

§ 422.152

42 CFR Ch. IV (10–1–05 Edition)

conditions on the acceptance of, an enrollee for the receipt of posthospital extended care services.

[68 FR 50857, Aug. 22, 2003, as amended at 70 FR 4723, Jan. 28, 2005]

Subpart D—Quality Improvement

SOURCE: 63 FR 35082, June 26, 1998, unless otherwise noted.

§ 422.152 Quality improvement program.

(a) General rule. Each MA organization (other than MA private-fee-for-service and MSA plans) that offers one or more MA plans must have, for each of those plans, an ongoing quality improvement program that meets the applicable requirements of this section for the services it furnishes to its MA enrollees. As part of its ongoing quality improvement program, a plan must—

- (1) Have a chronic care improvement program that meets the requirements of paragraph (c) of this section concerning elements of a chronic care program;
- (2) Conduct quality improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction, and meet the requirements of paragraph (d) of this section; and
- (3) Encourage its providers to participate in CMS and HHS quality improvement initiatives.

(b) Requirements for MA coordinated care plans (except for regional MA plans) and including local PPO plans that are offered by organizations that are licensed or organized under State law as HMOs. An MA coordinated care plan's (except for regional PPO plans and local PPO plans as defined in paragraph (e) of this section) quality improvement program must—

- (1) In processing requests for initial or continued authorization of services, follow written policies and procedures that reflect current standards of medical practice.
- (2) Have in effect mechanisms to detect both underutilization and overutilization of services.
- (3) Measure and report performance. The organization offering the plan must do the following:

(i) Measure performance under the plan, using the measurement tools required by CMS, and report its performance to CMS. The standard measures may be specified in uniform data collection and reporting instruments required by CMS.

(ii) Make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them, as provided in § 422.64.

(4) Special rule for MA local PPO-type plans that are offered by an organization that is licensed or organized under State law as a health maintenance organization must meet the requirements specified in paragraphs (b)(1) through (b)(3) of this section.

(c) Chronic care improvement program requirements. Develop criteria for a chronic care improvement program. These criteria must include—

(1) Methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program; and

(2) Mechanisms for monitoring MA enrollees that are participating in the chronic care improvement program.

(d) Quality improvement projects. (1) Quality improvement projects are an organization's initiatives that focus on specified clinical and nonclinical areas and that involve the following:

- (i) Measurement of performance.
- (ii) System interventions, including the establishment or alteration of practice guidelines.
- (iii) Improving performance.
- (iv) Systematic and periodic follow-up on the effect of the interventions.

(2) For each project, the organization must assess performance under the plan using quality indicators that are—

- (i) Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research; and
- (ii) Capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes.

(3) Performance assessment on the selected indicators must be based on systematic ongoing collection and analysis of valid and reliable data.

(4) Interventions must achieve demonstrable improvement.

(5) The organization must report the status and results of each project to CMS as requested.

(e) *Requirements for MA regional plans and MA local plans that are PPO plans as defined in this section*—(1) *Definition of local preferred provider organization plan.* For purposes of this section, the term local preferred provider organization (PPO) plan means an MA plan that—

(i) Has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(ii) Provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and

(iii) Is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(2) MA organizations offering an MA regional plan or local PPO plan as defined in this section must:

(i) Measure performance under the plan using standard measures required by CMS and report its performance to CMS. The standard measures may be specified in uniform data collection and reporting instruments required by CMS.

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

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

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

(B) 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 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 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.

[70 FR 4723, Jan. 28, 2005, as amended at 70 FR 52026, Sept. 1, 2005]

EFFECTIVE DATE NOTE: At 70 FR 52026, Sept. 1, 2005, in § 422.152, paragraphs (a)(1) and (c) were suspended, effective September 1, 2005 through January 1, 2006.

§ 422.156 Compliance deemed on the basis of accreditation.

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

(1) The MA 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 MA organization's compliance with Medicare requirements.

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

(1) Quality improvement.

(2) Antidiscrimination.

(3) Access to services.

(4) Confidentiality and accuracy of enrollee records.

(5) Information on advance directives.

(6) Provider participation rules.

(7) Part D prescription drug benefit programs that are offered by MA programs.

(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: