

## Washington Quality Improvement Strategy: User Guide for the 2027 Plan Year

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The Washington Health Benefit Exchange (WAHBE or the Exchange) uses a Washington-specific Quality Improvement Strategy. 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 2027 QHP certification. The 2027 QIS form includes an accompanying QIS Quantitative Reporting excel workbook to provide data on specific QIS reporting elements. Issuers must complete the fields shaded in green on the excel workbook. WAHBE entered formulas in fields shaded in blue to calculate all measures.

*Part A of the User Guide provides the following information*

- Background on the QIS
- QIS schedule for the 2027 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 2027 plan year is any QHP issuer that is planning on offering medical coverage through the Exchange in 2027.

The QIS requirements apply to all eligible issuers offering QHPs, including QHPs compatible with health savings accounts (HSAs). For plan year 2027, 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 2027 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.
- Address health and health disparities by choosing “activities to reduce health and health care disparities” as a specific topic area.
- Implement a QIS that includes activities in at least one of the following areas (in addition to health and health care disparities):
  - Improving health outcomes;
  - Preventing hospital readmissions;
  - Improving patient safety and reducing medical errors;
  - Wellness and health promotion
- Implement a QIS that monitors QIS progress by using the following CMS Consensus-Based Entity (CBE) endorsed clinical measure:
  - Cervical Cancer Screening (CBE ID: 0032);
  - Breast Cancer Screening (CBE ID: 2372);
  - Controlling High Blood Pressure (CBE ID: 0018)
- 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 2027 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 2027 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 2027 plan year are expected to submit a 2027 QIS Washington Health Benefit Exchange Quality Improvement Strategy form in 2026 to either:

- (a) Implement a new QIS beginning no later than January 2027, or
- (b) Provide a progress update on an existing QIS.

All issuers, regardless of submission type, must use the 2027 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
- Part H: Issuer Attestations

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 CBE-endorsed measures, but are highly encouraged to use a measure from this measure set. If Issuers use an CBE-endorsed measure that is a QRS (Quality Rating System) measure, then they must report their QRS results as baseline and follow up results. Issuers should not use a modified CBE-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.

WAHBE selected three required measures for the QIS submissions: Cervical Cancer Screening (CBE ID: 0032), Breast Cancer Screening (CBE ID: 2372), and Controlling High Blood Pressure (CBE ID: 0018). These Exchange chose these measures because many reporting issuers fell below the national 50<sup>th</sup> percentile, population health impact, and alignment with state initiatives/measure sets. In designing their QIS, issuers should consider strategies to reach and/or maintain the CMS 2025 QRS 75<sup>th</sup> Percentile QRS score (measurement year 2024) for this measure as outlined in the Guidance for Participation. When setting QIS measure goals for other QRS measures, WAHBE recommends issuers select a target that is the rate associated with the latest CMS QRS 75<sup>th</sup> percentile benchmark or higher.

In alignment with CMS QRS reporting, WAHBE is having issuers report the new age band for Breast Cancer Screening (42-51 years) and report both versions Controlling High Blood Pressure (hybrid and ECDS). Issuers do not need to set different goals for the new Breast Cancer Screening age band or Controlling Blood Pressure ECDS reporting. The QIS Quantitative excel form has these required

measures pre-populated and the goals pre-populate for the new age band and ECDS reporting. To support the identification and improvement of health disparities, issuers are required to stratify results of all QIS measures by race and ethnicity on the 2027 QIS form submission.

### Updated QIS Requirements for 2027

(a) Required Measures and Performance Standards:

Beginning with the 2027 QIS, issuers are required to include Breast Cancer Screening and Controlling High Blood pressure as QIS measures. By the 2029 QIS report, Issuers are expected to either achieve a breast screening rate of 77% and a Controlling High Blood pressure rate of 74% or achieve meaningful improvement (measurement years 2027 and 2028). The performance standard of a 65% screening rate remains in place for Cervical Cancer Screening. These performance standards represent the CMS 2025 QRS 75<sup>th</sup> percentile benchmark scores (from Measurement Year 2024). Per the 2027 Guidance for Participation, the Exchange may take a range of actions such as limiting the issuer’s participation in Plan Preview if issuers do not meet targets or make sufficient improvement. The Exchange considers an issuer to have made sufficient improvement on a measure if they have a statistically significant improvement every year.

Here is a sample calculation using the measure of Breast Cancer Screening, which has different denominators:

- p<sub>1</sub>= Performance prior year 65.1%
- p<sub>2</sub>= Performance latest year 67.71%
- n<sub>1</sub>= Prior year denominator, 4,570
- n<sub>2</sub>= Latest year denominator, 4,472

Step 1: Calculate Standard Error

$$SE = \sqrt{\frac{p_1(1 - p_1)}{n_1} + \frac{p_2(1 - p_2)}{n_2}}$$

**For sample 1:**

$$p_1(1 - p_1) = 0.651(0.349) = 0.227199$$

$$\frac{0.227199}{4570} = 0.00004973$$

**For sample 2:**

$$p_2(1 - p_2) = 0.6771(0.3229) = 0.21899959$$

$$\frac{0.21899959}{4472} = 0.00004896$$

**Combine:**

$$SE = \sqrt{0.00004973 + 0.00004896}$$

$$SE = \sqrt{0.00009869}$$

$$SE \approx 0.009934$$

Step 2: Calculate margin of error – selected 95% confidence interval

$$CI = (\hat{p}_1 - \hat{p}_2) \pm 1.96 \cdot SE$$

### Compute margin of error:

$$1.96 \cdot 0.009934 = 0.01947$$

### Apply to the difference:

$$-0.0261 \pm 0.01947$$

As we are looking for positive increases, the Issuer would need to have a minimum 1.9 percentage point increase in their breast screening rate for it to be a statistically significant improvement (screening rate of 67%).

If the denominator is the same for both years, WAHBE will use this standard error formula for step 1:

$$SE = \sqrt{\frac{p_1 + p_2 - (p_1 - p_2)^2}{n}}$$

- (b) Primary Care Spend – Report is due 7/31 to [qhp@wahbexchange.org](mailto:qhp@wahbexchange.org).

**Reporting:** Issuers who only offer On-Exchange plans in the individual market will submit the same Primary Care Expenditure Report to WAHBE that they submit to the OIC. Issuers who offer off-Exchange plans in the individual market will need to modify the Primary Care Expenditure Report and remove any off-Exchange expenditures in the “All Other Individual Health Plans” column before submitting to WAHBE because this column does not separate on and off exchange figures. The Exchange is collaborating with the OIC and HCA to update the Primary Care Expenditure Report template so that it can serve the needs of the QIS for all issuers in the next reporting cycle and minimize administrative burden.

**Goal setting to increase spend:** The Primary Care Expenditure reports submitted on the 2026 QIS showed issuer spending on primary care varies widely from a low of 2% to 10%. The Health Care Cost Transparency Board primary care spending target, set by the Legislature is 12%. Issuers are to report on their efforts to increase primary care spending by one percentage point each year until they meet the 12% Legislative target. Issuers are to report on their mid-year learnings as they work to achieve the increase in primary care spend target calculated on their 2026 QIS.

- (c) Partnering with producers to improve race and ethnicity data collection

In the 2025 QIS, WAHBE added a requirement for issuers to report on plans to work with producers to increase collection of race and ethnicity data. Exchange application data continues to indicate customers partnered with producers are less likely to respond to the race and ethnicity questions on their application than customers alone or working with navigators. Beginning with Plan Year 2027 enrollments, issuers who have financial agreements with Producers must have an enforceable contractual requirement for brokers to collect race and ethnicity. In the 2027 QIS form, issuers will report on results from partnering with Producers to increase collection of this information and report on their proposed contract term. Issuers will report on the impact of their contract term in their 2028 QIS form (submitted in 2027).

#### (d) Race and Ethnicity QIS Reporting Requirements

The performance standard that all issuers must achieve and maintain eighty percent (80%) self-reported race or ethnicity data for *Washington Healthplanfinder* (HPF) enrollees remains in place. If an issuer has not met the 80% standard, they are expected to demonstrate a statistically significant improvement each year as calculated on their QIS form or be subject to the actions outlined in the Guidance for Participation (e.g., excluded from plan display).

Issuers will be required to stratify all QIS measures on their QIS form by race and ethnicity.

#### QIS Evaluation Process and Methodology

On an annual basis, issuers must meet the QIS requirements as a part of QHP certification. 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 may set up a follow-up meeting with an issuer 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.

The Exchange recognizes that the process to finalize a QIS may necessitate an extension beyond the due date on the Plan Certification Timeline given the complex nature of this QIS. However, if issuers do not finalize their QIS prior to the start of open enrollment without securing an extension, the Exchange will treat this as a missed deadline. This may impact the issuer’s ability to participate in open enrollment preparatory activities such as pre-open enrollment shopping (“Plan Preview”) and/or display of its plans in Healthplanfinder.

## ***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 a new WABHE required measures

**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 (except as required by CMS and/or WAHBE)
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. If issuers are adjusting their baseline and follow up results to QRS results as outlined in the QIS Requirement section on page 4, then this is not considered a correction, and issuers would submit this as a Continuing QIS with Modifications and check the option “Updating baseline and/or follow up results to match QRS values”.

**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:** The Exchange requires addressing health and health care disparities as a specific topic area in an issuer's QIS per federal regulations in addition to a minimum of a second topic area of the issuer's choice from the Topic Area Selection list.

**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, with the exception of CMS and/or WAHBE required topic(s).

**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 three measures. The following measures are required and must be included as part of the issuer's QIS goals: Cervical Cancer Screening (CBE ID: 0032), Breast Cancer Screening (CBE ID: 2372), and Controlling High Blood Pressure (CBE ID: 0018). Issuers can

include multiple goals and measures if they wish. The QIS form includes space for three goals and three measures per goal. If an issuer wishes to address more goals or measures, they should contact the Exchange for a modified QIS form. Note: WAHBE pre-populated the required measures on the 2027 QIS Quantitative form to ensure all issuers listed these measures in the same order to streamline aggregate analyses WAHBE completes. This may not be the same order of measures and goals an issuer has on their 2027 QIS form (word document). WAHBE will be able to match the measure to your respective goal(s) and information about the measures on the QIS form.

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

**A:** CBE-endorsed measures are required for the three mandatory measures of Cervical Cancer Screening, Breast Cancer Screening, and Controlling High Blood Pressure.

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

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

**Q:** Can I modify an CBE-endorsed measure?

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

**Q:** Where should I report my QIS measure score values?

**A:** Please report the numerical values on the separate excel spreadsheet “2027 QIS Quantitative Reporting” called “Tab 1 QIS Measures”. The spreadsheet includes formulas to calculate scores and to help issuers check their work. There is a dropdown list for Issuers to select their QIS measures. Issuers can contact the Exchange to add measure names for any additional measures to the form.

**Q:** If my QIS measure is also a QRS measure that has a hybrid rate and an administrative rate, which value should I report on the QIS?

**A:** Please report the hybrid rate and not the current year administrative rate (CYAR). The hybrid rate is a more complete picture of measure performance.

**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. Measurement Year 2027 will be the baseline year for issuers joining the Exchange for Plan Year 2027.

**Q:** What is my baseline rate if the issuer was new in plan year 2026 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. The exception is if you change your baseline and follow up results to match QRS results. In this situation, you will indicate this is a Continuing QIS with modifications and select the option “Updating baseline and/or follow up results to match QRS values.”

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

**A:** WAHBE recommends Issuers who have no baseline rate set a performance target using the latest CMS QRS 75<sup>th</sup> Percentile benchmark score for the measure or external benchmark that is appropriate for measuring achievement of its identified goal. If Issuers opt to use an external benchmark, they will need to provide context for their benchmark selection. Issuers newly entering the Exchange must set targets where applicable.

**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:** Are the “Follow-Up Results” sections of “Tab 0 General Information and Tab 1 QIS Measures” 2027 QIS Quantitative Reporting excel workbook required?

**A:** Issuers who are continuing a QIS are required to fill in the “Follow-Up Results” sections of “Tab 0 General Information and Tab 1 QIS Measures” 2027 QIS Quantitative Reporting excel workbook. This section of the excel sheet 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:** Issuers must report their directly collected race and ethnicity data on “Tab 0 General Information” and their Primary Care relationship breakdown on “Tab 3 Primary Care” for a QIS that has been in effect for a few months. Issuers do not need to report follow-up results for other measures until the QIS they submit following the first full year of implementation.

**Q:** I have several 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 two full years of data in the “Follow-Up Results” section. For 2027 certification, this should include plan year 2024 and plan year 2025 for those whose QIS is in its third year. Note that the QIS spreadsheet will auto populate the date ranges for the last 2 years on the QIS Quantitative form.

**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/Tab 2 Paying for Value?

**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/Tab 2 Paying for Value?

**A:** Issuers who participate in HCA’s Paying for Value (value-based purchasing) 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. An issuer is not required to fill out Part E/ Tab 2 Paying for Value if an issuer chooses to authorize HCA to share this data with the Exchange and:

- The issuer’s submission to HCA reports results for each HIOS ID separately
- The issuer’s submission to HCA includes their On-Exchange population

Issuers who do not participate in HCA’s VBP survey, who opt not to send their survey data to the Exchange, or who do not submit a report meeting the above requirements must fill out Tab 2 Paying for Value.

Issuers completing Tab 2 Paying for Value should enter the total annual payments made for Exchange plans through each type of payment arrangement on the excel workbook. 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. The total dollar amount of annual payments should be within 10% of the total issuers submit on their financial reports to the OIC. WAHBE compares the QIS to Line 15 column 2a individual contract on the Additional Data Statement Form for the Year. The exception to this guideline is if the issuer has off-Exchange individual market customers. The QIS spreadsheet will compare the total to the OIC report and advise if the total is within the 10% range with a message if the information passes validation or if the issuer needs to recheck the data.

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

**A:** The APM Framework was created 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/wp-content/uploads/2025/08/APM-Framework-White-Paper.pdf>  
HCP-LAN APM Measurement Guide: <https://hcp-lan.org/wp-content/uploads/2025/08/2024-HCPLAN-Methodology-Report.pdf> **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 issuers 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:** How should issuers report race and ethnicity in “Tab 0 General Information” of the 2027 QIS Quantitative Reporting excel workbook?
- A:** Issuers should use the crosswalk in Table 1-2 for guidance on how to roll up race and ethnicity information received through the 834 enrollment files and other data sources into larger reporting categories.
- Q:** What data methods can Issuers use when reporting “Tab 0 General Information” when reporting race and ethnicity data?
- A:** Issuers must report data on Exchange enrollees where there is race or ethnicity self-reported data attributed to the enrollee. **Indirect data methods must not be used in the QIS.** “Null”, “blank”, “missing”, “unknown”, “not reported”, “decline to state”, values should be included in the “Race Not Provided” and “Ethnicity Not Provided” rows.
- Q:** What is the denominator (e.g., “Race Total Verification” and “Ethnicity Total Verification”) for “Tab 0 General Information” when reporting race and ethnicity data?
- A:** The denominator should be the total Exchange enrollee population for the issuer’s plans.
- Q:** What time period and method should the Issuer use for reporting this information:
- A:** For ease of validation, HBE recommends Issuers report point-in-time data from March 2026 when coverage effectuated following open enrollment. WAHBE expects the percentage breakdowns issuers report for each subpopulation to be within 5% of the WAHBE 2026 Spring enrollment report unless the issuer collects significant supplemental data from sources other than the 834 file. The QIS spreadsheet will compare the issuer’s data to the spring enrollment report and advise if the total is within the 5% range with a message if the information passes validation or if the issuer needs to recheck the data.
- Q:** Why is the font red for the calculations for “Race total verification” and “Ethnicity Total Verification”?
- A:** There is conditional formatting included to turn the font red if the totals for these two fields do not match. Issuers should double check their entries if this happens.
- Q:** Can race and ethnicity data that was not collected by the health plan be reported in “Tab 0 General Information”?
- A:** Yes, all self-reported race and ethnicity data should be included on “Tab 0 General Information” even if it wasn’t collected by the health plan. The questions, “Race/Ethnicity Issuer Collected” on “Tab 0 General Information”, 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 the. The “% Issuer Collected” will be populated with a formula from the above charts. If the issuer’s only source of data is from the 834 file, the issuer should enter “0”.

**Q:** How is the 80% threshold measured?

**A:** In accordance with NCQA’s plan scoring, the 80% threshold is measured separately for race and ethnicity.

**Q:** How should issuers report their QIS measures stratified by race and ethnicity?

**A:** Issuers should report their stratified measure results on “Tab 1 QIS Measures” of the “2027 QIS Quantitative reporting” excel workbook. Indirect data methods to determine enrollee race and ethnicity for measure stratification must not be used, and enrollees without directly collected race and ethnicity information should be counted in the “ethnicity not reported” and “race not reported” fields. Issuers are expected to use the race and ethnicity data the Exchange provides via the 834 enrollment file and/or any other directly reported data sources to stratify the required quality measures. If a measure has a hybrid reporting methodology, issuers must report the hybrid result so that WAHBE may compare measure results between populations.

**Q:** Why is the font red for the calculations on “Tab 1 QIS Measures” for numerators and denominators in the “Race Total Verification” and “Ethnicity Total Verification”?

**A:** There is conditional formatting included to turn the font red if the totals for these fields does match the numerators and denominators for the whole population for this measure. Issuers should double check their entries if this happens.

**Q:** How should issuers report their rural QIS measurement data?

**A:** Issuers should report their QIS measure rates specific to rural areas in “Tab 1 QIS Measures” of the excel workbook. If a measure has a hybrid reporting methodology, issuers should report the hybrid result for both populations so that WAHBE may compare rural measure results to aggregate results. If the issuer’s measure data on their rural population is a subset of the data for their whole population, issuers do not need to complete the “Urban” column, and the “REFERENCE” column will calculate the urban measure results. If the rural population is a separate population sample from the whole measure population, issuers must enter results in the “Urban” column.

**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://doh.wa.gov/public-health-healthcare-providers/rural-health/data-maps-and-other-resources>

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://doh.wa.gov/sites/default/files/2022-09/346089.xlsx>

## **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:** What time period and method should the Issuer use for reporting Primary Care relationship data on Tab 3 Primary Care ?

**A:** WAHBE recommends Issuers report point-in-time data from March 2026 when coverage effectuated following open enrollment. The total number of customers should be within 5% of the issuer's enrollment. The QIS spreadsheet will compare the issuer's data to the spring enrollment report and advise if the total is within the 5% range with a message if the information passes validation or if the issuer needs to recheck the data.

**Q:** What is the purpose of the Primary Care Expenditure report?

**A:** Financial investment in primary care is critical to improving and maintain population health. WAHBE is aligning with our partners at HCA and is requiring Exchange issuers to report on primary care spend. Issuers who only offer on-Exchange plans in the individual market do not need to complete a separate Primary Care Expenditure report as part of their QIS and may submit the same report to WAHBE that they submitted to the OIC. Issuers who offer off-Exchange plans in the individual market will need to submit a revised Primary Care Expenditure report with any off-Exchange expenditures removed from the column "All Other Individual Health Plans" column prior to submitting to WAHBE. Issuers must email their Primary Care Expenditure reports to WAHBE by 7/31/26 to [qhp@wahbexchange.org](mailto:qhp@wahbexchange.org). WAHBE plans to monitor primary care spend trends to inform future quality and policy work. Issuers should contact OIC for any technical questions about completing the report.

### **QIS Form Part H**

**Q:** What is the purpose of Part H of the QIS form?

**A:** These attestations are reminders for issuers to double check their entries in places where WAHBE has commonly seen errors or blanks and expedite the QIS approval process. The Multi-Payer Collaborative attestation is asking issuers to confirm their participation in this initiative and inclusion of their Exchange population.