

§ 158.150 Activities that improve health care quality.

(a) *General requirements.* The report required in § 158.110 must include expenditures directly related to activities that improve health care quality, as such activities are 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 3502 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.

(6) Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

(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.

(B) [Reserved]

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include—

(1) Wellness assessments;

(2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(4) Public health education campaigns that are performed in conjunction with State or local health departments;

(5)(i) For MLR reporting years before 2021, actual rewards, incentives, bonuses, and reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;

(ii) Beginning with the 2021 MLR reporting year, actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims, to the extent permitted by section 2705 of the PHS Act;

(6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and

(8) Health information technology to support these activities.

(B) [Reserved]

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with § 158.151 of this subpart.

(c) *Exclusions.* Expenditures and activities that must not be included in quality improving activities are:

(1) Those that are designed primarily to control or contain costs;

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with 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, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.

(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 (a) or (b) 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.

[75 FR 74921, Dec. 1, 2010, as amended at 76 FR 76592, Dec. 7, 2011; 77 FR 28790, May 16, 2012; 79 FR 30352, May 27, 2014; 85 FR 29262, May 14, 2020; 87 FR 27393, May 6, 2022]