Washington Quality Improvement Strategy: User Guide for the 2022 Plan Year

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The Washington Health Benefit Exchange (WAHBE or the Exchange) uses a Washington-specific Quality Improvement Strategy form and no longer uses the CMS QIS Implementation Plan and Progress Report Form. This change to the Washington specific form was effective as of plan year 2020. Issuers may refer to this User Guide as they complete the WAHBE Quality Improvement Strategy (QIS) form for guidance on meeting the QIS requirements for 2022 QHP certification.

Part A of the User Guide provides the following information

- Background on the QIS
- QIS schedule for the 2022 Plan Year
- Exchange responsibilities
- QIS requirements
- QIS evaluation process and methodology

Part B of the User Guide provides the following information

Part B of the User Guide provides instructions for issuers on how to complete and submit the Washington Quality Improvement Strategy form in the format of frequently asked questions. The User Guide covers aspects of the QIS application and submission process that frequently prompt questions, including:

- When to submit a new QIS vs. a continuing QIS
- How to complete certain sections of the form
- What fields are required
- How to report progress in a QIS from one year to the next

PART A – Information About Quality Improvement Strategies

Background

Any eligible QHP issuer participating in the Exchange must implement, and report on, a quality improvement strategy (QIS), in accordance with Section 1311(g) of the Patient Protection and Affordable Care Act entitled "Rewarding Quality Through Market-Based Incentives," 45 CFR 156.1130, other applicable law, and Exchange guidance.

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.

An eligible issuer for the 2022 plan year is any QHP issuer that is planning on offering medical coverage through the Exchange in 2022.

The QIS requirements apply to all eligible issuers offering QHPs, including QHPs compatible with health savings accounts (HSAs). For plan year 2022, QIS requirements will not apply to child-only plans or stand-alone dental plans.

All eligible issuers must comply with the following QIS requirements for the 2022 plan year:

- Implement a QIS, which is a payment structure that provides increased reimbursement or other market-based incentives for improving health outcomes of plan enrollees.
- Implement a QIS that includes activities in at least one of the following areas:
    - Improving health outcomes;
    - Preventing hospital readmissions;
    - Improving patient safety and reducing medical errors;
    - Wellness and health promotion; and
    - Reducing health and health care disparities.
- Implement a QIS that monitors QIS progress by using the following National Quality Forum (NQF)-endorsed clinical measures:
    - Cervical Cancer Screening (NQF ID: 0032);
    - Plan All-Cause Readmissions (NQF ID: 1768).
- Address health and health disparities by choosing "activities to reduce health and health care disparities" as a topic area or addressing the reduction of health and health care disparities as part of the activities implemented within any other chosen topic area(s).
- Adhere to federal QIS requirements.
- Adhere to Exchange guidelines, including instructions for QIS submissions contained in this User Guide.

- Complete and submit the Washington Health Benefit Exchange Quality Improvement Strategy form including, if applicable, reporting on progress implementing the QIS to the Exchange in accordance with guidelines established by the Exchange.

Issuers may implement one QIS that applies to all eligible QHPs in the Exchange, or may implement more than one QIS, tailored to the needs of different QHPs. A QIS does not have to address the needs of all enrollees in a given QHP but may address needs of specified sub-populations. All QHPs must be covered by a QIS.

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. ACA Section 1311(g) specifies two market-based incentives types that issuers may include in their quality improvement strategies: (1) increased reimbursement or (2) other incentives. These incentive types are defined below:

(1) Increased Reimbursement
    a. Providers receive an increased or higher level of payment and/or a bonus payment based on whether they meet certain quality performance targets.
    b. 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
    a. "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.
    b. "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, coinsurance) 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).

QIS Schedule for the 2022 Plan Year

Issuers applying for QHP certification in Washington will submit QIS forms during the annual plan certification process and should refer to the plan certification timeline for all applicable dates for QIS. Issuers can find the current certification timeline here:

https://www.wahbexchange.org/about-the-exchange/committees-and-workgroups/plan-certification-workgroup/

Washington Health Benefit Exchange Responsibilities

The Exchange is responsible for the evaluation of an issuer's Quality Improvement Strategy submission as well as overseeing the implementation of the program as a condition of QHP certification for the 2022 Plan Year.

The QIS requirements outlined by CMS give the Exchange the flexibility to establish the timeline, reporting form, validation, and other requirements related to the annual submission of QIS data by issuers that participate in the Exchange in Washington State. WAHBE's requirements support compliance with 45 CFR 155.200(d).

QIS Requirements

Issuers applying for QHP certification through WAHBE for the 2022 plan year that meet the QIS participation criteria are expected to submit a 2022 QIS Washington Health Benefit Exchange Quality Improvement Strategy form in 2021 to either:

(a) Implement a new QIS beginning no later than January 2022, or

(b) Provide a progress update on an existing QIS.

All issuers, regardless of submission type, must use the 2022 WAHBE Quality Improvement Strategy form. The goal of the QIS form is to collect QIS information from issuers. This information will demonstrate compliance with ACA Section 1311(c)(1)(E). It will also facilitate understanding of the issuer's payment structure framework that provides increased reimbursement or other market-based incentives for the implementation of activities related to the topics specified in ACA Section 1311(g).

The Washington QIS form collects information from issuers in the following sections:

Part A: Issuer Information

Part B: QIS Submission Type

Part C: QIS Summary

Part D: QIS Details

Part E: Payment Models Description

Part F: Reducing Health and Health Care Disparities

Part G: Incentivizing Primary Care

Issuers must articulate at least one goal for their QIS. For each QIS goal, issuers should identify at least one primary, quantitative measure to track progress toward the goal. Issuers are not required to use NQF-endorsed measures, but are highly encouraged to use a measure from this measure set. Issuers should not use a modified NQF-endorsed measure in their submissions.

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.

<u>New QIS Requirements for 2022</u>

All issuers must include the following National Quality Forum (NQF)-endorsed clinical measures in their QIS submission for 2022: Cervical Cancer Screening (NQF ID: 0032) and Plan All-Cause Readmissions (NQF ID: 1768). These measures were chosen because all reporting issuers fell below the national 50th percentile for these measures in MY 2019. WAHBE encourages issuers to adopt Breast Cancer Screening into their QIS but will not require it for 2022

All issuers will be required to select one of the following primary care strategies identified by the Bree Collaborative Primary Care workgroup to focus on in their QIS submission:

1. Enrollees should receive information about the value of primary care, how to access primary care within the available plan options, and are asked or otherwise encouraged to select a primary care provider/team at enrollment.

2. Members select or are paneled to a primary care provider/team through a claims-based attribution process or other assignment mechanism.

3. A payment mechanism supports primary care features that are not reimbursed through traditional fee-for-service payments. These mechanisms include value-based reimbursement such as fee-for-service enhancements or prospective payments made in the form of per member per month (PMPM) payments that could include incentives for transformation, performance-based incentives, or more expansive forms of capitation.

Issuers will select a strategy and identify this strategy through the Quality Improvement Strategy form. WAHBE encourages issuers to work on a new strategy for their QHP line of business. If an issuer selects a strategy that they are already implementing, they will work with the Exchange to identify an appropriate improvement benchmark. Issuers agree to work with the Exchange on these focus areas and report their progress to the Exchange.

Upcoming QIS Requirement

All issuers should be aware of the upcoming requirement to achieve sixty percent (60%) self-reported race or ethnicity data for *Washington Healthplanfinder* (HPF) enrollees by 2022. Issuers will report on the current status of race and ethnicity data collection in this year's QIS submission. This requirement will not be effective until next year's submission.

QIS Evaluation Process and Methodology

On an annual basis, issuers must meet the QIS requirements as a part of QHP certification. In 2022, all sections of the QIS form are required regardless of submission type. If issuers are submitting a new QIS, they will not be required to provide information on the "Follow-Up Results" data fields, the "Progress" sections of the form, or the "Reporting Period" section of QIS activities.

Once issuers submit their QIS forms to the Exchange for review, the Exchange will review and follow up with an evaluation and questions. The Exchange reviews the form for completeness and whether the completed fields meet QIS requirements. The Exchange will set up a follow-up meeting with each of the issuers to discuss the QIS submission and any edits to the submission.

Issuers will receive confirmation from the Exchange once their QIS submission is deemed complete and in compliance with QHP certification requirements.

PART B – Questions and Answers on the Quality Improvement Strategies Form

Frequently asked questions

QIS Form Part A

Q: What is the purpose of Part A of the Form?

A: Part A collects identifying information about the issuer

Q: How should Part A, Question 13 be answered if an issuer previously offered coverage on the Exchange and is re-entering the Exchange?

A: Issuers should only report periods of uninterrupted coverage on the Exchange.

QIS Form Part B

Q: What is the purpose of Part B of the form, and how do I fill it out?

A: Part B of the QIS form asks issuers to identify what type of QIS submission they are submitting to the Exchange. All issuers should fill out Part B, Question 1 and report whether they are submitting:

1. A new QIS
2. A continuing QIS
3. A discontinuing QIS

If an issuer is submitting a new QIS, they should answer Question 1 and Question 2.
If an issuer is submitting a continuing QIS, they should answer Question 1 and Question 3.

Q: I made changes to my QIS. Do I need to submit a new QIS?

A: Issuers may continue with an existing QIS even if they make the following changes:

1. Change QIS measures
2. Change QIS activities
3. Change QIS performance target (after meeting performance target)
4. Update issuer information
5. Update data sources
6. Update payment models description
7. Added QIS goal to accommodate new required measures for 2022

Q: When do I need to discontinue a current QIS and submit a new QIS?

A: Issuers should discontinue their current QIS and submit a new QIS in the following circumstances:

1. Change in QIS market-based incentive type
2. Change in QIS topic area
3. Change in QIS goals *(other than change 7 noted above)*
4. The QIS has resulted in negative outcomes or unintended consequences

Q: What if I am discontinuing a QIS and submitting a new QIS?

A: Issuers discontinuing a QIS should submit **two QIS forms** to the Exchange. One form should be submitted to discontinue the current QIS and report on progress under that QIS. The issuer should mark "Discontinuing QIS" in Part B, Question 1 of this form.

The second form should report on the implementation of the new QIS. On this form, issuers should mark "New QIS" in Part B, Question 1 of the form. In Question 2, they should indicate "New QIS after discontinuing you current QIS" and answer Question 2a.

Q: Can I submit a new QIS while keeping my existing QIS in place?

A: Yes, issuers can have multiple QIS. Issuers who submit a new QIS with an existing one in place should select, "New QIS with continuing QIS remaining in place." They should fill out one form for their new QIS and a separate form for the continuing QIS.

Q: What if I want to discontinue a QIS for a reason other than those listed in Question 2a?

A: The Exchange has identified the reasons listed in Question 2a as the valid reasons for discontinuing a QIS. If an issuer wishes to discontinue a QIS for a different reason, the Exchange will consider that request on a case-by-case basis.

Q: What is considered a "correction" for Part B, Question 3?

A: If an issuer reported any data in the previous QIS submission incorrectly, they should indicate this by marking "Continuing QIS with corrections." Any corrections should be detailed in Question 3a. For example, if an issuer incorrectly reported a baseline measure in the previous submission, they should indicate the correct baseline in Question 3a.

Q: What is considered a "modification" for Part B, Question 3?

A: A modification is any of the following changes to the QIS:

1. Change QIS measures
2. Change QIS activities
3. Change performance target (after meeting performance target)
4. Update data sources

Updates to issuer information or the payment models description are not considered modifications of the QIS.

Q: What if the issuer meets the QIS performance target?

A: An issuer who meets its performance target has two options. It can:

1. Submit a continuing QIS with modifications. The issuer will need to set a new performance target.
2. Discontinue its current QIS and submit a new QIS. Issuers who wish to change the market-based incentive type, target area, or goals of the QIS should choose this option.

QIS Form Part C

Q: What is the purpose of Part C of the form?

A: Part C is where issuers provide summary information about their QIS including a high-level description of the quality improvement strategy along with rationale for why the QIS was chosen.

Q: Should Part C change from my submission last year if I am continuing a QIS?

A: Part C should remain consistent for issuers submitting a continuing QIS. Issuers can copy and paste their QIS title and description from last year's submission. The form asks issuers to describe the rationale for the QIS in two separate narrative responses:

1. Identifying the QIS target population and how the QIS addresses that population
2. Identifying why the need addressed in the QIS is a priority for the issuer

QIS Form Part D

Q: What is the purpose of Part D of the form?

A: Part D is where issuers describe their QIS in detail. This part of the form collects information on:

1. The market-based incentive type (provider or enrollee incentive);
2. The QIS topic area (e.g., improving health outcomes, reducing medical errors, etc.);
3. The QHPs covered by the QIS submission;
4. Goals, measures, and performance targets used to monitor QIS progress; and
5. Description and status of activities performed to carry out the QIS.

Q: How do I complete Part D, Question 1 of the QIS from?

A: All QIS submissions must utilize at least one market-based incentive - a provider market-based incentive or an enrollee market-based incentive.

In Table 1-1, issuers should report the uptake of the market-based incentive over time. All issuers should set a target for uptake in the incentive in the "Performance Target" column.

Q: Can I choose any topic area in Part D, Question 2?

A: Issuers can choose any topic area when submitting their QIS. The Exchange encourages addressing health and health care disparities in an issuer's QIS. This can be done by choosing "implementation of activities to reduce health and health care disparities" as a topic area in the QIS or addressing the reduction of health and health care disparities as part of the activities implemented with any other chosen topic area(s).

Q: Can I choose multiple topic areas in Part D, Question 2?

A: Yes, issuers should select all topic areas that are applicable under the QIS submission. This information should remain consistent from previous years if an issuer is submitting a continuing QIS.

Q: How specific or general should my QIS goal(s) be?

A: Goals of the QIS should be high-level goals of the quality improvement strategy. The goal(s) must be linked to the issuer's QIS topic area(s), as well as the quantitative performance targets.

Q: How many QIS goals and measures does my QIS need to have?

A: A QIS must have at least one goal and two measures: the required measures of Cervical Cancer Screening (NQF ID: 0032) and Plan All-Cause Readmissions (NQF ID: 1768). Issuers can include multiple goals and measures if they wish. The QIS form includes space for three goals and two measures per goal. If an issuer wishes to address more goals or measures, they should contact the Exchange for a modified QIS form.

Q: Am I required to use NQF-endorsed measures for the QIS?

A: NQF-endorsed measures are required for the two mandatory measures of Cervical Cancer Screening and Plan All-Cause Readmissions.

For other measures, NQF-endorsed measures encouraged, but not required. However, it is recommended that issuers use standardized or uniform performance measures.

Issuers who are using NQF measures should provide the 4-digit ID.

Q: Can I modify an NQF-endorsed measure?

A: Modified NQF-endorsed measures **should not** be used for the QIS program.

Q: What is my baseline rate if the issuer is new to the Exchange market?

A: Issuers who are new to the Exchange market are not expected to report a baseline rate.

Q: What is my baseline rate if the issuer is new in plan year 2021 and does not have a whole year of data?

A: Issuers who do not have a whole year of data are not expected to report a baseline rate.

Q: Should my baseline rate change from year to year?

A: Your baseline rate should remain consistent from the baseline rate submitted in your initial QIS submission. The baseline rate is how you will measure progress of the QIS.

The baseline rate should only change if an issuer is correcting an incorrectly reported baseline in a previously submitted QIS. This should be reported in Part B, Question 3a.

Q: How should an issuer establish a performance target with no baseline rate?

A: Issuers who have no baseline rate can still set a performance target using a national standard or external benchmark that is appropriate for measuring achievement of its identified goal.

Q: How should I report a performance target?

A: Issuers should report the actual rate they are aiming to meet as the performance target, not a percentile benchmark published by a quality metric publisher.

Q: Is the "Follow-Up Results" section of the Measure Assessment table required?

A: Issuers who are continuing a QIS are required to fill in the "Follow-Up Results" section of the Measure Assessment table. This section of the table should be left blank for issuers submitting a new QIS.

Q: Is an issuer who started a QIS this year required to report follow-up results? This QIS has only been in effect for a few months.

A: Yes. We understand that these issuers will not have a full year of reporting results at the time of QIS submission. These issuers should report on the first five to six months of implementation.

Q: How should an issuer in its second year of its QIS report their follow-up results?

A: Issuers should transition to full-year reporting of the progress of their QIS in the second year of the QIS and beyond. Follow-up results should be reported for the full previous year(s).

Q: I have three years of follow-up results for the QIS but there are only two "Follow-Up Results" columns. Which years should I report on the form?

A: Issuers should report the most recent full years of data in the "Follow-Up Results" section. For 2022 certification, this should include plan year 2018 and plan year 2019 for those whose QIS is in its third year.

Q: How should I report activities in my QIS?

A: Part D, Section 5 collects information about the activities performed to implement the QIS. Issuers can now report activities in Part D, Table 5-1. Issuers should list any planned activities for the QIS in the "Activity" column of the table and associate any activity with the QIS goal number.

In the "Target" column of the table, issuers should identify their target for the plan year. For example, if the activity is "perform outreach to providers," the target could be "complete outreach to 50% of the provider population."

Issuers with continuing QIS forms should report progress on their planned activities in the "Progress Report" column of the table. For example, completed outreach to 45% of providers. In the "Reporting Period" column, include the date the progress report metric was collected.

Q: Should I delete activities in my QIS that have been completed?

A: No, issuers should not delete past activities in the table, but should report these activities as "Completed" in the "Progress Report" column. The QIS activities table will be a running list of all activities (completed, in progress, and scheduled for future implementation) for the QIS.

QIS Form Part E

Q: What is the purpose of Part E?

A: The Exchange gathers payment model information to understand how issuers use payment mechanisms tied to quality and value to advance our shared goals of enhancing health plan competition on value and offering affordable coverage in the Exchange. This information has been collected in past QIS forms, and is required under federal baseline requirements, but we have modified the Washington QIS form to collect more specific information about the payment methods used by issuers.

Q: Am I required to fill out Part E?

A: Issuers who participate in HCA's Value-Based Payment (VBP) Survey will submit this information on their Exchange plans in their survey response, and will have the opportunity to direct HCA to send this data to the Exchange on the issuer's behalf. If an issuer chooses to authorize HCA to share this data with the Exchange, they are not required to fill out Part E.

Issuers who do not participate in HCA's VBP survey or who opt not to send their survey data to the Exchange are required to fill out Part E.

Issuers completing Part E should enter the percentage of total annual payments made for Exchange plans through each type of payment arrangement in Table 1-1. These issuers should describe their

usage of payment models that are not "fee-for-service-no link to quality and value" in Questions 1a, 1b, and 1c.

Q: What is the Alternative Payment Model (APM) framework?

A: The APM Framework was creased by the Health Care Learning and Action Network (LAN) to track progress toward payment reform. To learn more about the framework and the definition of each APM category, issuers should refer to the following resources:

HCP-LAN APM Framework: https://hcp-lan.org/apm-refresh-white-paper/

HCP-LAN APM Measurement Guide: https://hcp-lan.org/2018-apm-measurement/

QIS Form Part F

Q: What is the purpose of Part F of the QIS form?

A: Addressing health disparities is critical to improving health equity. Part F of the QIS collects information on how issuers are collecting data from their enrollees that are critical to assessing health disparities. Part F also asks carriers to summarize outcomes of their QIS in rural areas of Washington. This data will allow the Exchange to better understand health and health care disparities that exist in the QHP population in order to more effectively direct our outreach to consumers, improve our health literacy education materials, and better address challenges that Exchange consumers face in navigating their health insurance and health needs.

Q: What is the numerator for Table 2-1 when reporting race and ethnicity data?

A: The numerator should be the number of Exchange enrollees where there is race or ethnicity self-reported data attributed to the enrollee. **Indirect data methods should not be counted in the numerator.** "Null", "blank", "missing", "unknown", "not reported", "decline to state", values should not be included in the numerator.

Q: What is the denominator for Table 2-1 when reporting race and ethnicity data?

A: The denominator should be the total Exchange enrollee population for the issuer's plans.

Q: Can race and ethnicity data that was not collected by the health plan be reported in Table 2-1?

A: Yes, all self-reported race and ethnicity data should be included in Table 2-1 even if it wasn't collected by the health plan. Question 2b asks specifically about health plan collection of race and ethnicity data. Only race and ethnicity data collected by the health plan should be reported in 2b.

Q: How do I fill out Table 3-1?

A: Issuers should report their QIS measure rates specific to rural areas in Table 3-1.

Q: What is the definition of "rural areas" for reporting in Table 3-1?

A: "Rural area" will be defined at the zip code level. Issuers should use the Washington State Department of Health's definition of rural using Rural-Urban Commuting Area (RUCA) codes that are based on Census 2010. "Rural areas" that should be reported in Table 3-1 include zip codes designated as "small town/rural" in RUCA's Consolidation Scheme 2 (tier4_2010_ruca_den100). The status of Washington State zip codes as "small town/rural" is signified with a 4 appearing in column U of the Excel file linked below.

Please see the below resources for additional information on these classification codes:

Washington State Department of Health Rural Health Data and Information website: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/RuralHealthData

Guidelines for RUCA's classification system are located here: https://www.doh.wa.gov/Portals/1/Documents/1500/RUCAGuide.pdf

Excel file identifying rural zip codes: https://www.doh.wa.gov/Portals/1/Documents/Pubs/346088.xls

QIS Form Part G

Q: What is the purpose of Part G of the QIS form?

A: There is well-established evidence supporting the influence of primary care and its important role in promoting health and value. Part G aims to gather information on how issuers are promoting primary care and care coordination and how connections are made between primary care clinicians and enrollees.

Q: Can an issuer select a Bree Collaborative Primary Care initiative that they are already working on?

A: WAHBE encourages issuers to select a new strategy if they have not implemented all three strategies. However, issuers are allowed select a strategy that they are already implementing. They will work with the Exchange to identify an appropriate improvement benchmark for the strategy to report on.

Q: How much information should I include in Question 3 of Part G? There are numerous care delivery models across our contracts.

A: Issuers should provide an overview of how they are connecting enrollees with care and what delivery models an enrollee can expect to find within the issuer's network. Are there any innovative models of care in their network that the issuer would like to highlight? Are there clinics or integrated clinic delivery systems that the issuer is partnering with? This text field is an opportunity for issuers to highlight innovative models that prioritize primary care and care coordination.