	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
12	QIS Secondary Contact's Phone	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."

QIS Progress Report					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1⁵⁵
13	QIS Secondary Contact's Email	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."
14	Date Issuer Began Offering Coverage Through the Exchange	None	This element is required but will not be scored.	None	Not Applicable
15	Current Payment Model(s) Description Select the category(ies) of payment models that are used by the issuer across the applicable Exchange product line. Provide the percentage of payments in each payment model category used by the issuer across the applicable Exchange product line. The total percentage of payments across all four payment model types should equal approximately 100 percent. These percentages can be estimates and do not need to be exact figures. Issuers may update this information from year to year, as needed.	None	This element is required but will not be scored.	None	Regardless of changes, issuer must select "Baseline Implementation Plan (only for the 2022 Plan Year) for Continuing a QIS."

QIS Progress Report					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1 ⁵⁵
Part C					
16	<p>Analyze Progress Using Baseline Data, as Documented in the Implementation Plan</p> <p>Restate the Goal(s) identified in Element 24 of the Implementation Plan on file.</p> <p>(Note: The Goal(s) and Measure(s) identified in this section (Part C: Progress Report Summary) are the Goal(s) and Measure(s) from the Implementation Plan form on file against which QIS progress is measured. (Note: All references to Implementation Plan form elements and criteria in this form refer to the 2020 Plan Year Implementation Plan.)</p>	<p>16a, 16h, 16o, 16v – Restate measure name(s) from Element 24 of the Implementation Plan on file.</p> <p>16b, 16i, 16p, 16w – Restate the baseline results from Element 24 of the Implementation on file by calculating the rate or providing the applicable data point. If the measure is a rate, provide the associated numerator and denominator and the calculated rate. Note: The numerator and denominator should calculate to the rate provided. If the measure is not a rate but another data point, enter the applicable number in the space provided.</p> <p>16c, 16j, 16q, 16x– Provide the baseline performance period (i.e., the month and year when data collection began and ended) covered by the baseline assessment from Element 24 of the Implementation Plan on file.</p> <p>16d, 16k, 16r, 16y – Provide the Progress Report results by calculating the rate or providing the applicable data point. If the measure is a rate, provide the associated numerator and denominator and the calculated rate. Note: The numerator and denominator should calculate to the rate provided. If the measure is not a rate but another data point, enter the applicable number in the space provided.</p> <p>16e, 16l, 16s, 16z – Provide the Progress Report performance period (i.e., month and year when data collection began and ended) covered by the progress report assessment.</p> <p>16f, 16m, 16t, 16aa – Restate the numerical value performance target for the measure (i.e., the target rate or data point the QIS intends to achieve). Note: This entry should NOT be a percentage change but a numerical value.</p> <p>16g, 16n, 16u, 16bb – Was the performance target achieved?</p>	<p>This element will be scored; Element 16 is a must-pass element.</p>	<p>500 characters per goal</p>	<p>Not Applicable</p>

QIS Progress Report					
Element #	Element Name and Explanation (if applicable)	Criteria	Scoring	Response Character Limit	Change Requires Discontinuation Selection in Element 1 ⁵⁵
17	Summary of Progress	<p>17a – Please provide a summary of progress covering the following details: (1) Indicate why progress was or was not made toward the performance target(s) documented in Element 24 of your QIS Implementation Plan on file and (2) Include a description of activities that led to the outcome.</p> <p>17b – If the issuer selected “Progress Report Closeout Form” in Element 1 of <i>this</i> Progress Report form, provide the rationale for discontinuing the QIS.</p> <p>17c – If the issuer received an “Interim Meets” scoring designation during the previous Post-certification Assessment (PCA) Period and was instructed to address the deficiencies in their subsequent Plan Year submission, please indicate which elements and/or criteria you updated based on PCA Notices and describe the changes.</p> <p>If the scenarios described in 17b or 17c do not apply, issuers should leave these fields blank.</p>	This element will be scored; Element 17 is a must-pass element.	1,000 characters per criterion	Not Applicable
18	Barriers and Mitigation Activities	<p>18a – Were barriers encountered in implementing the QIS? If “Yes,” describe: (1) The barriers and (2) The mitigation activities implemented (including the results of such activities) to address each barrier.</p> <p>18b – Were there problems meeting timelines as indicated in Element 25 of the QIS Implementation Plan on file? If “Yes,” describe: (1) The problems in meeting timelines, and (2) The mitigation activities implemented to address each problem in meeting the timeline.</p>	This element will be scored. Both criteria must be completed.	1,500 characters per criterion	Not Applicable

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

Exhibit 22 describes common situations for issuers seeking to comply with the QIS requirements, and provides information about what sections of the QIS forms they should complete based on the type of QIS submission.

The “Type of QIS Submission” column corresponds to the check box selections found in Part A (QIS Submission Type) of the QIS forms. Issuers that meet the QIS participation criteria must complete Part A of each of the applicable QIS form(s) annually, in addition to any other required sections.

Exhibit 22: 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 QIS⁵⁶ with No Previous QIS Submission	<ul style="list-style-type: none"> ▪ The issuer has offered QHPs through an Exchange for at least two consecutive years, AND ▪ Has not previously submitted a QIS Implementation Plan⁵⁷ 	<ul style="list-style-type: none"> ▪ Complete the Background Information section (Parts B and C of the Implementation Plan form), <u>AND</u> ▪ Complete the QIS Implementation Plan section (Parts D and E of the Implementation Plan form)
New QIS After Discontinuing a QIS Submitted During a Prior QHP Application Period	<ul style="list-style-type: none"> ▪ 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) 	<ul style="list-style-type: none"> ▪ Complete two forms ▪ Complete a new/separate form to submit the new QIS: <ul style="list-style-type: none"> – Complete the Background Information section (Parts B and C of the Implementation Plan form) – Complete the QIS Implementation Plan section (Parts D and E of the Implementation Plan form) ▪ <i>See also “Progress Report Closeout Form”</i>
Baseline Implementation Plan	<ul style="list-style-type: none"> ▪ The issuer has previously submitted a QIS and needs to establish a baseline Implementation Plan on the new separate forms for the 2022 Plan Year 	<ul style="list-style-type: none"> ▪ Complete the Background Information section (Parts B and C), <u>AND</u> ▪ Complete the QIS Implementation Plan form (Parts D and E) ▪ <i>See also “Progress Report form”</i>

⁵⁶ 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.

⁵⁷ 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
Progress Report	<ul style="list-style-type: none"> ▪ The issuer previously submitted a QIS Implementation Plan, <u>AND</u> ▪ Will continue its existing QIS⁵⁸ 	<ul style="list-style-type: none"> ▪ Update the Background Information section (Parts B of the Progress Report form) as needed, <u>AND</u> ▪ Complete the QIS Progress Report Summary (Part C)
Progress Report Closeout Form	<ul style="list-style-type: none"> ▪ The issuer has previously submitted a QIS Implementation Plan, <u>AND</u> ▪ 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). 	<ul style="list-style-type: none"> ▪ Complete two forms ▪ Update the Background Section (Part B of the Progress Report form) ▪ Complete the QIS Progress Report Summary (Part C) ▪ <i>See also "New QIS after Discontinuing a QIS Submitted during a Prior QHP Application Period"</i>

⁵⁸ Any modifications to the QIS should be reflected directly in Parts D and/or E of the 2022 Plan Year baseline Implementation Plan.

Appendix E. Market-Based Incentive Examples

Exhibit 23 and Exhibit 24 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 21 in the QIS Implementation Plan form.

Exhibit 23: 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, ⁵⁹ and/or health IT implementation.

Exhibit 24: 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.

⁵⁹ For technical support to qualify as an in-kind incentive, it must include not only data collection/sharing, but must 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 F. Glossary

Unless otherwise stated in this document, the definitions in Exhibit 25 are QIS-specific, apply to key terms, and are defined within the context of the QIS requirements. Some of these terms may be defined differently in other contexts.

Exhibit 25: Glossary

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. ⁶⁰
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. ⁶¹
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. ⁶²
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^{®63} (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.

⁶⁰ Patient Protection and Affordable Care Act. <http://housedocs.house.gov/energycommerce/ppacacon.pdf>

⁶¹ <https://www.healthcare.gov/glossary/co-insurance/>

⁶² <https://www.healthcare.gov/glossary/co-payment/>

⁶³ Health Insurance Marketplace[®] is a registered service mark of the U.S. Department of Health & Human Services.

Term	Definition
health maintenance organization (HMO)	A type of health insurance product that usually limits coverage to care from providers that work for or contract with the HMO and generally will not cover out-of-network care, except in an emergency.
hospital value-based purchasing program	<p>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.</p> <p>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.</p> <p>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 2003.⁶⁴</p>
Medicare Shared Savings Program	<p>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).</p> <p>The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:</p> <ul style="list-style-type: none"> ▪ 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 <p>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.⁶⁵</p>
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).
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. ⁶⁶
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.

⁶⁴ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf

⁶⁵ <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>

⁶⁶ <http://www.innovations.ahrq.gov/issue.aspx?id=157>

Term	Definition
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 form	The QIS Implementation Plan form is a form QHP issuers in the FFE use for annual reporting to the applicable Exchange. The form is comprised of three sections: QIS Submission Type, Background Information, and QIS Implementation Plan Section. Issuers complete the QIS Implementation Plan Section of the form to describe their quality improvement strategies and submit them to the Exchange.
QIS Modification Summary Supplement⁶⁷	The QIS Modification Summary Supplement is a form QHP issuers in the FFE use for annual reporting to the applicable Exchange. Issuers use this form if they are reporting modifications to components of their QIS. This is not a standalone form, and must be submitted in conjunction with the Progress Report form.
QIS Progress Report form	The QIS Progress Report form is a form QHP issuers in the FFE use for annual reporting to the applicable Exchange. The form is comprised of three sections: QIS Submission Type, Background Information, and QIS Progress Report Section. Issuers that have already implemented a QIS complete the QIS Progress Report form annually to communicate their quality improvement strategies' progress to the applicable Exchange.
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-April 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. ⁶⁸

⁶⁷ This form will not be available until the 2023 Plan Year. If issuers are modifying any elements of their QIS, those changes should be directly incorporated into the baseline Implementation Plan for the 2022 Plan Year.

⁶⁸ 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>

Term	Definition
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. ⁶⁹ 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)	An Exchange model in which a state operates its own Health Insurance Exchange 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	FFEes where the state performs plan management for QHPs offered through the Exchange. Consumers in these states apply for and enroll in coverage through the FFEes.
System for Electronic Rate Filing and Forms (SERFF)	SERFF is an electronic filing mechanism that allows for standardized health product filings, including rate review and QHP submissions. SERFF is affiliated with the National Association of Insurance Commissioners (NAIC).
topic areas	The specific areas for quality improvement cited in Section 1311(g) of the 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.

⁶⁹ Ibid.

Appendix G. Acronym List

Exhibit 26 includes acronyms used in this document.

Exhibit 26: Acronym List

Acronym	Complete Term or Name
ACO	Accountable Care Organization
AHRF	Area Health Resource File
CCIIO	Center for Consumer Information & Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
EPO	Exclusive Provider Organization
FFE	Federally-facilitated Exchange
FFM	Federally-Facilitated Marketplace
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HMO	Health Maintenance Organization
HRSA	Health Resources And Service Administration
HSA	Health Savings Account
IQR	Inpatient Quality Reporting
LAN	Learning & Action Network
MQI	Marketplace Quality Initiatives
MSD	Marketplace Service Desk
NAIC	National Association of Insurance Commissioners
NQF	National Quality Forum
PCA	Post-Certification Assessment
POC	Point of Contact
POS	Point Of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
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 Rates and Forms Filing
SERVIS	State Exchange Resource Virtual Information System
SHOP	Small Business Health Options Program
SMIPG	State Marketplace and Insurance Programs Group
TIN	Tax Identification Number