America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

July 17, 2018

Maria Durham
Director, Division of Program and Measurement Support
Quality Measurement & Value-Based Incentives Group
Center for Clinical Standards & Quality
Centers for Medicare & Medicaid Services
7500 Security Blvd., Bldg. S3-07-03
Baltimore, MD 21244-1850
Submitted via: http://www.regulations.gov

RE: Document Identifier: CMS–10540— Quality Improvement Strategy Implementation Plan and Progress Form – AHIP Comments

Dear Ms. Durham,

America's Health Insurance Plans (AHIP) is writing in response to the Paperwork Reduction Act (PRA) Notice concerning the Quality Improvement Strategy Implementation Plan and Progress Form (QIS Form); published by the Centers for Medicare & Medicaid Services (CMS) in the *Federal Register* (81 FR 45167) on May 18, 2018, and the corresponding detailed PRA materials. AHIP is the national trade association representing the health insurance community.

AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Section 1311(c)(1)(E) of the Affordable Care Act requires qualified health plans (QHPs) offered through an Exchange to implement a quality improvement strategy (QIS), and Section 1311(g)(2) of the Act requires the periodic reporting to the applicable Exchange the activities that a qualified health plan has conducted to implement the QIS. CMS intends to have QHP issuers complete the QIS Plan and Reporting Template annually for initial certification and subsequent annual updates of progress in implementation of their strategy.

AHIP is committed to transparency in quality reporting, and we appreciate the opportunity to comment on the QIS Form. Our comments are based on the extensive experience of our member health plans with quality reporting and improvement activities through participation in the Medicare Advantage, Medicaid, and commercial markets, engagement in quality measure development projects, and advancement of alternative payment models that incentivize providers to deliver high-quality care. We commend CMS for its efforts to streamline the information gathered in this form and reduce plan reporting burden. We offer the following recommendations for further improvements to the QIS Form:

1. **Change the form submission deadline from June 20th to August 1st.** The deadline for plans to submit final HEDIS data results is June 15th, and the data is frozen on June 29th. The current QIS Form submission date of June 20th means that plans must always include preliminary (not final) measure results and are not sufficiently able to fully analyze and provide a meaningful, current summary.

2. **Provide plans with a pre-populated QIS form each year containing responses from the prior year.** Currently, plans must manually re-enter information from the prior plan year's QIS form into the current plan year form This will reduce plan reporting burden and reduce the potential for reporting error.

3. **Increase the character limit for the following criterion to provide sufficient space for describing elements of a QIS lasting more than one year**:

    a. Criterion 30 (Summary of Progress): Increase the character limit from 1,500 to 3,000.
    b. Criterion 32 (Mitigation Activities): Increase the character limit from 750 to 1,500.
    c. Criterion 22 (Rationale for QIS): Increase the character limit from 1,000 to 1,500.
    d. Criterion 23 (Activity(ies) that Will Be Conducted to Implement the QIS): Increase the character limit from 1,000 to 1,500.

4. **Clarify the wording of Criterion 2 (Targets All Health Plans and Product Types Offered Through an Exchange) to allow issuers to identify which HIOS IDs apply to the QIS form when the form is applicable to only a subset of QHPs:**

    a. We support the removal of Criteria 21b from the QIS Form, which previously asked to specify all eligible QHPs covered by the QIS by listing each plan's unique 14-digit HIOS Plan ID (Standard Component ID [SCID]). We also support the removal of Criteria 27b from the QIS Form, which asked issuers to list all HIOS IDs they were adding to or removing from the QIS originally listed in Criterion 21b. However, there continues to be value in listing HIOS IDs when the form is applicable to a subset of QHPs and not all of an issuers' QHPs.
    b. We recommend adding an option under Criterion 2a if a plan indicates the QIS form applies to a subset of its QHPs to list the HIOS IDs the QIS form applies to.
    c. We also recommend editing Criterion 2a to remove the phrase "If you select "All QHPs," skip to Criterion 2c," as Criterion 2c does not appear in the form.

5. **Remove the sections of Criterion 18 (QIS Description) that ask issuers to state Goal 1 and Goal 2.** These sections are redundant of sections in Criterion 24 (Goal(s),

Measure(s), and Performance Target(s) to Monitor QIS Progress), which proves a more complete picture of QIS goals.

6. **Add functionality for Criterion 28 (Modifying Product Types) that allows an issuer to click "add" and "remove" simultaneously for the same product type**. This will allow issuers who have both removed and added product types to their QIS to indicate as such on the QIS form.

We look forward to continuing to work with CMS to improve the Quality Improvement Strategy Implementation Plan and Progress Form. Please feel free to contact me if you have any questions.

Sincerely,

Danielle A. Lloyd

Danielle A. Lloyd, MPH
Senior Vice President, Private Market Innovations and Quality Initiatives

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

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Director, Division of Program and Measurement Support
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Submitted via the Federal Regulations Web Portal, www.regulations.gov

RE: CMS-10540 Quality Improvement Strategy Implementation Plan and Progress Form

Dear Director Durham:

The Blue Cross Blue Shield Association ("BCBSA") appreciates the opportunity to comment on the Paperwork Reduction Act ("PRA") package for the updated Quality Improvement Strategy ("QIS") Implementation Plan and Progress form published on May 31, 2018.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for one in three Americans. For more than 80 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

We support CMS' effort to reduce burden on Plans by proposing to remove duplicate questions while maintaining the consistency of the reporting requirements for the 2020 plan year. For example, we appreciate that the data collection form maintains the progress report section as this is an important part of the evaluation of plan progress. Additionally, we support the flexibility for Plans to report data from the previous plan year to allow for a more comprehensive measure of QIS performance and the ability to customize goals and measures to best serve a Plan's unique population.

We offer the following recommendations to further improve and streamline the QIS data collection:

- **Change the form submission deadline from June 20 to August 1:** The deadline for plans to submit final HEDIS data results is June 15, and the data is then frozen on June 29. We are concerned that the QIS Form submission date of June 20 would force Plans to include preliminary measure results instead of the final results. By extending the submission deadline to August 1, Plans would be able to better ensure the quality of their submissions.

- **Provide Plans with a pre-populated QIS form each year containing their responses from the prior year:** The existing, burdensome process requires Plans to manually re-enter information from the prior plan year's QIS submission into the current plan year's form. By pre-

populating this information, CMS would decrease the burden of the reporting process and decrease the potential for data errors associated with manually re-entering information.

- **Increase the character limit for responses to certain criteria:** The proposed response character limits may be too restrictive when reporting certain elements of a QIS that span multiple plan years. In particular, we suggest the following increases:

    - *Criterion 30 (Summary of Progress)*: Increase the character limit from 1,500 to 3,000.
    - *Criterion 32 (Mitigation Activities)*: Increase the character limit from 750 to 1,500.
    - *Criterion 22 (Rationale for QIS)*: Increase the character limit from 1,000 to 1,500.
    - *Criterion 23 (Activity(ies) that Will Be Conducted to Implement the QIS)*: Increase the character limit from 1,000 to 1,500.

- **Clarify the wording of Criterion 2 (Targets All Health Plans and Product Types Offered Through an Exchange) to allow Plans to identify which Health Information Oversight Systems (HIOS) IDs are covered by a QIS when a QIS is applicable to only a subset of QHPs:** We recommend adding an option under Criterion 2a for Plans to indicate that the QIS only applies to a subset of their QHPs and provide an opportunity to list the HIOS IDs to which a QIS applies.

- **Remove the sections of Criterion 18 (QIS Description) that ask Plans to state Goal 1 and Goal 2:** These sections are redundant to sections in Criterion 24 (Goal(s), Measure(s), and Performance Target(s) to Monitor QIS Progress), which provides a more complete picture of QIS goals.

- **Add functionality for Criterion 28 (Modifying Product Types) that allows an issuer to specify that they added and removed simultaneously for the same product type**: This modification will allow issuers who have both removed and added product types to their QIS to indicate such information on the QIS form.

We appreciate your consideration of our comments. If you have any questions, please contact Anshu Choudhri, Managing Director, Value-Based Policy, at 202-626-8606 or anshuman.choudhri@bcbsa.com.

Sincerely,

Kris Haltmeyer
Vice President, Legislative and Regulatory Policy
Office of Policy and Representation

Document Metadata:CMS-2018-0091-0004

Document Details

Docket ID:	CMS-2018-0091
Docket Title:	þÿ C M S 1 0 5 4 0 Q u a l i t y I m p r o v e m e n t S t r a t e g y I m p l e m Progress Form *
Document File:	
Docket Phase:	ICR 60 day
Phase Sequence:	1
Original Document ID:	CMS-2018-0091-DRAFT-0003
Current Document ID:	CMS-2018-0091-0004
Title:	CO
Number of Attachments:	0
Document Type:	PUBLIC SUBMISSIONS *
Document Subtype:	Public Comment
Comment on Document ID:	CMS-2018-0091-0001
Comment on Document Title:	Agency Information Collection Activities; Proposals, Submissions, and Approvals
Status:	Posted
Received Date:	07/17/2018 *
Date Posted:	07/18/2018
Posting Restriction:	No restrictions
Submission Type:	Web
Number of Submissions:	1 *

Document Optional Details

Status Set Date:	07/18/2018
Current Assignee:	NA
Status Set By:	Hill, Jamaa (CMS)
Component:	
File Code:	
Tracking Number:	1k2-94bu-7kre
Page Count:	1

Total Page Count Including Attachments:	1

Submitter Info

Comment:	It's good that CMS is collecting information to be used that can be used to evaluation the efficacy of qualified health care provides. Extra points for referring to the "Affordable Care Act" instead of using one of President Tiny Hands' pejoratives. Speaking of President Tiny Hands, did you get a chance to watch his appearance yesterday when he sold out our country for a photo op, some flattering words and hopes of future election interference aimed at getting him a second term? A surprising number of wingnuts thought this was just fine. Not sure if this is just cognitive dissidence or if MAGA caps cut off circulation to the brain. But a few did say Houston we have a problem: "not helpful" - Susan Collins "missed opportunity" - Lindsay Graham "a step backwards" - Tim Scott "bizarre and flat-out wrong" - Ben Sasse "shameful" - Jeff Flake "disgraceful" - John McCain "not... a good moment for our country" - Bob Corker "a dark day" - Mike Murphy "serious mistake" - Newt Gingrich "disgusting" - Neil Cavuto "nothing short of treasonous" - John Brennan *
First Name:	Anonymous
Last Name:	Anonymous
City:	
Country:	United States
State or Province:	Colorado
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