

(2) Evaluate the continuity and coordination of care furnished to enrollees.

(3) If the organization uses written protocols for utilization review, the organization must—

(i) Base those protocols on current standards of medical practice; and

(ii) Have mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation.

(f) *Requirements for all types of plans—*

(1) *Health information.* For all types of plans that it offers, an organization must—

(i) Maintain a health information system that collects, analyzes, and integrates the data necessary to implement its quality assessment and performance improvement program;

(ii) Ensure that the information it receives from providers of services is reliable and complete; and

(iii) Make all collected information available to CMS.

(2) *Program review.* For each plan, there must be in effect a process for formal evaluation, at least annually, of the impact and effectiveness of its quality assessment and performance improvement program.

(3) *Remedial action.* For each plan, the organization must correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms.

[63 FR 35082, June 26, 1998, as amended at 65 FR 40323, June 29, 2000]

#### § 422.154 External review.

(a) *Basic rule.* Except as provided in paragraph (c) of this section, each M+C organization must, for each M+C plan it operates, have an agreement with an independent quality review and improvement organization (review organization) approved by CMS to perform functions of the type described in part 466 of this chapter.

(b) *Terms of the agreement.* The agreement must be consistent with CMS guidelines and include the following provisions:

(1) Require that the organization—

(i) Allocate adequate space for use of the review organization whenever it is conducting review activities; and

(ii) Provide all pertinent data, including patient care data, at the time the review organization needs the data to carry out the reviews and make its determinations.

(2) Except in the case of complaints about quality, exclude review activities that CMS determines would duplicate review activities conducted as part of an approved accreditation process or as part of CMS monitoring.

(c) *Exceptions.* The requirement of paragraph (a) of this section does not apply for an M+C private fee-for-service plan or a non-network M+C MSA plan if the organization does not carry out utilization review with respect to the plan.

[63 FR 35082, June 26, 1998, as amended at 65 FR 40323, June 29, 2000]

#### § 422.156 Compliance deemed on the basis of accreditation.

(a) *General rule.* An M+C organization is deemed to meet all of the requirements of any of the areas described in paragraph (b) of this section if—

(1) The M+C organization is fully accredited (and periodically reaccredited) for the standards related to the applicable area under paragraph (b) of this section by a private, national accreditation organization approved by CMS; and

(2) The accreditation organization used the standards approved by CMS for the purposes of assessing the M+C organization's compliance with Medicare requirements.

(b) *Deemable requirements.* The requirements relating to the following areas are deemable:

(1) Quality assurance.

(2) Antidiscrimination.

(3) Access to services.

(4) Confidentiality and accuracy of enrollee records.

(5) Information on advance directives.

(6) Provider participation rules.

(c) *Effective date of deemed status.* The date on which the organization is deemed to meet the applicable requirements is the later of the following:

(1) The date on which the accreditation organization is approved by CMS.

(2) The date the M+C organization is accredited by the accreditation organization.