§ 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.

4. If an MA organization elects to furnish SNF care in the absence of a prior qualifying hospital stay under § 422.101(c), then that SNF care is also subject to the home skilled nursing facility rules in this section. In applying the provisions of this section to coverage under this paragraph, references to a hospitalization, or discharge from a hospital, are deemed to refer to wherever the enrollee resides immediately before admission for extended care services.

(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 the 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 re-
quirements of paragraph (d) of this sec-
tion, and address areas identified by
CMS; and
(3) Encourage its providers to partici-
pate in CMS and HHS quality improve-
ment 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 med-
ical practice.
(2) Have in effect mechanisms to de-
tect both underutilization and over-
utilization 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 re-
quired by CMS, and report its perform-
ance to CMS. The standard measures
may be specified in uniform data col-
lection and reporting instruments re-
quired by CMS.
(ii) Collect, analyze, and report qual-
ity performance data identified by
CMS that are of the same type as those
under paragraph (b)(3)(i) of this sec-
tion.
(iii) Make available to CMS informa-
tion on quality and outcomes measures
that will enable beneficiaries to com-
pare 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 orga-
nization that is licensed or organized
under State law as a health mainte-
nance organization must meet the re-
quirements specified in paragraphs
(b)(1) through (b)(3) of this section.
(5) All coordinated care contracts (in-
cluding local and regional PPOs, con-
tracts with exclusively SNP benefit
packages, private fee-for-service con-
tracts, and MSA contracts), and all
cost contracts under sections 1876 of the
Act, with 600 or more enrollees in July
of the prior year, must contract with
approved Medicare Consumer Assess-
ment of Healthcare Providers and Sys-
tems (CAHPS) survey vendors to con-
duct 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 en-
rollees with multiple or sufficiently se-
vere 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 unambigu-
ously defined, and based on current
clinical knowledge or health services
research; and
(ii) Capable of measuring outcomes
such as changes in health status, func-
tional 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 de-
monstrable 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.

(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).
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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.


§ 422.156 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.

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: