

meet the requirements using administrative claims data only.

[70 FR 4723, Jan. 28, 2005, as amended at 70 FR 52026, Sept. 1, 2005; 73 FR 54249, Sept. 18, 2008; 75 FR 19805, Apr. 15, 2010]

§ 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 only 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 limited 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.

[75 FR 19806, Apr. 15, 2010]

§ 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) 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:

- (1) The date on which the accreditation organization is approved by CMS.
- (2) The date the MA organization is accredited by the accreditation organization.

(d) *Obligations of deemed MA organizations.* An MA organization deemed to meet Medicare requirements must—

- (1) Submit to surveys by CMS to validate its accreditation organization's accreditation process; and
- (2) Authorize its accreditation organization to release to CMS a copy of its most recent accreditation survey, together with any survey-related information that CMS may require (including corrective action plans and summaries of unmet CMS requirements).

(e) *Removal of deemed status.* CMS removes part or all of an MA organization's deemed status for any of the following reasons:

- (1) CMS determines, on the basis of its own investigation, that the MA organization does not meet the Medicare requirements for which deemed status was granted.
- (2) CMS withdraws its approval of the accreditation organization that accredited the MA organization.
- (3) The MA organization fails to meet the requirements of paragraph (d) of this section.

(f) *Authority.* Nothing in this subpart limits CMS' authority under subparts K and O of this part, including but not limited to, the ability to impose intermediate sanctions, civil money penalties, and terminate a contract with an MA organization.

[63 FR 35082, June 26, 1998, as amended at 65 FR 40323, June 29, 2000; 65 FR 59749, Oct. 6, 2000; 70 FR 4724, Jan. 28, 2005; 75 FR 19806, Apr. 15, 2010]

§ 422.157 Accreditation organizations.

(a) *Conditions for approval.* CMS may approve an accreditation organization with respect to a given standard under this part if it meets the following conditions:

- (1) In accrediting MA organizations, it applies and enforces standards that