§ 158.150 Activities that improve health care quality.

(a) General requirements. The report required in §158.110 of this subpart must include expenditures for activities that improve health care quality, as described in this section.

(b) Activity requirements. Activities conducted by an issuer to improve quality must meet the following requirements:

(1) The activity must be designed to:
   (i) Improve health quality.
   (ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
   (iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
   (iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(2) The activity must be primarily designed to:
   (i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
   (A) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee’s representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
      (1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act.
   (2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
   (3) Quality reporting and documentation of care in non-electronic format.
   (4) Health information technology to support these activities.
   (5) Accreditation fees directly related to quality of care activities.

   (B) [Reserved]

   (ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:
      (A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
      (B) Patient-centered education and counseling.
      (C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
      (D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
      (E) Health information technology to support these activities.
   (iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.
   (A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:
      (1) The appropriate identification and use of best clinical practices to avoid harm.
      (2) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
      (3) Activities to lower the risk of facility-acquired infections.
      (4) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.
      (5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
      (6) Health information technology to support these activities.
§ 158.151  Expenditures related to Health Information Technology and meaningful use requirements.

(a) General requirements. An issuer may include as activities that improve

grant money or other funding separate from premium revenue;

(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended, including the new ICD–10 requirements);

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

(7) All retrospective and concurrent utilization review;

(8) Fraud prevention activities;

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(10) Provider credentialing;

(11) Marketing expenses;

(12) Costs associated with calculating and administering individual enrollee or employee incentives;

(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

(14) Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity’s costs support the definitions and purposes in this Part or otherwise support monitoring, measuring or reporting health care quality improvement.