Health Insurance Exchange

Quality Improvement Strategy: Technical Guidance and User Guide for the 2025 Plan Year

April 2024

Table of Contents

List of Exhibits

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 (FFEs):** Please submit questions via email to the MSD at CMS_FEPS@cms.hhs.gov and reference "Marketplace Quality Initiatives (MQI)-QIS" in the subject line.
- **Other interested parties:** 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 2025 Plan Year QIS Implementation Plan form, Progress Report form, and Modification Summary Supplement 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/health-insurance-marketplace-initiatives
CMS QHP Certification website	This website provides issuers with detailed application instructions, forms—including the QIS forms—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 of the Implementation Plan form and Element 15: Current Payment Model(s) Description of the Progress Report form.	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.cms.gov/ (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://portal.cms.gov/ (registration required)

Other Resources

- The *2025 Final Letter to Issuers in the Federally-facilitated Exchanges* (Final 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 2025 Plan Year (PY).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 (2016 Payment Notice)[3] includes implementation requirements for QHP quality improvement strategies beginning with the 2016 Plan Year.
- The Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (2023 Payment Notice)[4] includes an update to the QIS standards to require QHP issuers to address health and health care disparities as a specific topic area within one of their quality improvement strategies beginning in calendar year 2023 for the 2024 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.

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

[4] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023; Final Rule, 87 FR 27208 at 27341 (May 6, 2022) (45 CFR § 156.1130).

2. Document Purpose and Scope

The *Quality Improvement Strategy: Technical Guidance and User Guide for the 2025 Plan Year* (2025 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 2025 Plan Year. This document is organized into two volumes:

- Volume I: QIS Technical Guidance for the 2025 Plan Year (QIS Technical Guidance) and
- Volume II: QIS User Guide for the 2025 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 Process (reflected in the Final Letter to Issuers), which may evolve on an annual basis.

2.1 Section Guide

Volume I: QIS Technical Guidance for the 2025 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 2025 Plan Year and the previous versions of the guidance.

This guidance will address changes to the QIS forms for the 2025 Plan Year, including updated guidelines regarding use of the Modification Summary Supplement form. Throughout this document, unless otherwise noted, references to an FFE or FFEs refer to both FFEs and FFEs where the state performs plan management. Similarly, references to an SBE or SBEs refer to both SBEs and SBEs on the Federal Platform (SBE-FPs), unless otherwise noted.

The requirements outlined in this document are based on statute and CMS regulations, including the Patient Protection and Affordable Care Act (PPACA), the 2016 Payment Notice, and the 2023 Payment Notice.

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 2025 Plan Year,
- Exchange oversight responsibilities,
- The QIS requirements, and
- The QIS evaluation process and methodology.

Key Differences Between the 2024 QIS Technical Guidance and 2025 QIS Technical Guidance

Section 5.3.2: Changing a QIS – Beginning with the 2025 Plan Year QHP Application Period, issuers who want to make changes to their QIS but have already submitted two Modification Summary Supplement forms to change the same QIS must submit a Progress Report Closeout form to discontinue that QIS and submit a new Implementation Plan form to create a new QIS.

Volume II: QIS User Guide for the 2025 Plan Year

The QIS User Guide provides issuers offering coverage in an FFE with directions to meet the QIS requirements for the 2025 Plan Year. The User Guide provides procedural, step-by-step instructions for issuers on how to access, complete, and submit the Implementation Plan form, Progress Report form, and Modification Summary Supplement form to CMS during the PY2025 QHP Application Period.[5]

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

The key differences between the 2024 QIS User Guide and the 2025 QIS User Guide are described below.

Key Differences Between the 2024 QIS User Guide and the 2025 QIS User Guide

Section 5: Complete the QIS Modification Summary Supplement Form – Information has been added to this section on how to use the Modification Summary Supplement form. Additional information is provided regarding situations when an issuer will need to discontinue a QIS and create a new QIS to make additional changes to an existing QIS.

[5] The PY2025 QHP Application Period occurs in calendar year 2024. See the 2025 Plan Year QHP Data Submission Key Dates Timeline available at: https://www.qhpcertification.cms.gov/s/Timeline. The 2025 Plan Year occurs in calendar year 2025.

Volume I. QIS Technical Guidance for the 2025 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 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 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 one of the following:

   i. Activities to improve health outcomes,

   ii. Activities to prevent hospital readmissions,

   iii. Activities to improve patient safety and reduce medical errors,

   iv. Activities for wellness and health promotion.

(3) Implement at least one QIS that includes activities to reduce health and health care disparities.

(4) Adhere to guidelines, including the QIS Technical Guidance and QIS User Guide, established by HHS in consultation with experts in health care quality and interested parties.

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

CMS envisions issuers aligning their quality improvement activities with the quality priorities identified in the Meaningful Measures Framework.[7] 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 incentive types that issuers may include in their quality improvement strategies: (1) increased reimbursement or

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

[7] 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.

(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).[8]

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 additional value to the recipient, whether that be through an additional service or a 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 Act[9]

QIS Topic Area	Examples of QIS Activities
Improve Health Outcomes	▪ Quality reporting ▪ Effective case management ▪ Care coordination ▪ Chronic disease management ▪ Medication and care compliance initiatives
Prevent Hospital Readmissions	▪ Comprehensive program for hospital discharge that includes: – Patient-centered education and counseling – Comprehensive discharge planning – Post discharge reinforcement by an appropriate health care professional
Improve Patient Safety and Reduce Medical Errors	▪ Appropriate use of best clinical practices ▪ Evidence-based medicine ▪ Health information technology

[8] 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).

[9] 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
Implement Wellness and Health Promotion Activities	▪ Smoking cessation ▪ Weight management ▪ Stress management ▪ Healthy lifestyle support ▪ Diabetes prevention
Reduce Health and Health Care Disparities	▪ Language services ▪ Community outreach ▪ Cultural competency trainings ▪ Social needs-sensitive self-management recommendations ▪ Expanded collection, reporting, and analysis of standardized demographic and social determinants of health (SDOH) data

All Exchanges are required[10] 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 PY2025 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.[11]
- 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

[10] 45 CFR § 155.200(d).

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

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, they 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 that is 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 calendar year 2022 and 2023 and continues operating in the Exchange in calendar year 2024 must make at least one initial Implementation Plan form submission to the applicable Exchange in calendar year 2024 for the 2025 Plan Year.

An issuer that submitted an Implementation Plan form or Progress Report form for the 2024 Plan Year must submit a Progress Report form for the 2025 Plan Year.

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 Implementation Plan form and/or Progress Report form as part of their QHP applications. These issuers are required 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.

CMS provides 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 2024.
2. FFE issuers will be informed via notifications from the Health Insurance Oversight System (HIOS) Marketplace Quality Module (MQM) when the draft QIS Issuer List is available on the MQI website.[12]
3. Issuers will be able to review the draft Issuer List to verify their information and may 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 2025 QIS forms.

The QIS elements and criteria in the QIS forms are described in detail in the QIS User Guide for the 2025 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 2025 QIS forms is provided in Section 5.2.1 of this Technical Guidance.

3. QIS Timeline for the 2025 Plan Year

Issuers applying for QHP certification in the FFEs will submit QIS forms during the annual QHP Application Period for the 2025 Plan Year. They should refer to the CMS final bulletin titled Qualified Health Plan (QHP) Data Submission and Certification Timeline for Plan Year 2025 for the finalized QHP data submission and certification timeline. Issuers operating in SBEs should refer to their Exchanges regarding specific time frames for the 2025 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 2025 Plan Year.

4.1 Federally-facilitated Exchanges

FFE states will follow the QHP Certification Process, which is outlined in the 2025 Final 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 use the federal QIS evaluation methodology to evaluate the QIS submissions of issuers offering coverage through their respective Exchanges; however, issuers should contact the states for

[12] More information about the HIOS MQM system can be found in the HIOS MQM Quick Reference Guide.

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 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 form and/or Progress Report form to the applicable Exchange (see Section 5.3 for additional QIS forms submission guidance for the 2025 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 2025 Plan Year that meet the QIS participation criteria are expected to submit one or more of the QIS forms in calendar year 2024

to either: (a) implement a new QIS beginning no later than January 1, 2025 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 2025 Plan Year if the following conditions apply:

- **An issuer offered coverage through an Exchange in calendar year 2022 and 2023.** The QIS reporting requirements apply to an issuer that has been operating in an Exchange for two consecutive years and will continue operating in the Exchange in calendar year 2024, regardless of whether its QHPs have changed during that time.
    - This phased-in approach gives the issuer the necessary time to understand the populations enrolling in a QHP offered through the Exchange and to build quality performance data on its respective QHP enrollees.
    - If an issuer offered coverage in calendar year 2023 and 2024 (but not in 2022), the issuer would not need to submit a QIS until calendar year 2025 for the 2026 Plan Year.
    - If an issuer is not continuing to offer coverage through an Exchange in the 2025 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, Expanded Bronze, Silver, Gold, Platinum, and Catastrophic) for the following product types: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS) plans, and exclusive provider organizations (EPOs). At this time, the QIS requirements do not apply to child-only plans, SADPs, indemnity plans, or Basic Health Program (BHP) plans. 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 2025 Plan Year QIS submissions.

[13] Issuers are permitted to use a QIS 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.

- **An issuer meets the QIS minimum enrollment threshold.** An issuer that had more than 500 enrollees within a product type per state as of July 1 of the prior year meets the minimum enrollment threshold. An issuer that changed product types will continue to meet the minimum enrollment threshold when the 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. An issuer that meets 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.

How Many QIS Implementation Plans Should an Issuer Submit?

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

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

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, SADPs, indemnity plans, or BHP plans should not be included in the minimum enrollment calculation.
- If issuers offer QHPs of the same product type in both the Individual Exchange and SHOP 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 calendar years 2022 and 2023, and continued offering coverage in calendar year 2024, in three states—West Virginia (WV), Florida (FL), and North Carolina (NC)—has applied for certification of those QHPs in calendar year 2024 for the 2025 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 West Virginia and Florida. The issuer does not need to submit a QIS Implementation Plan in North Carolina because it did not have a sufficient number of enrollees within each product type as of July 1, 2023.

Exhibit 2: Example Issuer Submissions Assessed Against QIS Participation Criteria

Reporting Unit	Number of Enrollees in the Product Type as of July 1, 2023 (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 – FL	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 Progress Report submissions. As such, an issuer must submit two consecutive years of Progress Report forms 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.

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[14]
2019	2020	2022 and 2023	2023	2024 and 2025
2020[15]	*2021*	*2022 and 2023*	*2023*	*2024 and 2025*
2021	2022	2023 and 2024	2024	2025 and 2026
2022	2023	2024 and 2025	2025	2026 and 2027
2023	2024	2025 and 2026	2026	2027 and 2028
2024	2025	2026 and 2027	2027	2028 and 2029

An issuer may discontinue 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 Progress Report form. If the issuer's product type(s) meets the minimum enrollment threshold for the third consecutive year of submitting a Progress Report form, the issuer must submit the Progress Report form for an additional two consecutive years.

[14] If an issuer's product type does not meet the minimum enrollment threshold when reassessed, the issuer would no longer be required to report on a QIS 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.

[15] 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 COVID-19 and Suspension of Certain Activities Related to the Health Insurance Exchange Quality Rating System, QHP Enrollee Experience Survey (QHP Enrollee Survey) and Quality Improvement Strategy Programs memo, available at: https://www.cms.gov/files/document/covid-qrs-and-marketplace-quality-initiatives-memo-final.pdf.

After the submission of those two additional Progress Report forms, there would be another reassessment of minimum enrollment size prior to the sixth consecutive year of submission of the Progress Report form. This reassessment would continue after every two consecutive years of submission of Progress Report forms.

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 meet the minimum enrollment threshold after two more consecutive years of Progress Report submissions. Instructions for how to calculate the minimum enrollment threshold are provided in Section 5.2.[16]

5.3 QIS Implementation Plan, Progress Report, and Modification Summary Supplement Forms

The QIS forms are separated into three component parts: the Implementation Plan form, the Progress Report form, and the Modification Summary Supplement form.

- Issuers submitting a new QIS complete must submit the Implementation Plan form only, while issuers continuing a QIS must submit the Progress Report form only.
- Issuers discontinuing a QIS and implementing a new QIS must submit the Implementation Plan form and Progress Report Closeout form.
- Issuers modifying components of an existing QIS for the upcoming year must submit the Modification Summary Supplement form and the Progress Report form.[17]

See Exhibit 16 in the QIS User Guide for a decision tree to determine the appropriate form(s) for submission.

Issuers applying for QHP certification in FFE states for the 2025 Plan Year and that meet the QIS participation criteria are expected to submit a QIS form in calendar year 2024 to either: (a) implement a new QIS beginning no later than January 1, 2025, (b) provide a progress update on an existing QIS, or (c) modify an existing QIS.[18]

5.3.1 QIS Forms Purpose and Use

The Implementation Plan form is prospective, detailing the components of the QIS an issuer plans to implement on January 1 of the upcoming plan year.

[16] Minimum enrollment is assessed prior to the third year in which an issuer would be reporting on progress on their QIS. Minimum enrollment is also assessed prior to the sixth year in which an issuer would be reporting on progress for a particular QIS. If an issuer closes out a QIS prior to the third year of progress reporting, the minimum enrollment will be assessed prior to the third year of progress reporting on the new QIS.

[17] Beginning with the 2025 Plan Year QHP Application Period, issuers who want to make changes to an existing QIS but have already submitted two Modification Summary Supplement forms to change the same QIS must submit a Progress Report Closeout form to discontinue that QIS and submit a new Implementation Plan form to establish a new QIS.

[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.

The Progress Report form is a retrospective look at the progress each issuer has made on the QIS since the last submission. This form is also used to discontinue and close out an existing QIS.

The Modification Summary Supplement form is also prospective, describing modifications to components of an existing QIS related to topic areas, product types, goals, activities, measures, or performance targets that the issuer plans to make in the upcoming plan year.

All issuers, regardless of submission type, must use the updated QIS forms.

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

The goal of the QIS forms is to collect information from issuers that demonstrates compliance with section 1311(c)(1)(E) of the PPACA. This information also facilitates CMS' 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 that their 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 they have examined their enrollee population and have designed a QIS that provides market-based incentives to drive quality improvement and improved health outcomes.

Issuers use the QIS forms to submit an Implementation Plan, Progress Report, and Modification Summary Supplement, as necessary, to the relevant Exchange. CMS has updated the submission type options to reflect the new separate forms and submission scenarios. Issuers should determine which forms are applicable for their submission scenario by reviewing the information in the QIS Issuer List posted to the MQI website. Issuers should also review the decision tree in Exhibit 16 in the QIS User Guide to help determine the appropriate form(s) for submission.

Once issuers have determined which form(s) they need to submit for the 2025 Plan Year, they should follow the applicable instructions throughout this document based on their determination of which forms are appropriate for that year. During the 2025 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:
    - New QIS After Discontinuing a QIS Submitted During a Prior Qualified Health Plan (QHP) Application Period

[19] The 2025 QHP Application Period occurs in calendar year 2024.

    - New QIS with No Previous QIS Submission[20]
- Progress Report form options:
    - Progress Report
    - Progress Report Closeout
    - Modification Summary Supplement form option:
        - Modification Summary Supplement

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. Issuers submitting the Modification Summary Supplement form to continue an existing QIS with modification(s) must also complete the Progress Report form to report progress on the QIS.

The different types of QIS submissions are identified and described in Exhibit 4.

Exhibit 4: Type of QIS Submission

Type of QIS Submission	Description of Each Submission Type
Implementation Plan forms	
New QIS After Discontinuing a QIS Submitted During a Prior QHP Application Period	▪ Select if the issuer: – Changed its Market-Based Incentive sub-type (Element 21), – Determines that its QIS is not having the expected impact, – Determines that its QIS resulted in unintended consequences (e.g., negative impact on enrollee population), and/or – Submitted two Modification Summary Supplement forms to change the same QIS and intends to modify the existing QIS for a third time. ▪ If selected, the issuer must discontinue its existing QIS by submitting a Progress Report Closeout form and implement a new QIS by submitting a new Implementation Plan form.[21]
New QIS with No Previous QIS Submission	▪ Select if the issuer: – Did not submit a QIS during the PY2024 QHP Application Period and meets the QIS requirements for the 2025 Plan Year specified in Section 5.1.1, or – Has a QIS on file and is submitting a new QIS that has not previously been submitted to an Exchange (e.g., the new QIS differs from the issuer's prior QIS due to changes in market-based incentive or certain other components that warrant a new QIS submission, as described in Exhibit 5 below). The issuer will continue reporting on progress for their existing QIS on file via the Progress Report form and will implement a new QIS by submitting a new Implementation Plan form.

[20] 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 incentives or certain other components that warrant a new QIS submission.

[21] Issuers may choose to discontinue a QIS for other reasons; however, as noted above, issuers are encouraged to leave a QIS in place for at least two years.

Type of QIS Submission	Description of Each Submission Type
Progress Report forms	
Progress Report (i.e., Continuing a QIS Submitted During a Prior QHP Application Period and Making No Changes or Making Changes that Do Not Warrant a Modification)	▪ Select if the issuer: – Is continuing its current QIS and is reporting progress on it, and/or – Is making one or more of the following changes to an existing QIS: • Updates to issuer information, • Updates to current payment model(s) description, • Updates to data sources, • Changes made in response to the prior year's QIS evaluation results not affecting Topic Areas, Goals, Activities, Product Types, Performance Targets, or Measures,[22,23] and/or • Other information not listed in the "Continuing QIS with Modifications" in this exhibit.
Progress Report Closeout Form (i.e., Discontinuing a QIS Submitted During a Prior Application Period)	▪ Select if the issuer: – Changed its Market-Based Incentive sub-type (Element 21), – Determines that its QIS is not having the expected impact, – Determines that its QIS resulted in unintended consequences (e.g., negative impact on enrollee population), and/or – Previously submitted two Modification Summary Supplement forms to change the same QIS and wants to modify the existing QIS for a third time. ▪ If selected, the issuer is discontinuing its existing QIS and must implement a new QIS by submitting a new Implementation Plan form.[24]
Modification Summary Supplement forms	
Continuing QIS with Modifications (i.e., Continuing a QIS Submitted During a Prior Application Period and Making Changes that Warrant a Modification)	▪ Select if the issuer is continuing and modifying an existing QIS to make one or more of the following changes: – Topic Area(s), – Product Types, – Goals, – Activity(ies) That Will Be Conducted to Implement the QIS, and/or – Measure(s) and Performance Target(s) to monitor QIS Progress. ▪ These issuers must also complete the Progress Report form.

5.3.2 Changing a QIS

Some issuers submitting a Progress Report form may choose to make changes to their Implementation Plan(s) submitted in a prior QHP application period. Certain changes can be made year over year and captured in updates provided as part of the Progress Report, while some changes necessitate completion of the Modification Summary Supplement form and others require issuers to discontinue the QIS and implement a new QIS. Beginning during the PY2025 QHP Application Period, issuers who want to make changes to their QIS but have already

[22] Changes made in response to the prior year's QIS evaluation results not affecting Topic Areas, Goals, Activities, Product Types, Performance Targets, or Measures do NOT warrant a modification to the QIS. Instead, in Element 17 of the Progress Report form, Summary of Progress, issuers must explain any changes made to address the prior year's QIS evaluation results 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 of the QIS User Guide for further details.

[23] Changes made in response to the prior year's QIS evaluation results that affect Topic Areas, Goals, Activities, Product Types, Performance Targets, or Measures do warrant a modification to the existing QIS submission and trigger the requirement to submit a Modification Summary Supplement form. See Section 5 of the QIS User Guide for more information.

[24] Issuers may choose to discontinue a QIS for other reasons; however, as noted above, issuers are encouraged to leave a QIS in place for at least two years.

submitted two Modification Summary Supplement forms to change the same QIS must discontinue that QIS and submit a new Implementation Plan form to implement a new QIS that reflects the additional desired changes. For each QIS that is modified by submission of the Modification Summary Supplement form, CMS will keep the Modification Summary Supplement form on file along with the relevant Implementation Plan form already on file and any applicable Progress Report forms and amend the baseline data for the relevant strategy (as applicable). Exhibit 5 provides information about the QIS submission requirements for and implications of changing various components of the QIS.

Exhibit 5: Changing Components of a QIS

No Implications/Completion of Progress Report form	Implementing a New QIS After Discontinuing a QIS	Completion of Modification Summary Supplement Form
▪ Update issuer information, ▪ Update current payment model(s) description, ▪ Update data sources, and/or ▪ Update other information not listed in the other columns in this Exhibit.	▪ Change QIS market-based incentive sub-type, ▪ The QIS is not having the expected impact, and/or ▪ The QIS results in negative outcomes or unintended consequences.	▪ Change QIS topic areas, ▪ Change QIS goals,[25] ▪ Change QIS activities, ▪ Change QIS measures, ▪ Change performance targets, and/or ▪ Change product types.

5.3.3 QIS Forms Structure

The sections of the QIS forms and their parts are listed in Exhibit 6.

Exhibit 6: QIS Forms – Sections and Parts

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

New issuers that have not previously submitted a QIS to an Exchange, issuers that are submitting a new QIS after discontinuing a QIS, or issuers that are submitting a new QIS that has not been previously submitted to an Exchange while continuing to report on progress for an existing QIS, will complete all sections of the Implementation Plan form. Issuers that are continuing an existing QIS will complete and submit a Progress Report form for that strategy. Issuers that wish to modify components of an existing QIS related to topic areas, product types, goals, activities,

[25] In Part D of the 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 in order to track the issuer's progress toward meeting its QIS goals.

measures, or performance targets will complete the Modification Summary Supplement form[26] in addition to the 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 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, Parts A and B of the Progress Report form, and Parts A and B of the Modification Summary Supplement form for completeness, but will not score these parts. Furthermore, CMS will review the information submitted in Part E of the Implementation Plan form, Part C of the Progress Report form, and Part C of the Modification Summary Supplement form for completeness **and** will 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 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 Completeness Assessment and Evaluation

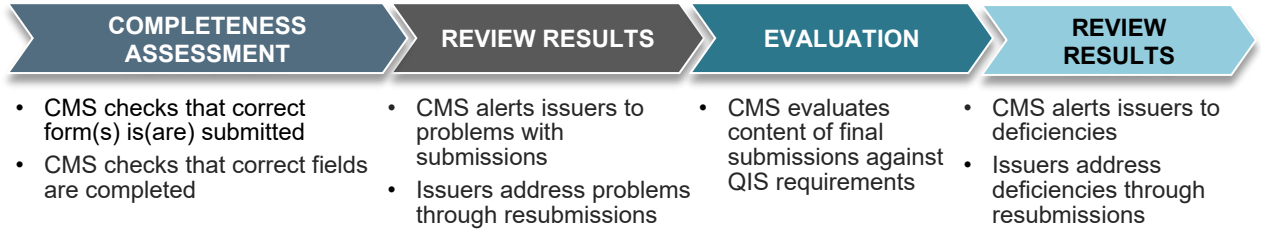
On an annual basis, issuers must meet the QIS requirements as part of the QHP Certification Process. Submitted QIS forms go through a series of reviews and communications referred to as the Completeness Assessment and Evaluation process. During the QHP Application Period, CMS[27] will assess QIS submissions for completeness and, following the conclusion of the QHP Application Period, CMS will evaluate the completed QIS forms to determine if they meet the QIS requirements. CMS will communicate QIS completeness assessment and evaluation results (e.g., identified deficiencies, potential concerns, and recommended actions to issuers). Exhibit 7 details the activities involved in each stage of the QIS Completeness Assessment and Evaluation process. CMS assesses and evaluates each issuer's QIS submission to determine whether the issuer's QIS meets the applicable requirements according to the applicable plan year's QHP Application and Certification Process review stages and timeline.[28] Exhibit 7 provides a high-level overview of the Completeness Assessment and Evaluation QIS submissions will undergo.

[26] See Section 5.3.1, Section 5.3.2, Exhibit 4, and Exhibit 5 of this Technical Guidance for information on the types of updates to a QIS that do not trigger the requirement to submit the Modification Summary Supplement form.

[27] 45 CFR § 155.200(d) directs the Exchange to evaluate QIS submissions. For an FFE state, CMS will perform the assessments and 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 made by CMS. For SBE states, the SBE will perform the assessments and evaluations.

[28] See the 2025 Plan Year QHP Data Submission Key Dates Timeline available at: https://www.qhpcertification.cms.gov/s/Timeline.

Exhibit 7: Completeness Assessment and Evaluation Process



In calendar year 2024, issuers submitting an Implementation Plan form will be required to provide information on the entire Implementation Plan form as part of their QHP application for the 2025 Plan Year, which includes the following sections[29]:

- 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 2024 Plan Year QHP applications are required to report on progress during the PY2025 QHP Application Period. These issuers do not need to complete an Implementation Plan form to report progress on those strategies.[30] Issuers can also use the Progress Report form to report certain updates to an existing QIS (e.g., to update issuer information, current payment model(s) descriptions and data sources).[31] As part of their QHP application for the 2025 Plan Year, these issuers are only required to submit information on the Progress Report form, which includes the following sections:

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

If issuers are modifying components of their existing QIS to make changes related to topic areas, product types, goals, activities, measures, or performance targets, in addition to reporting on progress via the Progress Report form, the issuer must submit the Modification Summary Supplement form, which includes the following sections:

- Part A: QIS Submission,
- Part B: Issuer Information, and
- Part C: QIS Modification Summary.

[29] This includes issuers submitting a new QIS after discontinuing a QIS submitted during a prior QHP Application Period, issuers submitting a new QIS in situations where there were no previous QIS submissions, and issuers submitting a new QIS that has not been previously submitted to an Exchange, while also continuing to report on progress for an existing QIS.

[30] An exception to this general rule is for issuers that use the Progress Report form to discontinue and close out an existing QIS who must also implement a new QIS by submitting a new Implementation Plan form. See Section 5.3.1, Section 5.3.2, Exhibit 4, and Exhibit 5 of this Technical Guidance for more information.

[31] See Section 5.3.1, Section 5.3.2, Exhibit 4, and Exhibit 5 of this Technical Guidance for more information on the different types of updates to an existing QIS and the different types of QIS submissions.

Beginning with the 2025 Plan Year QHP Application Period, issuers who want to make changes to an existing QIS but have already submitted two Modification Summary Supplement forms to change the same QIS must submit a Progress Report Closeout form to discontinue that QIS and submit a new Implementation Plan form to establish a new QIS.

For more information about how issuers determine which forms to submit, please see the decision tree in Exhibit 16 in the QIS User Guide.

6.1 QIS Form Completeness Assessment Process

CMS assesses the completeness of QIS forms received during each submission window of the QHP Application Period. Following the initial submission window, only issuers that meet the QIS participation criteria but did not submit at least one QIS as required will receive notification that they must submit a QIS.

Following the close of the rate review submission window, issuers whose submissions contain blank fields and/or are missing required information will receive review results indicating which fields were missing information. Issuers that are notified of missing information errors must correct and resubmit their QIS form(s)[32] during the subsequent submission window within the current QHP Application Period. CMS does not notify issuers if their QIS submissions are assessed as fully complete.

Following the close of the final submission window, issuers that meet the QIS participation criteria but did not submit at least one QIS as required will receive notification that they must submit a QIS.

Exhibit 8 outlines the three scenarios in which an issuer will receive correction notifications and the estimated communication time frame.

Exhibit 8: Corrections Timeline

QIS Submission Status	Corrections Timeline
Issuer meets the QIS participation criteria but did not submit at least one QIS as required during the initial submission window.	The issuer will receive notification following the initial submission period.
Issuer meets the QIS participation criteria and submitted at least one QIS during the initial submission window, but the QIS form(s) is(are) missing information.	The issuer will receive notification of required corrections following the rate review period.
Issuer meets the QIS participation criteria but did not submit at least one QIS as required during the subsequent submission window in the current QHP Application Period.	The issuer will receive notification following the final submission period.

Once a QIS submission is deemed complete, CMS will then begin the evaluation process.

[32] Note: Issuers must only resubmit the form for which the correction was identified.

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. CMS assesses the following inputs for completeness: all fields in Elements 1–19 in Parts A–D of the Implementation Plan form, Elements 1–15 in Parts A–B in the Progress Report form, and Elements 1–7 in Parts A–B in the Modification Summary Supplement form.

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. For Part C of the Modification Summary Supplement form, CMS uses a "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 form, Part C of the Progress Report form, and Part C of the Modification Summary Supplement form.

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 its submission: (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 20–25 and 27 in Part E of the Implementation Plan form are must-pass, and there is no partial credit offered for these seven 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 26 in Part E of the Implementation Plan form 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 9 for details on the scored elements that issuers are required to address in Part E of the Implementation Plan form.

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

Element Type	Definition	Individual Elements
Must-Pass Elements	▪ Issuer must meet all criteria within an element to receive 1.00 point. ▪ There is no partial credit; meeting less than all criteria results in receipt of 0.00 point. ▪ Receiving 0.00 point on any must-pass element will result in issuer receiving a correction notification.	▪ Element 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	▪ 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.	Element 26: Timeline for Implementing the QIS

CMS scores Element 26 (Timeline for Implementing the QIS) in Part E of the Implementation Plan form, 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 10 for details.

Exhibit 10: Scoring Scale for Element 26 in the Implementation Plan Form (Part E)

		100%	50%	0%
Element 26, Timeline for Implementing the QIS (2 criteria)	*# of Criteria Met*	Issuer meets 2 criteria	Issuer meets 1 criterion	Issuer meets no criteria
	Points Awarded	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 of the Progress Report form 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 in Part C of the Progress Report form 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 in Part C of the Progress Report form 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 11 for details on the scored elements that issuers are required to address in Part C of the Progress Report form.

Exhibit 11: Progress Report Form (Part C) Scored Elements by Type

Element Type	Definition	Individual Elements
Must-Pass Elements	▪ Issuer must meet all criteria within an element to receive 1.00 point. ▪ There is no partial credit; meeting less than all criteria results in receipt of 0.00 point. ▪ Receiving 0.00 point on any must-pass element will result in issuer receiving a correction notification.	▪ Element 16: Analyze Progress Using Baseline Data, as Documented in the Implementation Plan ▪ Element 17: Summary of Progress
Other Scored Elements	▪ Issuer may receive partial credit based on how many criteria within an element are met. ▪ Issuer must receive at least 50 percent (0.50 point) on each of these elements to receive full credit.	Element 18: Barriers and Mitigation Activities

CMS scores Element 18 (Barriers and Mitigation Activities) in Part C of the Progress Report form, 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 receives full credit (i.e., 100 percent or 1.00 point) for meeting both criteria. See Exhibit 12 for details.

Exhibit 12: Scoring Scale for Element 18 in the Progress Report Form (Part C)

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

6.3.3 Modification Summary Supplement Form (Part C) Scoring

There is one element in Part C of the Modification Summary Supplement form, it is scored, and it is worth 1.00 point. An issuer will receive a passing score for Part C of the Modification Supplement form if it meets all the criteria (i.e., receives 1.00 point).

Element 8 in Part C of the Modification Summary Supplement form is must-pass. 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. See Exhibit 13 for details on the element that issuers are required to address in Part C of the Modification Summary Supplement form.

Exhibit 13: Modification Summary Supplement Form (Part C) Scored Elements by Type

Element Type	Definition	Individual Elements
Must-Pass Elements	▪ Issuer must meet all criteria within an element to receive 1.00 point. ▪ There is no partial credit; meeting less than all criteria results in receipt of 0.00 point. ▪ Receiving 0.00 point on any must-pass element will result in issuer receiving a correction notification.	Element 8: Modifying Topic Areas, Product Types, Goals, Activities, and Measures or Associated Performance Targets

6.3.4 QIS Forms Evaluation Process and Evaluation Outcomes

CMS will begin its evaluations of complete QIS submissions after the close of the PY2025 QHP Application Period (in calendar year 2024). CMS will communicate evaluation results for QIS submissions for the 2025 Plan Year to issuers in the late fall of 2024.

Based on the results captured in the QIS evaluation, CMS assigns an overall outcome of "Meets," "Interim Meets," or "Does Not Meet" to each issuer's QIS submission(s). Note, the "Interim Meets" designation only applies to the Progress Report form. Exhibit 14 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. Issuers are expected to make corrections to the form(s) through resubmissions following the release of the QIS evaluation results as directed by CMS.

At this time, CMS does not penalize issuers if they do not achieve the performance targets set out in their QIS Implementation Plan forms; however, these issuers are required to track progress and adjust their quality improvement strategy, as appropriate.[33]

Exhibit 14: Scoring Designations

Score	Conditions
Meets	▪ An issuer receives a scoring designation of "Meets" for its Implementation Plan form if it: (1) successfully completes all fields in Elements 1–20 in Parts A–E, 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 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 Part C (see Section 6.3.2). ▪ An issuer receives a scoring designation of "Meets" for its Modification Summary Supplement form if it: (1) successfully completes all fields in Elements 1–7 in Parts A–B, and (2) **successfully completes all elements and criteria AND** receives a passing score for Element 8 in Part C (see Section 6.3.3).
Does Not Meet	▪ An issuer receives a "Does Not Meet" scoring designation if it is still missing any critical information in its Implementation Plan form, Progress Report form, or Modification Summary Supplement form following the QHP Application Period or does not receive a passing score for Part E of the Implementation Plan form, Part C of the Progress Report form, or Part C of the Modification Summary Supplement form after evaluation. CMS will require the issuer to correct and resubmit its QIS form(s) following the release of the 2025 Plan Year QIS evaluation results as directed by CMS. Additionally, the issuer may be required to develop a Work Plan to address identified deficiencies.[34] ▪ An issuer receives a "Does Not Meet" scoring designation if it makes the same "Interim Meets" type of error two years in a row in its Progress Report form.
Interim Meets	An issuer can receive a scoring designation of "Interim Meets" for its Progress Report form if one or more deficiencies prevent the issuer from receiving a passing score for Part C, but CMS deems that the intent of the element or criterion is still understood. An example would be a minor data entry error(s) like the rate provided does not equal the numerator divided by the denominator. The "Interim Meets" designation requires an issuer to confirm and correct any deficiencies in its Progress Report form in the relevant QIS upon submission(s) for the 2025 Plan Year. ***Note: An issuer may not receive an "Interim Meets" designation on the same type of error two years in a row. If an issuer makes the same type of error two years in a row, the issuer will receive a "Does Not Meet" designation and must correct the error within the form they submitted for the applicable plan year.***

[33] See the 2016 Payment Notice, 80 FR 10750 at 10876.

[34] The Work Plan may be required as part of CCIIO's QHP compliance reviews.

6.3.5 QIS Evaluation Results Communication

After CMS conducts an evaluation of complete QIS submissions to determine whether the QIS meets the QIS requirements, communications will be made to issuers to inform them of their evaluation results. CMS will begin evaluation after the close of the PY2025 QHP Application Period (in calendar year 2024) and will communicate QIS evaluation results (including identified deficiencies, potential concerns, and recommended actions) to issuers in the fall of 2024. Exhibit 15 describes the different CMS QIS evaluation results communications.

As part of the FFE's annual QHP Application and Certification Process, an issuer must attest to complying with each Exchange certification standard.[35] 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.

Exhibit 15: CMS QIS Evaluation Results Communication

Score	Conditions
Meets	CMS does not notify issuers if their QIS submissions receive an overall outcome of "Meets."
Does Not Meet	If an issuer receives a "Does Not Meet" designation, the issuer must confirm receipt of the feedback and correct all potential concerns following the release of the 2025 Plan Year QIS evaluation results as directed by CMS. Additionally, these issuers may be required to develop a Work Plan to address identified deficiencies.
Interim Meets	If an issuer submission receives an "Interim Meets" designation for its Progress Report submission, the issuer must confirm receipt of the feedback and correct any instances of data entry errors in the relevant QIS submission for the 2025 Plan Year. Note: An issuer may not receive an "Interim Meets" designation on the same type of error two years in a row. If an issuer makes the same type of error two years in a row, the issuer receives a "Does Not Meet" designation and must correct the error for the 2025 Plan Year.

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

Volume II. QIS User Guide for the 2025 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 PY2025 QHP applications.[36] Issuers should also review the 2025 Final Letter to Issuers for additional guidance specific to the 2025 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 QRS and QHP Enrollee Survey.[37]

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

Step 1: Select 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 select the file name to view it.

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

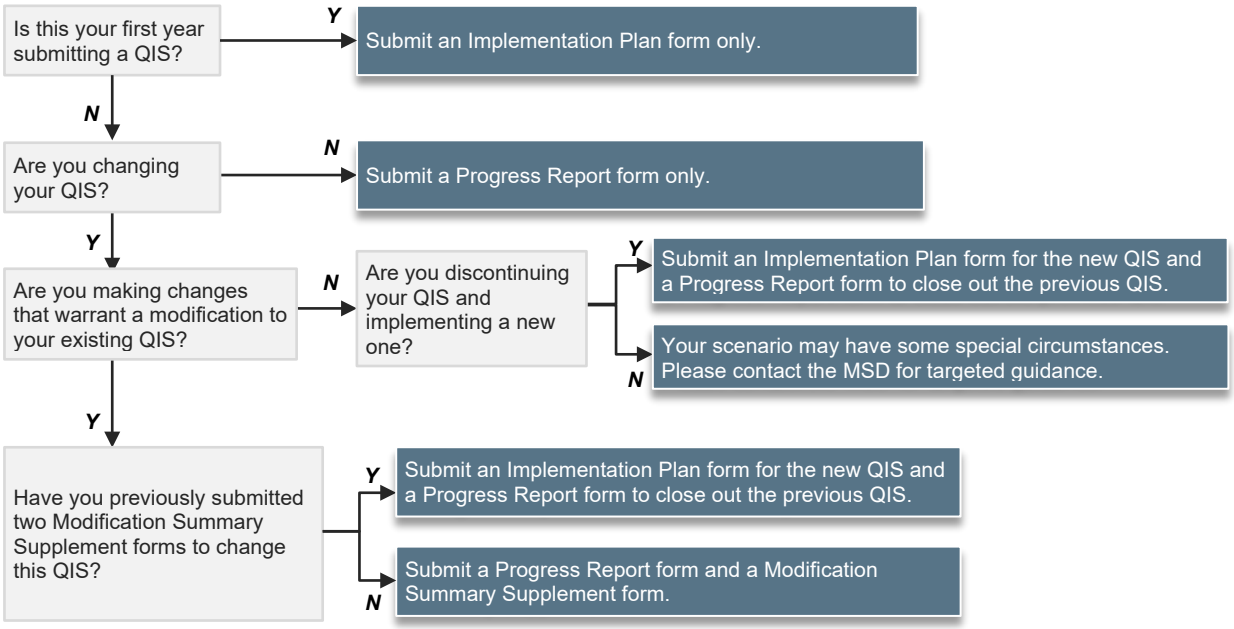
1.2 Determine Which QIS Form(s) to Complete

There are three separate QIS forms: the Implementation Plan form, Progress Report form, and Modification Summary Supplement form. Issuers participating in an FFE and FFEs where the state performs plan management that meet the QIS participation criteria, regardless of submission type, must use the updated QIS forms. Exhibit 16 outlines the decision criteria issuers can use to determine which QIS form(s) to submit.

[36] The PY2025 QHP Application Period occurs in calendar year 2024. See the 2025 Plan Year QHP Data Submission Key Dates Timeline available on the CMS website. The 2025 Plan Year occurs in calendar year 2025.

[37] 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.

Exhibit 16: QIS Form(s) Selection Decision Tree



1.3 Prepare to Complete the QIS Forms

After reviewing the Technical Guidance and User Guide, issuers submitting a new QIS must complete the Implementation Plan form, and issuers continuing a QIS must complete the Progress Report form (and Modification Summary Supplement form, as applicable) by following these instructions:

Step 1: Select the PDF file(s) titled "QIS Implementation Plan form," "QIS Progress Report form," and/or "QIS Modification Summary Supplement form" (as applicable) and confirm that "2025 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, QIS Progress Report form and/or QIS Modification Summary Supplement form (as applicable) by following the instructions provided in Volume II, Sections 2, 3, 4, and 5 below.

This Technical Guidance and User Guide provides information and instructions for all three forms; however, issuers must determine which form options and instructions apply to them by reading the detailed QIS participation criteria and/or reviewing the QIS Issuer List on the MQI website.

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.[38] Issuers may not upload additional materials beyond the form itself via SERFF or HIOS, and CMS will not accept any additional materials 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 refer to it as often as necessary. Save the forms regularly as responses are entered.

2. Complete Introductory Sections of the Applicable QIS Forms

All issuers must complete Parts A–C of the Implementation Plan form and/or Parts A and B of the Progress Report form and Modification Summary Supplement form (as applicable) for the respective QIS submission. An issuer must submit the appropriate complete form(s) to each Exchange in which the QHP associated with the QIS is offered. Parts A and B of each form consist of the following two sections:

- **Part A: QIS Submission Type**
    - Type of QIS Submission (Implementation Plan form): New after Discontinuing[39] or New with No Previous Submission
    - Type of QIS Submission (Progress Report form): Progress Report or Progress Report Closeout form
    - Type of QIS Submission (Modification Summary Supplement form): Continuing QIS with Modifications
    - Targets All QHPs and Product Types Offered Through an Exchange (found in Implementation Plan form only)
- **Part B: Background Information**
    - Issuer Information
    - Current Payment Model(s) Descriptions (found in Implementation Plan and Progress Report)

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

[38] See 45 CFR § 156.705.

[39] Beginning with the PY2025 Plan Year QHP Application Period, issuers who want to make changes to their QIS but have already submitted two Modification Summary Supplement forms to change the same QIS must submit a Progress Report Closeout form to discontinue that QIS and submit a new Implementation Plan form to establish a new QIS.

TIP: Issuers must complete the Submission Date field at the top of each form to indicate the date they're submitting the form to CMS.

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

TIP: CMS will blind and redact submissions to remove any identifying information prior to evaluation for scoring. 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 for each form.

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 Part A. QIS Submission Type

Part A of each of the QIS forms ask issuers to identify what type of QIS submission they are making. During the PY2025 QHP Application Period, issuers will complete the Implementation Plan form to submit a new QIS with no previous QIS submission, to implement a new QIS after discontinuing an existing QIS, or to implement a new QIS while continuing to report on progress for an existing QIS.[40] Issuers will complete the Progress Report form to report on progress for an existing strategy they're continuing or to close out an existing strategy. Issuers will also need to submit the Modification Summary Supplement form if they wish to modify components of an existing QIS related to topic areas, product types, goals, activities, measures, or performance targets. 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. CMS requires completion of all Part A elements, but will not score them. There are associated criteria in Part A of the Implementation Plan form, but there are no associated criteria in Part A of the Progress Report form or Modification Summary Supplement form.

Issuers continuing a QIS will NOT need to complete and submit the Implementation Plan form, only the Progress Report form (and Modification Summary Supplement form, as applicable).

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

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 available option on the respective form that describes what type of QIS submission the issuer is making (i.e., "Implementing a New QIS with No Previous QIS Submission" or "Implementing a New QIS After Discontinuing a QIS Submitted During a Prior QHP Application Period" in the Implementation Plan form, the "Progress Report" or "Progress Report Closeout Form" in the Progress Report form, or "Continuing a QIS with Modifications" in the Modification Summary Supplement form).

An issuer that does not submit a QIS during the PY2024 QHP Application Period and newly meets the QIS participation criteria for the 2025 Plan Year must select "New QIS with No Previous QIS Submission." An issuer that submitted a QIS during the PY2024 QHP Application Period and would like to implement a new QIS while continuing to report on progress for an existing QIS must also select "New QIS with No Previous QIS Submission."[41] All other issuers that submitted a QIS during the PY2024 QHP Application Period must select from the other submission type options and complete the required sections of the form(s).

If an issuer wants to discontinue its existing QIS and submit a new QIS, it must complete two forms: a Progress Report form to close out and discontinue the existing QIS and an Implementation Plan form for its new QIS. An issuer that is continuing its QIS but wishes to modify components related to topic areas, product types, goals, activities, measures, or performance targets must complete two forms: a Progress Report form to report progress on its QIS and the Modification Summary Supplement form to capture the modifications to its existing QIS. Beginning with the PY2025 QHP Application Period, issuers who want to make changes to their QIS but have already submitted two Modification Summary Supplement forms to change the same QIS must submit a Progress Closeout form to discontinue that QIS and submit a new Implementation Plan form to establish a new QIS. See Appendix B for additional information on how to complete Part A of the forms.

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 in the Implementation Plan form, 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.

[41] 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 or certain other components that warrant a modification to an existing QIS.

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, 2023). QHPs within product types that do not meet the minimum enrollment threshold (i.e., non-eligible QHPs) are not required to be covered by a QIS.[42] 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 an additional QIS for each eligible QHP offered by the issuer through an Exchange.

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 to cover each 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 ensure all eligible QHPs are covered by an existing or new QIS.

To complete Criterion 2b in the Implementation Plan form, check the appropriate box(es) to indicate the product type(s) (e.g., HMO, POS) to which the QIS applies for the 2025 Plan Year.

TIP: If an issuer is adding or removing product types to an existing QIS, the issuer should reflect that in the Modification Summary Supplement form.

2.2 Part B. Issuer Information

Part B of all three QIS forms 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 all three forms:

Step 1: Enter the issuer's legal name into the space provided for Element 3 (PR 2, MS 2[43]).

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, MS 2–4) (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 2024 Plan Year. Once a Modification Summary Supplement form has been submitted, it is considered part of the Implementation Plan on file. Therefore, in the following plan year,

[42] See supra note 14.

[43] Element numbers vary between the Implementation Plan, Progress Report, and Modification Summary Supplement. For clarity, "(PR #, MS #)" has been added after each Implementation Plan element reference to indicate the corresponding element in the Progress Report form or Modification Summary Supplement.

issuers reporting on progress should report on the modified information (if applicable) contained in the Modification Summary Supplement form.

TIP: If the issuer previously completed Elements 3–16 (PR 2–15, MS 2–7) in its Implementation Plan form and is now submitting a Progress Report form 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 background elements do not warrant a modification or require completion of a Modification Summary Supplement form.

Step 2: Enter 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, MS 3).

Enter the HIOS Issuer ID, which is a five-digit numeric identifier that is assigned to each issuer during HIOS registration.[44]

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, MS 4), 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, MS 5-7).

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.

[44] 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.

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.

The information provided in Element 16 (PR 15) will help CMS gauge progress toward meeting value-based payment goals.[45] Exhibit 17 provides a description of each of the four categories.

Exhibit 17: Examples of Payment Models by Category[46]

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 are still triggered by delivery of services, but there are opportunities for shared savings or two-sided risk.
Population-based Payment	Payment is not directly triggered by service delivery, so 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., 1¾) 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.

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

[46] Categories of payment models are defined in the APM Framework: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

3. Complete the QIS Implementation Plan Form (Part C. Data Sources, Part D. QIS Summary, and Part E. QIS Requirements)

For the 2025 Plan Year, eligible issuers starting a new QIS must complete and submit the Implementation Plan form to CMS. This submission will establish a baseline Implementation Plan form, which will be kept on file with CMS. Issuers continuing a QIS no longer need to complete and submit an Implementation Plan form after the first year. In addition to Parts A and B described in the previous section, an Implementation Plan form consists of the following sections:

- **Data Sources Used for Goal Identification and Monitoring Progress**
  - Part C: Data Sources
- **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 form. If any required elements and/or criteria are left blank, the issuer will receive review results indicating that the submission is missing information. The review results will include specific information on which element(s) and/or criteria need information to be revised and resubmitted during the QHP Application Period. ***Note: ONLY the form in which the error is identified needs to be resubmitted.***

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

TIP: Prior to submitting the Implementation Plan form to CMS, an issuer should use the QIS Forms Pre-Submission Checklist provided in Appendix B to confirm it has provided responses to all required[47] elements—including must-pass elements—and criteria. This checklist also helps guide issuers through the submission process.

3.1 Part C: Data Sources

Part C of the Implementation Plan form collects information about the data sources the issuer used to inform the development and implementation of its QIS. CMS uses the information requested in this element 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 Implementation Plan form:

[47] 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.

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);[48] all-payer claims data; state health department population data; and/or regional collaborative health data.

Check one or more boxes to indicate which of the data sources listed in Element 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.

3.2 Part D. QIS Summary

Part D of the 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 CMS will not score these responses. 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 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."

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

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.[49] Issuers may also use information submitted to a recognized accrediting entity for QIS purposes if 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 and the completeness of these responses to each element and criterion throughout the Implementation Plan prior to submission.

3.3 Part E. QIS Requirements

Part E of the Implementation Plan form collects detailed information about the QIS for evaluation. Responses to all elements are required and scored by CMS (with the exception of Element 20, which is required but will not be scored). In addition, there are associated criteria requested in Part E that are also required and scored by CMS.

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 a 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., statement of goals, listing of activities) is required, but will not be scored. If any element is left blank, the issuer will receive notification that its submission is missing information. The notification will specify which element(s) and/or criteria need to be revised and resubmitted.

Follow these steps to complete Part E. QIS Requirements in the Implementation Plan form:

Step 1: 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 22. Issuers must address at least one, but no more than two, goals in support of their QIS.

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

TIP: Issuers should not include specific performance targets or tie goals to a specific calendar year or plan year because the Implementation Plan form will remain on file and references to specific years or performance targets will likely become outdated over time.

Step 2: 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 reduction[50]) the QIS includes. An issuer may choose to implement a provider market-based incentive, an enrollee market-based incentive, or both.

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" is 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.

Step 3: 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.[51] Issuers may select more than one topic to address with a single QIS.

TIP: QHP issuers are required to select "Reduce health and health care disparities" as a topic area within at least one of their quality improvement strategies on file. Issuers may achieve this by either submitting one Implementation Plan that selects at least one topic area in addition to "Reduce health and health care disparities;" by submitting two Implementation Plans, one that selects the "Reduce health and health care disparities" topic area and another that focuses on another topic area; or by submitting multiple Implementation Plans with at least one that selects the "Reduce health and health care disparities" topic area.

TIP: If an issuer selects "Reduce health and health care disparities" as a topic area, it must state the population(s) addressed by the quality improvement strategy.

TIP: If an issuer wants to change its topic area selections for an existing QIS, it must submit a Modification Summary Supplement form.

[50] 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).

[51] Section 1311(g)(1) of the PPACA.

Step 4: 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 current QHP enrollee population and how the QIS will address the needs of the current population. [52]

Step 5: List the activities implemented to achieve the identified goals. Describe how the activities advance the QIS in the space provided in must-pass Element 24. Be sure to address all of the specified criteria (i.e., a–c)

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 and (2) the topic area(s) chosen in Element 22.

For example, assume an issuer selects "Preventing hospital readmissions" and "Reduce health and health care disparities" as its QIS topic areas, "Bonus payments" to providers as its market-based incentive, and "reducing readmission rates for the age 64-and-under patient population with an index admission of heart failure from the baseline assessment" as its goal. The issuer's QIS 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 providing information on community supports and services.

To complete Criterion 24a, list the activities that will be implemented to achieve the identified goals.

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).

Step 6: 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(s) 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 form 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 form.

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

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 form.

For Criteria 25a, 25f, 25k, and 25p, in addition to the measure name, an issuer must provide a narrative description of the measure, including a clear description of the measure numerator and denominator if a rate was provided. If the issuer provided a data point for the measure, a clear description of how the data point was calculated must be provided in Criterion 25a. Next, the issuer should specify whether it is using a consensus-based entity (CBE)-endorsed measure by checking "Yes" or "No."[53] If it selects "Yes," the issuer should provide the CBE ID in the space provided and indicate whether the issuer modified the CBE-endorsed measure specifications.

TIP: Issuers are not required to use CBE-endorsed measures to complete Element 25. However, if an issuer chooses to do so, it must include the measures' CBE 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 example, issuers may reference benchmarks for the measures collected for the Quality Rating System (QRS) via the Nationwide QRS Public Use File (PUF).[54] CMS releases the Nationwide QRS PUF annually and anticipates releasing the PUF prior to the start of the individual market open enrollment period.[55]

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.

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[53] The CBE sets measure evaluation criteria through experts and multi-stakeholder groups involved in the evaluation process. For further details regarding CBE endorsed quality measures, please visit the CBE measure database (http://www.p4qm.org/measures).

[54] [54] The Nationwide QRS PUF for Plan Year 2024 is available for download on the CMS MQI website: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/aca-mqi/downloads/mqi-downloads.

[55] The individual market open enrollment period starts on November 1 of the calendar year before the applicable plan year. See 45 CFR 155.410(e)(4). The 2025 Plan Year individual market open enrollment period will begin on November 1, 2024.

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.

TIP: Baseline assessment results should measure an issuer's performance before implementation of the QIS.

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 baseline data needed to complete their QIS submissions by the final 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. If the final, validated measure rates differ from what was submitted in the Implementation Plan, issuers may update their QIS by submitting Modification Summary Supplement form with updated baseline data in the following plan year's QHP Application Period.

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 must specify the baseline performance period (e.g., measurement year) covered by the baseline data assessment provided in the Implementation Plan on file for each respective QIS.

To complete Criteria 25e, 25j, 25o, and 25t, provide the performance target for each specified measure.

TIP: The numerical value performance target should be a rate (%) or a data point target, NOT a percentage change.

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).

Step 7: 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 or will **first** begin implementing the QIS for the Exchange product types and health plans specified in Element 2.

For example, an issuer that submitted its initial Implementation Plan form during the PY2019 QHP Application Period (calendar year 2018) and its initial Progress Report form during the PY2020 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 Implementation Plan form for the first time during the PY2025 QHP Application Period (calendar year 2024) should list its QIS initiation/start date as 01/2025 or earlier (if applicable).

TIP: 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/start 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 as the prior year's submission when continuing a QIS.

Step 8: 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 27a. Issuers will not be penalized for any barriers they may encounter.

Step 9: If applicable, provide any additional information on the Implementation Plan form that reviewers may find useful in the Optional text box. This field will not be scored.

Step 10: Save the completed Implementation Plan form 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 Implementation Plan form as a PDF file. The file name should follow this naming convention: **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP]**. For example, a file named "12345_Issuer ABC_QIS_IP" 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]_[#]**. For example, if an issuer submits two 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 copy of the completed Implementation Plan form and make it available to any staff who may be responsible for QIS implementation and reporting. Issuers should refer to their completed Implementation Plan form each year to facilitate any corrective actions they may need to take based on the QIS evaluation results and to help complete the Progress Report form and Modification Summary Supplement form, if applicable, in future years.

4. Complete the QIS Progress Report Form

In each subsequent year following the submission of an Implementation Plan form, an issuer must submit a Progress Report form to the applicable Exchange. The Progress Report form collects information about the issuer's progress in implementing its QIS. **Note: Issuers completing a Progress Report form NO LONGER need to resubmit the Implementation Plan form for a continuing QIS.** Issuers also use the Progress Report form to discontinue and close out an existing QIS.

Issuers that submitted an Implementation Plan form, Progress Report form, or Modification Summary Supplement form for the 2024 Plan Year are required to report on activities conducted to implement the QIS by completing and submitting applicable section(s) of the 2025 Plan Year Progress Report form. Issuers submitting a QIS for the first time during the PY2025 QHP Application Period are not required to submit a Progress Report form until the PY2026 QHP Application Period.

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

- Enter submission date at the top of the first page,
- Attest that they have reviewed the Implementation Plan form on file in preparing the Progress Report form to ensure all the baseline information is correct,
- 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 A: QIS Submission

There are two QIS Submission Types for the Progress Report form: "Progress Report" and "Progress Report Closeout Form."

If an issuer is continuing an existing QIS and is NOT making changes that warrant a modification, they should select the "Progress Report" option and ONLY complete the Progress Report form. If an issuer is continuing an existing QIS and is also making changes that warrant a modification, they should select the "Progress Report" option, complete the Progress Report form, and submit a Modification Summary Supplement form.

If an issuer is discontinuing an existing QIS in PY2025, they should select the "Progress Report Closeout Form" option, complete the Progress Report form, and submit an Implementation Plan form.

Issuers must restate the title of the QIS that the Progress Report form applies to in this section.

4.2 Part B: Issuer Information

Part B of the Progress Report form captures the same issuer information as Part B of the Implementation Plan form. Responses to all elements are required, but are not scored by CMS. See Section 6.3.2 of the Technical Guidance for more details.

Updates or changes to the issuer information captured in Part B of an Implementation Plan form do not warrant a modification to an existing QIS.[56] These types of changes can instead be reported by submitting the updated information in Part B of the Progress Report form for the applicable QIS.

4.3 Part C. Progress Report Summary

Part C of the Progress Report form collects detailed information about the progress of the issuer's QIS for evaluation and information on the discontinuation of a QIS, if applicable. Responses to all elements and criteria are required. Contextual information (e.g., restatement of goals, listing of activities) will not be scored. The criteria for the progress report results will be scored.

The discussion that follows outlines the elements and criteria issuers must populate in Part C of the Progress Report form. If any element is left blank, the issuer will receive notification that its submission is missing information. The notification will specify which element(s) and/or criteria need to be revised and resubmitted.

Follow these steps to complete Part C. Progress Report Summary in the Progress Report form:

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 Implementation Plan form, or Element 8 of the Modification Summary Supplement form, if applicable.

TIP: If an issuer is continuing a QIS and did not submit a Modification Summary Supplement form during the 2024 Plan Year in calendar year 2023, the baseline assessment results reported in Element 16 of the 2025 Plan Year Progress Report form should match the baseline assessment results reported in Element 25 of the Implementation Plan form on file.

TIP: If an issuer is continuing a QIS with modifications for the 2024 Plan Year (i.e., the issuer submitted a Modification Summary Supplement form during the PY2024 QHP Application Period in calendar year 2023 describing the modifications that will be implemented to its QIS by January 1, 2024), the baseline assessment results reported in Element 16 of the 2025 Plan Year Progress Report form should match the baseline assessment results reported in Element 8 of the 2024 Plan Year Modification Summary Supplement form.

TIP: If an issuer intends to modify its QIS for the 2025 Plan Year by submitting a Modification Summary Supplement form during the PY2025 QHP Application Period in calendar year 2024, the baseline assessment results reported in Element 16 of the Progress Report form for the 2025 Plan Year should still reflect the baseline assessment results reported in Element 25 of the Implementation Plan form on file. This is because the modified measures described in the 2025 Plan Year Modification Summary Supplement

[56] See Section 5.3.1, Section 5.3.2, Exhibit 4, and Exhibit 5 of this Technical Guidance, for information on the types of updates to an existing QIS that do not warrant a modification or otherwise trigger the requirement to submit the Modification Summary Supplement form.

form will not be implemented in an issuer's QIS until after submission of the 2025 Plan Year Progress Report in calendar year 2024.

The issuer should analyze progress by providing follow-up results and indicating whether the performance target in Element 25 of the Implementation Plan form or Element 8 of the Modification Summary Supplement form, if applicable, 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, or Element 8 of the Modification Summary Supplement form, if applicable.

Element 16 should reflect progress made on the baseline data for the QIS since the last submission.

To complete Criteria 16a, 16h, 16o, and 16v, provide the measure name and CBE measure ID number as indicated in Element 25 of the issuer's Implementation Plan form, or Element 8 of the Modification Summary Supplement form, if applicable.

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 baseline Implementation Plan form if they have not modified their measures.

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.

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 Implementation Plan form or Element 8 of its Modification Summary Supplement form, if applicable. Enter the response in MM/YYYY format.

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 form or Element 8 of the Modification Summary Supplement form, if applicable, 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 25 of the baseline QIS Implementation submission, is met, or is no longer feasible or accurate. Issuers should include the modified targets in Element 8 of the Modification Summary Supplement form 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., HEDIS measure rates), issuers may not have all the final data needed to complete their QIS submissions by the final 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.

To complete Criteria 16e, 16l, 16s, and 16z, specify the Progress Report form 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 from the Implementation Plan or Modification Summary Supplement form on file. This entry should be a rate (%) or a data point target, NOT a percentage change.

To complete Criteria 16g, 16n, 16u, and 16bb, indicate whether the performance target specified in Element 25 of the Implementation Plan form or Element 8 of the Modification Summary Supplement form 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 Implementation Plan form or Element 8 of the Modification Summary Supplement form, if applicable. 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 Implementation Plan form or in Element 8 of the Modification Summary Supplement form, if applicable. Include a description of activities that led to the outcome.

TIP: Regardless of whether issuers made progress toward the performance target(s) in Criterion 17a, issuers are required to describe any barriers encountered in Element 18.

Issuers should complete Criterion 17b ONLY if they selected "Progress Report Closeout Form" as their submission type in Element 1. These issuers should provide the rationale for discontinuing their QIS.

Issuers should complete Criterion 17c if they received an "Interim Meets" determination within their previous QIS evaluation results and were instructed to address a deficiency or error in their submission for the upcoming plan year. These issuers should provide information about changes made to their QIS to address these concerns and specify which elements/criteria they apply to.

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

TIP: If the description of activities in Criterion 17a includes barriers to implementing the QIS, issuers are still required to complete Criterion 18a and elaborate on those barriers and any other barriers to implementing the QIS, if applicable, by describing the barriers and mitigation activities implemented to address the barriers in Criterion 18a.

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

TIP: If the description of activities in Criterion 17a includes problems meeting timelines, issuers are still required to complete Criterion 18b and elaborate on those problems and any other problems in meeting timelines, if applicable, by describing the problems and mitigation activities implemented to address the problems in meeting timelines in Criterion 18b.

Step 4: If applicable, provide any additional information on the Progress Report form that reviewers may find useful in the Optional text box. This field will not be scored.

Step 5: Save the completed Progress Report form 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 will instruct these issuers to correct and resubmit their Progress Report forms during the QHP Application Period.

Save the completed Progress Report form as a PDF file. The file name should follow this naming convention: **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[PR]**. For example, a file named "12345_Issuer ABC_QIS_PR" 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__[PR]_[#]**. For example, if an issuer submits two Progress Report forms, the first file should be named "12345_Issuer ABC_QIS_PR_1" and the second file should be named "12345_Issuer ABC_QIS_PR_2." All QIS forms must follow these naming conventions when submitted.

5. Complete the QIS Modification Summary Supplement Form

If an issuer chooses to make changes that warrant a modification to an existing QIS, the issuer should complete the Modification Summary Supplement form in addition to the Progress Report

form. Changes to the following components warrant a modification to an existing QIS and trigger submission of the Modification Summary Supplement form: topic areas, goals, activities, measures, performance targets, and/or product types.[57] The Modification Summary Supplement form is NOT a standalone form and, therefore, must always accompany a Progress Report form.

Once a Modification Summary Supplement form has been submitted, it is considered part of the Implementation Plan on file. Therefore, in the following plan year, issuers reporting on the progress of an existing QIS should report on the QIS using the updated information contained in the Modification Summary Supplement form. Beginning with the 2025 Plan Year QHP Application Period, if an issuer previously submitted two Modification Summary Supplement forms to change the same QIS, that issuer must submit a Progress Report Closeout form to discontinue that QIS and submit a new Implementation Plan form to establish a new QIS that incorporates the desired changes.

To complete the Modification Summary Supplement form, issuers must perform all of the following activities:

- Enter submission date at the top of the first page,
- 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 **QIS Modification Summary** section (Part C).

5.1 Part A: QIS Submission

The only option for QIS Submission Type for the Modification Summary Supplement form is "Continuing QIS with Modifications."

This option and form should be selected by issuers that want to make changes that warrant a modification to an existing QIS.[58]

If an issuer is submitting a new QIS, it should instead complete the Implementation Plan form. If an issuer is continuing an existing QIS and is NOT making changes that warrant a modification, it should instead ONLY complete the Progress Report form.

Issuers must restate the title of the QIS the Modification Summary Supplement applies to in this section.

5.2 Part B: Issuer Information

Part B is abbreviated in the Modification Summary Supplement form as it is not a standalone form and this information is captured in more detail in the Progress Report form.

Issuer information captured in Part B of the Modification Summary Supplement form should match the information entered in Part B of the Progress Report form.

[57] Ibid.

[58] Ibid.

5.3 Part C: QIS Modification Summary

The Modification Summary Supplement form, Part C: QIS Modification Summary captures the details of which components the issuer is modifying for the **upcoming** plan year. This form is required if issuers want to change any of the following components of an existing QIS: topic areas, goals, activities, measures, performance targets, and/or product types. Responses to the applicable elements and criteria are required and are scored.

The discussion that follows outlines the elements and criteria issuers must populate in Part C of the Modification Summary Supplement form. If any element or criterion is left blank but should have been completed (as indicated by the selection the issuer made in Criterion 8a of the Modification Summary Supplement form), the issuer will receive notification that its submission is missing information. The notification will specify which element(s) and/or criteria need to be revised and resubmitted.

Follow these steps to complete Part C. QIS Modification Summary in the Modification Summary Supplement form:

Step 1: In Criterion 8a, select which components the issuer intends to modify.

TIP: Issuers must provide a high-level description of the modifications being made across all selected components in the text box provided.

Step 2: Complete 8b through 8f, as applicable.

TIP: Issuers should ONLY complete the criteria for components that have been selected in Criterion 8a.

If an issuer is modifying product types, the issuer should select whether it is adding or removing the relevant product type(s) in Criterion 8b.

If an issuer is modifying topic areas, the issuer should select whether it is adding and/or removing the topic area(s) in Criterion 8c and should describe how that topic area(s) will be addressed within its existing QIS. If an issuer is modifying its topic area(s), the issuer must also use the Modification Summary Supplement form to modify the goal(s) listed in Element 20 of the Implementation Plan form on file by completing Criterion 8d and the activities listed in Element 24 of the Implementation Plan form on file by completing Criterion 8e. The issuer may also need to update the measures and performance targets listed in Element 25 of the Implementation Plan form on file by completing Criterion 8f.

TIP: If an issuer selects "Reduce health and health care disparities" as an added topic area, it must state the population(s) addressed by the QIS.

If an issuer is modifying a goal, the issuer should select which goal it is modifying in Criterion 8d (Goal 1 or Goal 2). The issuer should then describe the new goal in the text box and provide the rationale for the modification in the following text box.

TIP: Issuers should not include specific performance targets or goals tied to a specific calendar year or plan year because the Modification Summary Supplement form will remain on file, and references to specific years or performance targets will become outdated over time.

If an issuer is modifying activities, it should describe the modified activities in the text box in Criterion 8e, as well as the rationale for the modification in the following text box.

If an issuer is modifying measures or performance targets, the issuer should first describe the modification in the text box in Criterion 8f. This description should include an explanation of whether the issuer is adding or removing a measure, changing measure specifications, or changing a measure target.

TIP: Issuers must provide all measure criteria (i.e., measure name, CBE ID number, baseline assessment results, baseline performance period, and performance target) for each measure selected for modification, even for criteria that are remaining the same.

TIP: To add a new measure to an existing goal that already has a measure, select the checkbox corresponding to the new measure and provide all requested criteria. Issuers do not have to restate information for measures that are not being changed (e.g., if an issuer is adding a measure to Goal 2 that already has Measure 2a, the issuer only needs to provide information in the Measure 2b section).

The issuer should then select the measure(s) to be changed and describe the modifications. Finally, the issuer should include the rationale for the modified measures.

TIP: The performance target should be a rate (%) or a data point target, NOT a percentage change.

Step 3: Save the completed Modification Summary Supplement form 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 will instruct these issuers to correct and resubmit their Implementation Plan forms during the QHP Application Period.

Save the completed Modification Summary Supplement form as a PDF file. The file name should follow this naming convention: **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[MS]**. For example, a file named "12345_Issuer ABC_QIS_MS" 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__[MS]_[#]**. For example, if an issuer submits two Modification Summary Supplement forms, the first file should be named "12345_Issuer ABC_QIS_MS_1" and the second file should be named "12345_Issuer ABC_QIS_MS_2." Issuers MUST make sure that the sequenced forms align with the numbering on the Progress Report forms as the Modification Summary Supplement form is not a standalone form and must be associated with the appropriate Progress Report form. All QIS forms must follow these naming conventions when submitted.

6. Submit the QIS Form(s)

Issuers will submit their completed QIS forms, along with all other QHP certification documentation,[59] during the annual QHP Application Period. For the PY2025 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 2025 Plan Year. For the 2025 Plan Year, the QIS forms will be submitted through the accreditation section.

- 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.

6.1 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. Once issuers have typed responses for each applicable element and criterion 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 will use the Marketplace Plan Management System (MPMS) to submit QHP data to CMS for review and certification.[60]

Issuers operating in FFEs where the state does not perform plan management should follow these steps to submit their completed Implementation Plan form, Progress Report form, and/or Modification Summary Supplement form via HIOS[61]:

Login steps for accessing the MPMS:

1. Navigate to the CMS Enterprise Portal Login page.

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

[60] All users must have a CMS Enterprise Portal Identifier (ID) and HIOS user role to access the MPMS. Users are required to have a PM Issuer Submitter role to access MPMS. For further details on how to establish a CMS Enterprise Portal ID, refer to the Enterprise Portal User Guide. For further details on how to request a PM Issuer Submitter role, please refer to the Identity Management User Guide.

[61] 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 6.2 of this QIS User Guide for further details.

2. Enter User ID and Password into the field.
3. Select the "I agree to the Terms & Conditions" check box.
4. Select the green "Login" button.
5. In My Portal, select the HIOS icon.
6. Select "Overview."
7. Select the "Access HIOS" link.
8. Select the green "Launch This Module" button for the Marketplace Plan Management Module.
9. Select "Access the Marketplace Plan Management System module" link.
10. Select the "Accreditation" section of the QHP Application.
11. Select Add Document to Supporting and Justifications Documents and select Quality Improvement Strategy from the dropdown options.
12. Use the document upload function to upload the completed Implementation Plan form, Progress Report form, and/or Modification Summary Supplement form to HIOS.

Issuers must label their submissions according to the aforementioned naming convention: **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP, PR or MS]**, for single submissions and **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP, PR or MS]_[#]**, 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) at CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515.

6.2 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, PR or MS]**, for single submissions and **[5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP, PR or MS]_[#]**, 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.

7. 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.[62]

7.1 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 required corrections to the issuer. The following steps provide information about what issuers should do if they are notified of required corrections during the QHP Application Period.

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

The review results 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 review results 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 review results.

The issuer should not make any changes to their response(s) for elements and/or criteria that CMS DID NOT specifically identify in the review results.

The issuer should update the Submission Date field at the top of the form.

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

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

Step 5: Upload the revised QIS form(s) 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 in the Marketplace Plan Management System (MPMS).

[62] 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.

7.2 Addressing Concerns After the QHP Application Period

CMS begins evaluations of complete QIS submissions after the close of the 2025 QHP Application Period. CMS will communicate evaluation results for QIS submissions for the 2025 Plan Year to issuers in the late fall of 2024. CMS will include in these communications directions on how to address concerns (e.g., remaining deficiencies or missing information) after the QHP Application Period.

Appendices

Appendix A. Excerpts of Relevant Statutory and Regulatory Citations

Exhibit 18: Patient Protection and Affordable Care Act, 42 U.S.C. Sec. 18031 (March 23, 2010)

Topic	Provisions	Citation
QHP certification standards for quality improvement strategies	(c) RESPONSIBILITIES OF THE SECRETARY.— (1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum— (E) implement a quality improvement strategy described in subsection (g)(1).	Section 1311(c)(1)(E)
Exchange standards for quality improvement strategies	(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES — (1) STRATEGY DESCRIBED — A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for— (A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; (B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; (C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; (D) the implementation of wellness and health promotion activities; and (E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings. (2) GUIDELINES — The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1). (3) REQUIREMENTS — The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).	Section 1311(g)

Exhibit 19: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, 77 Fed. Reg. 18310-18475 (March 27, 2012)

Topic	Provisions	Citation
Exchange oversight responsibilities for quality activities	(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Patient Protection and Affordable Care Act.	45 CFR § 155.200(d) Functions of an Exchange

Exhibit 20: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, Final Rule, 79 Fed. Reg. 30240-30353 (May 27, 2014)

Topic	Provisions	Citation
QHP issuer participation standards	(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. (b) *QHP issuer requirement.* A QHP issuer must— (5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Patient Protection and Affordable Care Act consistent with the standards of section 1311(g) of the Patient Protection and Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Patient Protection and Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Patient Protection and Affordable Care Act; (h) As a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements described in subparts D, E, H, K, L, and M of this part.	45 CFR § 156.200(a), (b)(5),(h) QHP issuer participation standards
Exchange QHP certification standards	a) *Definition.* The following definition applies in this subpart: Multi-state Plan means a health plan that is offered in accordance with section 1334 of the Patient Protection and Affordable Care Act. (b) *General requirement.* The Exchange must offer only health plans which have in effect a certification issued or are recognized as plans deemed certified for participation in an Exchange as a QHP, unless specifically provided for otherwise. (c) *General certification criteria.* The Exchange may certify a health plan as a QHP in the Exchange if— (1) The health insurance issuer provides evidence during the certification process in §155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156, as applicable; and (2) The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, except that the Exchange must not exclude a health plan— (i) On the basis that such plan is a fee-for-service plan; (ii) Through the imposition of premium price controls; or (iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.	45 CFR § 155.1000, Certification standards for QHPs

Exhibit 21: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule, 80 Fed. Reg. 10750-10877 (February 27, 2015)

Topic	Provisions	Citation
Quality improvement strategy standards	*(a) General requirement*. A QHP issuer participating in an Exchange for 2 or more consecutive years must implement and report on a quality improvement strategy including a payment structure that provides increased reimbursement or other market-based incentives in accordance with the health care topic areas in section 1311(g)(1) of the Patient Protection and Affordable Care Act, for each QHP offered in an Exchange, consistent with the guidelines developed by HHS under section 1311(g) of the Patient Protection and Affordable Care Act. *(b) Data requirement.* A QHP issuer must submit data that has been validated in a manner and time frame specified by the Exchange to support the evaluation of quality improvement strategies in accordance with 155.200(d) of this subchapter. *(c) Timeline.* A QHP issuer must submit data annually to evaluate compliance with the standards for a quality improvement strategy in accordance with paragraph (a) of this section, in a manner and time frame specified by the Exchange.	45 CFR § 156.1130(a)-(c), Quality Improvement Strategy

Exhibit 22: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, Final Rule, 87 Fed. Reg. 27208-27393 (May 6, 2022)

Topic	Provisions	Citation
Quality improvement strategy standards	As stated in the HHS Notice of Benefit and Payment Parameters for 2023 final rule ,QHP issuers are required to address health and health care disparities as a specific topic area within their QIS, in addition to at least one other topic area described in section 1311(g)(1) of the PPACA. This expansion of the QIS standards aligns with health equity efforts across Federal government policies and programs; however, we did not amend the regulatory text outlined in § 156.1130.	45 CFR § 156.1130, Quality Standards: Quality Improvement Strategy

Appendix B. QIS Forms Pre-Submission Checklist

The checklist shown as Exhibit 23 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 23: Implementation Plan Form and Progress Report Form Pre-Submission Checklist

QIS FORMS PRE-SUBMISSION CHECKLIST

A. PREPARATION

- ☐ Review the applicable regulations, the entire 2025 QIS Technical Guidance and QIS User Guide, and the relevant sections of the 2025 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 forms appropriate to the issuer's situation (see Appendix D for more information).

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 Implementation Plan form.
- ☐ Complete all of the elements and criteria in Part E: QIS Requirements in the 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

- ☐ 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 2–5 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. COMPLETE THE MODIFICATION SUMMARY SUPPLEMENT FORM

- ☐ Enable JavaScript in the fillable PDF form before you enter your QIS information.
- ☐ Complete Part A: QIS Submission by checking the applicable Type of QIS Submission.
- ☐ Complete all elements in Part B: Issuer Information in the Background Information section.
- ☐ Complete the required elements and criteria in Part C: Modification 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.

E. 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_[IP or PR or MS] or [5-digit HIOS Issuer ID]-_[Issuer Legal Name]_QIS_[IP or PR or MS]_[#]. 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 24: QIS Implementation Plan Form Elements and Criteria

QIS Implementation Plan Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1**[63]
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	Not Applicable
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

[63] This column indicates whether a change to a given element/criterion from a previous QIS requires selecting "New QIS after Discontinuing a QIS Submitted during a Prior Qualified Health Plan (QHP) Application Period" or "New QIS with No Previous QIS Submission" in Element 1 of the Implementation Plan form. 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 Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1**[63]
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	Not Applicable
8	**QIS Primary Contact's Title**	None	This element is required but will not be scored.	None	Not Applicable
9	**QIS Primary Contact's Phone**	None	This element is required but will not be scored.	None	Not Applicable
10	**QIS Primary Contact's Email**	None	This element is required but will not be scored.	None	Not Applicable
11	**QIS Secondary Contact's Name**	None	This element is required but will not be scored.	None	Not Applicable
12	**QIS Secondary Contact's Title**	None	This element is required but will not be scored.	None	Not Applicable
13	**QIS Secondary Contact's Phone**	None	This element is required but will not be scored.	None	Not Applicable
14	**QIS Secondary Contact's Email**	None	This element is required but will not be scored.	None	Not Applicable
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 Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1[63]**
16	**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%. 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	Not Applicable
Part C					
17	**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.	None	This element is required but will not be scored.	100 characters if "Other" is selected	Not Applicable
Part D					
18	**QIS Title** Provide a short title for the QIS.	None	This element is required but will not be scored.	200 characters	Not Applicable

QIS Implementation Plan Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1[63]**
19	**QIS Description** 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? Is the QIS submission a strategy that the issuer currently has in place for its Exchange product line and/or for other product lines? If "Yes" was checked for either/both of the above, please describe the state initiative and/or current issuer strategy.	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	Not Applicable

QIS Implementation Plan Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1**[63]
Part E					
20	**QIS Goals** 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. *Note: The topic area(s) selected in Element 22 and the measure(s) described in Element 25 should be linked to these goals. Please do not include specific performance targets or goals tied to a specific calendar year or plan year because this Implementation Plan Form will remain on file and references to specific years or performance targets will become outdated over time.*	None	This element is required but will not be scored.	500 characters per text box	Not Applicable
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.

QIS Implementation Plan Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1**[63]
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. If the "Reduce health and health care disparities" Topic Area is selected, what population(s) does the QIS address?	None	This element will be scored; Element 22 is a must-pass element.	500 characters	Not Applicable
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	Not Applicable
24	**Activity(ies) That Will Be Conducted to Implement the QIS**	24a – List the activities that will be implemented to achieve the identified goals in Element 20. 24b – Describe how the activities listed in Criterion 24a relate to the market-based incentive(s) selected in Element 21. 24c – Describe how the activities listed in Criterion 24a relate to the selected topic area(s) selected in Element 22.	This element will be scored; Element 24 is a must-pass element.	1,500 characters per criterion	Not Applicable

QIS Implementation Plan Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1**[63]
25	**Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress** 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.	25a, 25f, 25k, 25p – Provide the name of the measure; narrative description of the measure numerator and denominator or how the data point was calculated; whether the measure is consensus-based entity (CBE)-endorsed; CBE ID, if applicable (CBE-endorsed measures are not required); if CBE-endorsed, whether the measure specifications were modified. 25b, 25g, 25l, 25q – Describe how the measure supports the tracking of performance related to the goal. 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.* 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 25 of the Implementation Plan on file. 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.*	This element will be scored; Element 25 is a must-pass element.	500 characters per measure description; 1,000 characters per description of how the measure supports tracking of goals	Not Applicable

QIS Implementation Plan Form					
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**	**Change Requires Discontinuation Selection in Element 1**[63]
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	Not Applicable
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	Not Applicable

Exhibit 25: QIS Progress Report Form Elements and Criteria

QIS Progress Report Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
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. **QIS Title** Restate the short title for the QIS.	None	This element is required but will not be scored.	None
Part B				
2	**Issuer Legal Name**	None	This element is required but will not be scored.	None
3	**Company Legal Name**	None	This element is required but will not be scored.	None
4	**HIOS Issuer ID**	None	This element is required but will not be scored.	None
5	**Issuer State**	None	This element is required but will not be scored.	None
6	**QIS Primary Contact's Name**	None	This element is required but will not be scored.	None
7	**QIS Primary Contact's Title**	None	This element is required but will not be scored.	None
8	**QIS Primary Contact's Phone**	None	This element is required but will not be scored.	None
9	**QIS Primary Contact's Email**	None	This element is required but will not be scored.	None

QIS Progress Report Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
10	**QIS Secondary Contact's Name**	None	This element is required but will not be scored.	None
11	**QIS Secondary Contact's Title**	None	This element is required but will not be scored.	None
12	**QIS Secondary Contact's Phone**	None	This element is required but will not be scored.	None
13	**QIS Secondary Contact's Email**	None	This element is required but will not be scored.	None
14	**Date Issuer Began Offering Coverage Through the Exchange**	None	This element is required but will not be scored.	None
15	**Current Payment Model(s) Description** Select the category(ies) of payment models that are used by the issuer across 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%. 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
Part C				
16	**Analyze Progress Using Baseline Data, as Documented in the Implementation Plan** Restate the Goal(s) identified in Element 20 of the Implementation Plan on file or	16a, 16h, 16o, 16v – Restate measure name(s) from Element 20 of the Implementation Plan on file or Element 8 of the Modification Summary Supplement form on file, if applicable, and provide the 4-digit CBE-ID number.	This element will be scored; Element 16 is a must-pass element.	500 characters per goal

QIS Progress Report Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
	Element 8 of the Modification Summary Supplement form on file, if applicable.	16b, 16i, 16p, 16w – Restate the baseline results from Element 20 of the Implementation Plan on file or Element 8 of the Modification Summary Supplement form on file, if applicable, 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.* 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 25 of the Implementation Plan on file or Element 8 of the Modification Summary Supplement form on file, if applicable. 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.* 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. 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) from Element 25 of the Implementation Plan on file or Element 8 of the Modification Summary Supplement form on file, if applicable. *Note: This entry should be a rate (%) or a data point target, NOT a percentage change*. 16g, 16n, 16u, 16bb – Was the performance target achieved?		

QIS Progress Report Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
17	**Summary of Progress**	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 25 of the QIS Implementation Plan on file or Element 8 of the Modification Summary Supplement form on file, if applicable, and (2) Include a description of activities that led to the outcome. *Note: Regardless of if you made progress toward the performance target(s), you will be required to describe any barriers encountered in Criterion 18a and any problems meeting timelines in Criterion 18b.* 17b – If the issuer selected **"Progress Report Closeout Form"** in Element 1 of *this* Progress Report form, provide the rationale for discontinuing the QIS. 17c – If the issuer received an **"Interim Meets"** scoring designation during the previous evaluation 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 the QIS evaluation results and describe the changes. If the scenarios described in 17b or 17c do not apply, issuers should leave these fields blank.	This element will be scored; Element 17 is a must-pass element.	1,000 characters per criterion

QIS Progress Report Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
18	**Barriers and Mitigation Activities**	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. *Note: If your description of activities in Criterion 17a includes barriers to implementing the QIS, you are still required to complete Criterion 18a and elaborate on those barriers and any other barriers to implementing the QIS, if applicable, by providing the below information.* 18b – Were there problems meeting timelines as indicated in Element 26 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. *Note: If your description of activities in Criterion 17a includes problems meeting timelines, you are still required to complete Criterion 18b and elaborate on those problems and any other problems in meeting timelines, if applicable, by providing the below information.*	This element will be scored. Both criteria must be completed.	1,500 characters per criterion

Exhibit 26: QIS Modification Summary Supplement Form Elements and Criteria

QIS Modification Summary Supplement Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
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. **QIS Title** Restate the short title for the QIS.	None	This element is required but will not be scored.	None

QIS Modification Summary Supplement Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
Part B				
2	**Issuer Legal Name**	None	This element is required but will not be scored.	None
3	**HIOS Issuer ID**	None	This element is required but will not be scored.	None
4	**Issuer State**	None	This element is required but will not be scored.	None
5	**QIS Primary Contact's Name**	None	This element is required but will not be scored.	None
6	**QIS Primary Contact's Email**	None	This element is required but will not be scored.	None
7	**QIS Primary Contact's Phone**	None	This element is required but will not be scored.	None

QIS Modification Summary Supplement Form				
Element #	**Element Name and Explanation (if applicable)**	**Criteria**	**Scoring**	**Response Character Limit**
Part C				
8	**Modifying Product Types, Topic Areas, Goals, Activities, and Measures or Associated Performance Targets** Complete the following section regarding modifications to the QIS for the upcoming plan year	8a - Which component(s) of your QIS are you modifying for the upcoming plan year? (check boxes for product types, goals, activities, measures, and performance targets) 8b - Modifying QIS Product Types: For product type changes, indicate whether you are adding and/or removing any product types to the QIS originally listed in Criterion 2b of your Implementation Plan on file. Select all that apply. 8c - Modifying QIS Topic Areas: For topic area(s) changes, indicate whether you are adding and/or removing any product types to the QIS originally listed in Element 22 of your Implementation Plan on file. Select all that apply. 8d - Modifying QIS Goals: For modified Goal(s), indicate which Goal(s) you are modifying and state the new Goal(s) in the space provided below: 8e - Modifying QIS Activities: If you are modifying QIS activities, describe them here. Provide a rationale for the modification(s) 8f - Modifying QIS Measures or Associated Performance Targets: For modified Measures or Associated Performance Targets, indicate which Measure(s) you are modifying and state the new Measure(s) and Performance Target(s). Describe modification (e.g., remove measure, change measure or measure specifications, change target, add new measure).	This element will be scored; Element 8 is a must-pass element.	500 characters per criterion

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

Exhibit 27 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 the applicable QIS form(s) annually, in addition to any other required sections.

Exhibit 27: Scenarios for Form Completion Based on Type of QIS Submission

Type of QIS Submission	Issuer and Prior QIS Submission History	QIS Form Sections To Be Completed
New QIS with No Previous QIS Submission	▪ The issuer has offered QHPs through an Exchange for at least two consecutive years AND ▪ Has not previously submitted an Implementation Plan form or intends to create a new QIS that is not replacing an existing one[64]	▪ Complete the QIS Submission Type and Background Information sections (Parts A, B and C) of the Implementation Plan form AND ▪ 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	▪ The issuer has previously submitted an Implementation Plan form and a Progress Report form based upon that Plan AND ▪ The issuer intends to discontinue its previous strategy to implement a new QIS (e.g., one with a different market-based incentive than its previous QIS) ▪ The issuer has previously submitted two Modification Summary Supplement forms to change the same QIS and intends to modify that strategy in the 2025 Plan Year for a third time.	▪ Complete two forms – (1) an Implementation Plan form and (2) Progress Report form ▪ Complete a new Implementation Plan form to create the new QIS: – Complete the QIS Submission Type and Background Information sections (Parts A, B and C) – Complete the QIS Implementation Plan section (Parts D and E) ▪ Complete a Progress Report Closeout form to discontinue the existing QIS: – Complete the QIS Submission Type and Background sections (Parts A and B) – Complete the QIS Progress Report Summary (Part C)

[64] The issuer must not have submitted an Implementation Plan for 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 those covered by the previously submitted QIS. 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 QIS Submission" in Element 1.

Type of QIS Submission	Issuer and Prior QIS Submission History	QIS Form Sections To Be Completed
Progress Report (i.e., Continuing an existing QIS with no changes or no changes that warrant a modification)	▪ The issuer previously submitted an Implementation Plan form AND ▪ Will continue its existing QIS[65]	▪ Complete the QIS Submission Type and Background Information sections (Parts A and B) of the Progress Report form AND ▪ Complete the QIS Progress Report Summary (Part C) of the Progress Report form
Progress Report Closeout Form	▪ The issuer has previously submitted an Implementation Plan form AND ▪ The issuer intends to discontinue its existing QIS to implement a new QIS (i.e., one with a different market-based incentive than its previous QIS).	Complete two forms – (1) Update the Background Section (Part B of the Progress Report form) AND (2) Complete the QIS Progress Report Summary (Part C) ▪ *See also "New QIS After Discontinuing a QIS Submitted during a Prior QHP Application Period"*
Continuing QIS with Modifications (i.e., Continuing a QIS Submitted During a Prior Application Period and Making Changes That Warrant a Modification)	▪ The issuer has previously submitted an Implementation Plan form and is reporting on progress AND ▪ Intends to make changes that warrant a modification to its existing QIS (i.e., changes to topic areas, goals, activities, measures, performance targets, or product types) and the issuer has not previously submitted two Modification Summary Supplement forms to change the same QIS.	▪ Complete the QIS Submission Type and Background sections (Parts A and B) of the Modification Summary Supplement form ▪ Complete the QIS Modification Summary section (Part C) of the Modification Summary Supplement form

[65] Changes that warrant a modification to the QIS must be captured through submission of the Modification Summary Supplement form.

Appendix E. Market-Based Incentive Examples

Exhibit 28 and Exhibit 29 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 Implementation Plan form.

Exhibit 28: 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,[66] and/or health IT implementation.

Exhibit 29: 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.

[66] For technical support to qualify as an in-kind incentive, it must not only include 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 30 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 30: 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.[67]
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.[68]
Consensus-based Entity (CBE)	Organization that is responsible for the endorsement and maintenance of the health care performance measures that are used throughout the Centers for Medicaid and Medicare Services (CMS) programs.
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.[69]
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 (FFEs) 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®[70] (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.

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

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

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

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

Term	Definition
Health Insurance Oversight System (HIOS)	A data submission tool that allows CMS to collect data from states and individual and small group market issuers, which will be aggregated with other data sources and made public on a consumer-facing website. The initial mechanism for the states and issuers to submit their data is through the use of the HIOS form.
Health Maintenance Organization (HMO)	A type of health insurance product that usually limits coverage to care from providers that work for or contract with the HMO and generally will not cover out-of-network care, except in an emergency.
Hospital Value-Based Purchasing program	Hospital Value-Based Purchasing (VBP) is part of the Centers for Medicare & Medicaid Services' long-standing effort to link Medicare's payment system to a value-based system to improve health care quality, including the quality of care provided in the inpatient hospital setting. The program attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country. Participating hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide. Congress authorized Inpatient Hospital VBP in Section 3001(a) of the Patient Protection and Affordable Care Act. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting (IQR) Program, which was authorized by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[71]
Marketplace Plan Management System (MPMS)	MPMS is a web application where users can validate plan data and submit their QHPs and Stand-Alone Dental Plans (SADPs) to CMS for review and certification.
Medicare Shared Savings Program	CMS has established a Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). The Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by: ▪ Promoting accountability for the care of Medicare FFS beneficiaries ▪ Requiring coordinated care for all services provided under Medicare FFS ▪ Encouraging investment in infrastructure and redesigned care processes The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Participation in an ACO is purely voluntary.[72]
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.[73]
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.

[71] https://qualitynet.cms.gov/inpatient/hvbp

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

[73] https://www.cms.gov/medicare/quality/value-based-programs

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 comprises three sections: QIS Submission Type, Background Information, and QIS Implementation Plan. Issuers complete the QIS Implementation Plan form to describe and report their quality improvement strategies to the applicable Exchange.
QIS Modification Summary Supplement form	The QIS Modification Summary Supplement form is a form QHP issuers in the FFE use for annual reporting to the applicable Exchange. The form comprises three sections: QIS Submission Type, Background Information, and QIS Modification Summary. Issuers use this form if they are reporting changes that warrant modification to an existing QIS (i.e., changes to topics areas, goals, activities, measures, performance targets, or product types). 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 comprises three sections: QIS Submission Type, Background Information, and QIS Progress Report. 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 for QIS, according to PPACA sections 1311(c)(1)(E) and 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 reducing health and health care disparities and addressing at least one of the other topic areas listed in section 1311(g), (2) complying with guidelines established by the Secretary of HHS in consultation with experts in health care quality and interested parties, and (3) reporting QIS progress to the applicable Exchange on an annual 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 time frame 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.

Term	Definition
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.[74]
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.[75] 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℠, for both the individual and small group markets, but relies on the federal platform to perform certain eligibility and enrollment functions. An SBE-FP is responsible for certifying issuers, overseeing issuer compliance with federal Exchange quality standards as a condition of certification.
States performing plan management	FFEs where the state performs plan management for QHPs offered through the Exchange. Consumers in these states apply for and enroll in coverage through the FFEs.
System for Electronic Rate Filing and Forms (SERFF)	SERFF is an electronic filing mechanism that allows for standardized health product filings, including rate review and QHP submissions. SERFF is affiliated with the National Association of Insurance Commissioners (NAIC).
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.

[74] 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

[75] Ibid.

Appendix G. Acronym List

Exhibit 31 includes acronyms used in this document.

Exhibit 31: Acronym List

Acronym	Complete Term or Name
ACO	Accountable Care Organization
AHRF	Area Health Resource File
CBE	Consensus-based Entity
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 Services Administration
HSA	Health Savings Account
IQR	Inpatient Quality Reporting
MPMS	Marketplace Plan Management System
LAN	Learning & Action Network
MQI	Marketplace Quality Initiatives
MSD	Marketplace Service Desk
NAIC	National Association of Insurance Commissioners
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