

§ 422.128 Information on advance directives.

(a) Each MA organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, *advance directive* has the meaning given the term in § 489.100 of this chapter.

(b) An MA organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MA organization.

(1) An MA organization must provide written information to those individuals with respect to the following:

(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.

(ii) The MA organization's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the MA organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

(A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.

(B) Identify the state legal authority permitting such objection.

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(D) Provide the information specified in paragraph (a)(1) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information

(due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the MA organization may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The MA organization is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

(E) Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

(F) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

(G) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.

(H) Provide for education of staff concerning its policies and procedures on advance directives.

(I) Provide for community education regarding advance directives that may include material required in paragraph (a)(1)(i) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the MA organization. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An MA organization must be able to document its community education efforts.

(2) The MA organization—

(i) Is not required to provide care that conflicts with an advance directive; and

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(ii) Is not required to implement an advance directive if, as a matter of conscience, the MA organization cannot implement an advance directive and State law allows any health care provider or any agent of the provider to conscientiously object.

(3) The MA organization must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

§ 422.132 Protection against liability and loss of benefits.

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

[63 FR 35077, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005]

§ 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.

[68 FR 50857, Aug. 22, 2003, as amended at 70 FR 4723, Jan. 28, 2005]

§ 422.134 Reward and incentive programs.

(a) *Definitions.* As used in this section, the following definitions are applicable:

Incentive item means the same things as reward item.

Incentive(s) program, reward(s) program, and R&I program mean the same thing as rewards and incentives program.

Incentive(s), R&I, and rewards and incentives mean the same things as reward(s).

Qualifying individual in the context of a plan-covered health benefit means any plan enrollee who would qualify for coverage of the benefit. In the context of a non-plan-covered health benefit, qualifying individual means any plan enrollee.

Reward and incentive program is a program offered by an MA plan to qualifying individuals to voluntarily perform specified target activities in exchange for reward items.

Reward item (or incentive item) means the item furnished to a qualifying individual who performs a target activity as specified by the plan in the reward program.

Target activity means the activity for which the reward is provided to the qualifying individual by the MA plan.

(b) *Offering an R&I program.* An MA plan may offer R&I program(s) consistent with the requirements of this section.

(c) *Target activities.* (1) A target activity in an R&I program must meet all of the following:

(i) Directly involve the qualifying individual and performance by the qualifying individual.

(ii) Be specified, in detail, as to the level of completion needed in order to qualify for the reward item.

(iii) Be health-related by doing at least one of the following:

(A) Promoting improved health.

(B) Preventing injuries and illness.

(C) Promoting the efficient use of health care resources.

(iv) Uniformly offer any qualifying individual the opportunity to participate in the target activity.

(v) Be provided with accommodations consistent with the goal of the target activity to otherwise qualifying individuals who are unable to perform the target activity in a manner that satisfies the intended goal of the target activity.

(2) The target activity in an R&I program must not do any of the following:

(i) Be related to Part D benefits.

(ii) Discriminate against enrollees. To ensure that anti-discrimination requirements are met, an MA organization, in providing a rewards and incentives

program, must comply with paragraph (g)(1) of this section and must not design a program based on the achievement of a health status measurement.

(d) *Reward items.* (1) The reward item for a target activity must meet all of the following:

(i) Be offered identically to any qualifying individual who performs the target activity.

(ii) Be a direct tangible benefit to the qualifying individual who performs the target activity.

(iii) Be provided, to the enrollee, such as through transfer of ownership or delivery, for a target activity completed in the contract year during which this R&I program was offered, regardless if the enrollee is likely to use the reward item after the contract year.

(2) The reward item for a target activity must not:

(i) Be offered in the form of cash, cash equivalents, or other monetary rebates (including reduced cost sharing or premiums). An item is classified as a cash equivalent if it either:

(A) Is convertible to cash (such as a check); or

(B) Can be used like cash (such as a general purpose debit card).

(ii) Have a value that exceeds the value of the target activity itself.

(iii) Involve elements of chance.

(3) Permissible reward items for a target activity may be reward items that:

(i) Consist of “points” or “tokens” that can be used to acquire tangible items.

(ii) Are offered in the form of a gift card that can be redeemed only at specific retailers or retail chains or for a specific category of items or services.

(e) *Marketing and communication requirements.* An MA organization that offers an R&I program must comply with all marketing and communications requirements in subpart V of this part.

(f) *R&I disclosure.* MA organization must make information available to CMS upon request about the form and manner of any rewards and incentives programs it offers and any evaluations of the effectiveness of such programs.