Workbook Title: QIS PRA Comment Tracker

Background:

The Quality Improvement Strategy (QIS) Technical Guidance and User Guide for the 2017 Coverage Year was PRA was released on July 1, 2015 for a 30-day public comment period (until 7/30/15). This document tracks comments received in response to the Technical Guidanceand User Guide.

Overview of the Worksheets:

Worksheet 1: Instructions

Worksheet 2: Comment Tracker: Each row represents a unique comment and contains information on CMS' response to the comment and whether or not the comment could impact the QIS burden estimate.

C001-1	BlueCross BlueShield Association	7/20/2015	15
C001-2	BlueCross BlueShield Association	7/20/2015	16
C001-3	BlueCross BlueShield Association	7/20/2015	24
C001-4	BlueCross BlueShield Association	7/20/2015	19
C001-5	BlueCross BlueShield Association	7/20/2015	21
C001-6	BlueCross BlueShield Association	7/20/2015	
C001-7	BlueCross BlueShield Association	7/20/2015	

C001-8	BlueCross BlueShield Association	7/20/2015	15
C001-9	BlueCross BlueShield Association	7/20/2015	16
C001-10	BlueCross BlueShield Association	7/20/2015	19
C001-11	BlueCross BlueShield Association	7/20/2015	21
C001-12	BlueCross BlueShield Association	7/20/2015	21
C001-13	BlueCross BlueShield Association	7/20/2015	22

C001-14	BlueCross BlueShield Association	7/20/2015	19
C001-15	BlueCross BlueShield Association	7/20/2015	24
C001-16	BlueCross BlueShield Association	7/20/2015	24
C001-17	BlueCross BlueShield Association	7/20/2015	24
C001-18	BlueCross BlueShield Association	7/20/2015	24
C001-19	BlueCross BlueShield Association	7/20/2015	26
C001-20	BlueCross BlueShield Association	7/20/2015	27
C001-21	BlueCross BlueShield Association	7/20/2015	28
C002-1	AHIP	7/17/2015	

C002-2	AHIP	7/17/2015	
C002-3	AHIP	7/17/2015	
C002-4	AHIP	7/17/2015	15
C002-5	AHIP	7/17/2015	
C002-6	AHIP	7/17/2015	22

C002-7	AHIP	7/17/2015	16
C002-8	AHIP	7/17/2015	24
C002-9	AHIP	7/17/2015	28
C002-10	AHIP	7/17/2015	
C002-11	AHIP	7/17/2015	
C002-12	AHIP	7/17/2015	

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Current Payment Model Description (Element 15) -- QHP issuers must collect information on the amount of FFS payments tied to quality or value or payments in an Alternative Payment Model tied to quality or value across *all product lines* [emphasis added], not for the QIS in particular. Therefore, this information is not relevant to evaluating issuers' quality improvement strategies for *compliance.*
Data Sources (Element 16) -- QHP issuers must collect information on the data sources used for developing and monitoring their quality improvement strategies. However, given the potentially wide variation across issuers in the different data sources used to inform their strategies - some of which may be proprietary - and the lack of standardized definitions, it is unclear how this will help the agency evaluate the compliance and adequacy of QHP issuers' quality improvement efforts.
Goal(s), Meausure(s), Performance Target(s) (Element 24) -- QHP issuers must collect information on clinical quality measures to monitor progress in meeting performance targets. We believe this detailed information is not necessary for CMS to comply with ACA requirements under section 1311(g) for guidelines to report on QIS implementation, and also duplicates QHP quality information already being collected through the Quality Rating System.
Market-based Incentive Types (Element 19) -- The current definition of market-based incentives offered by CMS is too narrow, and therefore could force issuers to implement programs and collect information that otherwise would not be necessary or may be duplicative of strategies issuers already have in place that address health and health care disparities. CMS should expand the incentives allowed for QIS to include population-directed initiatives.
Targets all Plans Offered Through the Marketplace (Element 21) -- The QIS should not have to apply to the full enrollee population. A QHP issuer serving urban and rural areas, for example, may wish to encourage a payment structure in densely populated urban areas with a high degree of provider competition, but use a different approach in rural areas that does not involve payment structures. A one-size-fits-all approach would unfairly penalize and burden QHPs that operate in rural or underserved areas that lack the infrastructure for robust payer-provider interactions.
CMS should require all QHP issuers, not only QHP issuers who have been participating in an Exchange for two or more consecutive years, to submit a QIS implementation plan for the 2017 coverage year.
CMS should clarify that if QIS information is eventually displayed publicly, it will display the same information for all QHPs (e.g., no QHP will be allowed to display information for three QISs when other QHPs have the one QIS).

Delete this element (Element 15, Current Payment Model(s) Description) from the form as it is outside of the scope of the Quality Improvement Strategy, as defined in 1311(c)(1)(E) of the Affordable Care Act.
Delete this element (Element 16, Data Sources) from the form, as its value for evaluating compliance with the QIS is unclear.
Expand the incentives allowed for a QIS to include population-directed initiatives such as grants to community organizations or direct outreach to populations in need.
BCBSA recommends that HHS clarify that a QIS does not have to apply to the full enrollee population – a QHP issuer serving urban and rural areas, for example, may wish to make heavy use of a particular payment structure in densely populated urban areas with a high degree of provider competition, but use a different approach in rural areas that does not involve payment structures.
BCBSA recommends that if a QHP serves an area where improvement strategies, that are not based on payment, are likely to be more cost-effective and successful than strategies that do not fit neatly into the market incentives orientation (e.g., rural, underserved, or provider shortage areas), that QHP should be excluded from the QIS requirements – unless HHS recognizes population-based, or community-oriented initiatives of the sort described above as QIS
BCBSA recommends that HHS provide further guidance on what is meant by “reducing health and health disparities” (including clarifying that activities may not necessarily include market-based incentives – see discussion under Element 23), and give QHP issuers flexibility in focusing on those disparities of greatest importance to the markets and covered populations.

Clarify that market-based activities include a wider range of incentives, as recommended for Element 19 (Market-based Incentive Type(s)).
BCBSA recommends that HHS not require clinical quality measures and performance targets to monitor strategy progress, as that is neither necessary nor useful for the agency to perform its functions.
If CMS keeps the requirement to set performance targets, it should clarify the length of the “initial years” period so that issuers can determine the amount of time they have to tweak or redesign their strategies.
If CMS keeps the requirement to set performance targets, it should provide further clarification for Element 24c regarding how QHP issuers should calculate the baseline, especially if QHP issuers are reporting on a new product or changing population, or if the strategy itself is brand new.
CMS encourages the use of national benchmarks for QIS performance targets, but should clarify that QHP issuers that utilize regional benchmarks will not be penalized
BCBSA supports this element (Element 26).
Provide flexibility for QHP issuers in responses provided in this section [Element 27: Addition of Health Plans to the Issuer's QIS].
Further clarify whether issuers may change goal(s) and performance target(s), or whether the goal(s) must remain the same while the target(s) may change.
We support the annual submission of a Reporting Template beginning one year after the submission of the Plan Template.

We recommend aligning Quality Reporting Strategy and QIS requirements wherever possible across both Federal and State based exchanges to avoid the use of disparate requirements and timelines that would add to cost and burden.
QHP issuers would benefit from additional training and resource materials similar to what is offered for the Chronic Care Improvement Program (CCIPs) and the Quality Improvement Project (QIP) for Medicare Advantage.
We caution HHS when evaluating Element 15: Current Payment Model(s) descriptions that there is no consistent recognized methodology to measure the percentage of provider's payments tied to quality or value.
Given that QHPs will benefit from greater flexibility in designing and implementing QIS, we recommend that QIS reporting be broad and flexible and reporting be focused at the strategy level.
We ask for clarification around expectations for reporting on activities to reduce health and health care disparaties.

We recommend the deletion of Element 16: Data Sources.
Further clarification is needed to accurately report the information requested under Elements 24c: Baseline results, 24d: Performance period, and 24e: Performance target.
We recommend issuers have the opportunity to modify performance goals in addition to the allowable modifications listed under Element 28a.
We recommend that HHS looks to the QRS to give consumers information on a standardized set of measures regarding quality of care and enrollee experience.
Should HHS choose to move forward with public reporting of QIS information, we request that HHS provide a future public comment period to provide input on making this information publicly available.
We recommend that HHS consider the development of a glide path for new QHP issuers and established QHP issuers when reporting on a Quality Improvement Strategy.

CMS agrees that there is no QIS statutory authority to collect information on issuers' other product lines. We removed all references to payment models used outside of the Marketplace.	N
CMS clarified that the purpose of collecting issuers' data sources (Element 16) is to promote transparency; CMS does not intend to publically display issuers' information that is considered confidential or proprietary.	N
CMS added clarifying language to the QIS User Guide to explain the purpose of collecting this information. CMS added a sentence to the description of Element 24 in the QIS User Guide clarifying that issuers have broad flexibility in selecting the measures used to track progress related to their QIS. A QIS should incentivize quality, tying payments to measures of performance, when providers meet specific quality indicators.	N
CMS added language to Section 1 of the QIS Technical Guidance to further clarify the definition of a market-based incentive.	N
CMS added clarifying language to Section 2 of the QIS Technical Guidance that describes how an issuer may submit one or more strategies, to clarify that there must be a QIS for each QHP, but the QIS (or QISs) do not have to cover all of each QHP's enrollees.	N
CMS added clarifying language to Section 5.1 of the Technical Guidance, citing Final Rule language, "[CMS] believes that two years is an appropriate time period for issuers to understand their populations who have enrolled through Exchanges, and develop relevant quality improvement strategies to meet the needs of that population."	N
CMS added clarifying language to Section 5.2 of the QIS Technical Guidance that for the 2017 coverage year, there are no plans for public reporting.	N

CMS added clarifying language to the QIS User Guide noting that these payment model categories reflect the goals of HHS' *Better, Smarter, Healthier* initiative which has set a goal of linking 30 and 50 percent of current Medicare fee for service payments to alternative payment models by 2016 and 2018, respectively. CMS noted that the information in Element 15 is collected for the purpose of broader health care delivery understanding, is intended to support overall health care system innovation, and is in no way meant to discourage innovation. Additionally, Element 15 is intended to reflect an issuers' overall payment models, not just the payment models in a specific QIS.	N
CMS clarified that the purpose of collecting issuers' data sources (Element 16) is to promote transparency; CMS does not intend to publically display issuers' information that is considered confidential or proprietary.	N
CMS added clarifying language to Section 1 of the QIS Technical Guidance to further clarify that a QIS that includes population- or community-based activities must also link those activities to a market-based incentive.	N
CMS added clarifying language to Section 2 of the QIS Technical Guidance that describes how an issuer may submit one or more than one QIS, to clarify that there must be a QIS for each QHP, but the QIS (or QISs) do not have to cover all of each QHP's enrollees.	N
CMS added clarifying language to Section 2 of the QIS Technical Guidance that describes how an issuer may submit one or more than one QIS, to clarify that there must be a QIS for each QHP, but the QIS (or QISs) do not have to cover all of each QHP's enrollees.	N
CMS revised the content of Element 22 (Rationale for QIS) of the Implementation Plan and Progress Report form to include examples of quality improvement activites as cited in the Affordable Care Act. CMS revised the QIS Technical Guidance to include language clarifying that the statutory requirements related to the QIS require the use of market-based incentives (either increased provider reimbursement or other incentives) to improve the quality and value of health care and services specifically for Marketplace enrollees. Activities related to reducing health and health care disparities – such as data analysis, consumer engagement, navigation tools or cultural competency training – must be tied to an incentive in order to comply with the QIS.	N

CMS added clarifying language to Section 1 of the QIS Technical Guidance to further clarify that a QIS that includes population- or community-based activities must also link those activities to a market-based incentive.	N
CMS added a sentence to the description of Element 24 in the QIS User Guide clarifying that issuers have broad flexibility in selecting the measures used to track progress related to their QIS. A QIS should incentivize quality, tying payments to measures of performance, when providers meet specific quality indicators.	N
CMS did not revise the content in the Technical Guidance and User Guide. The Technical Guidance already specifies that issuers will not be penalized for failure to meet performance targets during the initial years of QIS implementation.	N
CMS added a sentence to the description of Element 24 in the QIS User Guide clarifying that while issuers have broad flexibility in selecting the measures used to track progress related to their QIS, CMS encouraged issuers to use national, state, or regional benchmarks when establishing performance targets.	N
CMS added a sentence to the description of Element 24 in the QIS User Guide clarifying that while issuers have broad flexibility in selecting the measures used to track progress related to their QIS, CMS encouraged issuers to use national, state, or regional benchmarks when establishing performance targets.	N
Supportive statement - CMS did not revise the content of Element 26 (Risk Assessment) of the Implementation Plan and Progress Report form.	N
Supportive statement - CMS did not revise the content of Element 27 of the Implementation Plan and Progress Report form.	N
CMS added clarifying language to Section 7 of the QIS Technical Guidance indicating what changes issuers are able to make to modify their quality improvement strategies, when these changes can be made, and what changes require a new QIS.	N
Supportive statement - CMS did not revise the content of the Implementation Plan and Progress Report form.	N

The QIS is designed to provide SBMs with flexibility to establish the timeline, format, validation, and other requirements related to the annual submission of QIS data by issuers that participate in their respective Marketplaces. CMS revised the QIS Technical Guidance to include language specifying that issuers offering Multi-State Plan (MSP) options should contact the Office of Personnel Management (OPM) to confirm the requirements and timing associated with QIS implementation.	N
CMS anticipates conducting issuer training sessions, including a demonstration of the evaluation and scoring tool, which will address the comment regarding how the "must-pass" and minimum score thresholds/partial credit is operationalized.	N
CMS added clarifying language to the QIS User Guide noting that these payment model categories reflect the goals of HHS' *Better, Smarter, Healthier* initiative which has set a goal of linking 30 and 50 percent of current Medicare fee-for-service payments to alternative payment models by 2016 and 2018, respectively. CMS noted that the information in Element 15 is collected for the purpose of broader health-care delivery understanding, is intended to support overall health care system innovation, and is in no way meant to discourage innovation.	N
CMS added clarifying language to the QIS Technical Guidance and User Guide. CMS revised Section 2 of the QIS Technical Guidance to indicated that issuers may use existing strategies, and those may include payment methodologies and other incentives such as those used under accountable care contracts. CMS added a sentence to the description of Element 24 in the QIS User Guide clarifying that issuers have broad flexibility in selecting the measures used to track progress related to their QIS. A QIS should incentivize quality, tying payments to measures of performance, when providers meet specific quality indicators.	N
CMS revised the content of Element 22 (Rationale for QIS) of the Implementation Plan and Progress Report form to include examples of quality improvement activites as cited in the Affordable Care Act. CMS revised the QIS Technical Guidance to include language clarifying that the statutory requirements related to the QIS require the use of market-based incentives (either increased provider reimbursement or other incentives) to improve the quality and value of health care and services specifically for Marketplace enrollees. Activities related to reducing health and health care disparities – such as data analysis, consumer engagement, navigation tools or cultural competency training – must be tied to an incentive in order to comply with the QIS. CMS revised the description of Element 22 in the QIS User Guide to include a call-out box describing options for gathering data to identify health and health care disparities.	N

CMS added clarifying language to the QIS User Guide to explain the purpose of collecting this information.	N
CMS did not revise the content of Element 24 of the Implementation Plan and Progress Report form. CMS added clarifying language to the QIS User Guide to explain the purpose of collecting this information. CMS added a sentence to the description of Element 24 in the QIS User Guide clarifying that issuers have broad flexibility in selecting the measures used to track progress related to their QIS. A QIS should incentivize quality, tying payments to measures of performance, when providers meet specific quality indicators.	N
CMS added clarifying language to Section 7 of the QIS Technical Guidance indicating what changes issuers are able to make to modify their quality improvement strategies, when these changes can be made, and what changes require a new QIS.	N
CMS added clarifying language to Section 5.2 of the QIS Technical Guidance that for the 2017 coverage year, there are no plans for public reporting.	N
CMS added clarifying language to Section 5.2 of the QIS Technical Guidance that for the 2017 coverage year, there are no plans for public reporting.	N
Supportive statement - no changes necessary.	N