§ 422.132 Protection against liability and loss of benefits.

Enrollees of MA organizations are entitled to the protections specified in § 422.504(g).


§ 422.133 Return to home skilled nursing facility.

(a) General rule. MA plans must provide coverage of posthospital extended care services to Medicare enrollees through a home skilled nursing facility if the enrollee elects to receive the coverage through the home skilled nursing facility, and if the home skilled nursing facility either has a contract with the MA organization or agrees to accept substantially similar payment under the same terms and conditions that apply to similar skilled nursing facilities that contract with the MA organization.

(b) Definitions. In this subpart, home skilled nursing facility means—

1. The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of posthospital extended care services;

2. A skilled nursing facility that is providing posthospital extended care services through a continuing care retirement community in which the MA plan enrollee was a resident at the time of admission to the hospital. A continuing care retirement community is an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period; or

3. The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from the hospital.

(c) Coverage no less favorable. The posthospital extended care scope of services, cost-sharing, and access to coverage provided by the home skilled nursing facility must be no less favorable to the enrollee than posthospital extended care services coverage that would be provided to the enrollee by a skilled nursing facility that would be otherwise covered under the MA plan.

(d) Exceptions. The requirement to allow an MA plan enrollee to elect to return to the home skilled nursing facility for posthospital extended care services after discharge from the hospital does not do the following:

1. Require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under Part A for Medicare beneficiaries not enrolled in the MA plan.

2. Prevent a skilled nursing facility from refusing to accept, or imposing conditions on the acceptance of, an enrollee for the receipt of posthospital extended care services.


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 that offers one or more MA plans must have, for each of those plans, an ongoing quality improvement program that meets applicable requirements of this section for the service 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 and addresses populations identified by CMS based on a review of current quality performance;

2. Conduct quality improvement projects that can be expected to have a
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favorable effect on health outcomes and enrollee satisfaction, meet the requirements of paragraph (d) of this section, and address areas identified by CMS; 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) Collect, analyze, and report quality performance data identified by CMS that are of the same type as those under paragraph (b)(3)(i) of this section.

(iii) 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.

(5) All coordinated care contracts (including local and regional PPOs, contracts with exclusively SNP benefit packages, private fee-for-service contracts, and MSA contracts), and all cost contracts under section 1876 of the Act, with 600 or more enrollees in July of the prior year, must contract with approved Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors to conduct the Medicare CAHPS satisfaction survey of Medicare plan enrollees in accordance with CMS specifications and submit the survey data to CMS.

(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,
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) Collect, analyze, and report quality performance data identified by CMS that are of the same type as those described under paragraph (e)(2)(i) of this section.

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

(iv) 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.

(g) Special requirements for specialized MA plans for special needs individuals. All special needs plans (SNPs) must be approved by the National Committee for Quality Assurance (NCQA) effective January 1, 2012 and subsequent years. SNPs must submit their model of care (MOC) to CMS for NCQA evaluation and approval, in accordance with CMS guidance. A SNP must conduct a quality improvement program that—

(1) Provides for the collection, analysis, and reporting of data that measures health outcomes and indices of quality pertaining to its targeted special needs population (that is, dual-eligible, institutionalized, or chronic condition) at the plan level.

(2) Measures the effectiveness of its model of care through the collection, aggregation, analysis, and reporting of data that demonstrate the following:

(i) Access to care as evidenced by measures from the care coordination domain (for example, service and benefit utilization rates, or timeliness of referrals or treatment).

(ii) Improvement in beneficiary health status as evidenced by measures from functional, psychosocial, or clinical domains (for example, quality of life indicators, depression scales, or chronic disease outcomes).

(iii) Staff implementation of the SNP model of care as evidenced by measures of care structure and process from the continuity of care domain (for example, National Committee for Quality Assurance accreditation measures or medication reconciliation associated with care setting transitions indicators).

(iv) Comprehensive health risk assessment as evidenced by measures from the care coordination domain (for example, accuracy of acuity stratification, safety indicators, or timeliness of initial assessments or annual reassessments).
§ 422.153 Use of quality improvement organization review information.

CMS will acquire from quality improvement organizations (QIOs) as defined in part 475 of this chapter data collected under section 1886(b)(3)(B)(viii) of the Act and subject to the requirements in § 480.140(g). CMS will acquire this information, as needed, and may use it for the following functions:

(a) Enable beneficiaries to compare health coverage options and select among them.

(b) Evaluate plan performance.

(c) Ensure compliance with plan requirements under this part.

(d) Develop payment models.

(e) Other purposes related to MA plans as specified by CMS.

[76 FR 26546, May 6, 2011]

§ 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. The deeming process should focus on evaluating and assessing the overall quality improvement (QI) program. However, the quality improvement projects (QIPs) and the chronic care improvement programs (CCIPs) will be excluded from the deeming process.

(2) Antidiscrimination.

(3) Access to services.

(4) Confidentiality and accuracy of enrollee records.

(5) Information on advance directives.

(6) Provider participation rules.

(7) The requirements listed in § 423.165(b)(1) through (3) of this chapter for MA organizations that offer prescription drug benefit 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: