

chronic care improvement program. These criteria must include the following:

(i) Methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program.

(ii) Mechanisms for monitoring MA enrollees that are participating in the chronic improvement program and evaluating participant outcomes such as changes in health status.

(iii) Performance assessments that use quality indicators that are objective, clearly and unambiguously defined, and based on current clinical knowledge or research.

(iv) Systematic and ongoing follow-up on the effect of the program.

(2) The organization must report the status and results of each program to CMS as requested.

(d) [Reserved]

(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), as defined under § 422.101(f), to CMS for NCQA evaluation and approval, in accordance with CMS guidance. In addition to the requirements under paragraphs (a) and (f) of this section, a SNP must conduct a quality improvement program that does the following:

(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).

(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.* MA PFFS and MSA plans are subject to the requirement that may not exceed the requirement specified in § 422.152(e).

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§ 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]

§ 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