(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 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, 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) 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—

(i) 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.

(ii) 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).

(v) Implementation of an individualized plan of care as evidenced by measures from functional, psychosocial, or clinical domains (for example, rate of participation by IDT members and beneficiaries in care planning).

(vi) A provider network having targeted clinical expertise as evidenced by measures from medication management, disease management, or behavioral health domains.

(vii) Delivery of services across the continuum of care.

(viii) Delivery of extra services and benefits that meet the specialized needs of the most vulnerable beneficiaries as evidenced by measures from the psychosocial, functional, and end-of-life domains.

(ix) Use of evidence-based practices and nationally recognized clinical protocols.

(x) Use of integrated systems of communication as evidenced by measures from the care coordination domain (for example, call center utilization rates, rates of beneficiary involvement in care plan development, etc.).

(3) Makes available to CMS information on quality and outcomes measures that will—

(i) Enable beneficiaries to compare health coverage options; and

(ii) Enable CMS to monitor the plan’s model of care performance.

(h) Requirements for MA private-fee-for-service plans and Medicare medical savings account plans. (1) Subject to paragraph (h)(2) of this section, MA PFFS and MSA plans are subject to requirements that may not exceed the requirements specified in § 422.152(e).

(2) For plan year 2010, MA PFFS and MSA plans are not subject to the limitations under § 422.152(e)(1)(i) and must meet the requirements using administrative claims data only.

§ 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)