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MEMORANDUM

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TO	Margaret O'Kane, President	**ORGANIZATION**	National Committee for Quality Assurance
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Privileged and Confidential

SUBJECT Medicare Advantage Deeming and Special Needs Plan Approval Authority

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You asked us to analyze whether the Centers for Medicare & Medicaid Services (CMS) has authority to deem Medicare managed care organizations compliant with Medicare Advantage (MA) program requirements related to Medicare Advantage organization (MAO) appeals, grievances and organization and coverage determinations as well as special needs plan (SNP) models of care (MOCs)[1] based on the plans' accreditation in these areas by a private accrediting organization like the National Committee for Quality Assurance (NCQA). We believe that CMS has authority to deem MAOs compliant in these areas based on NCQA accreditation for several reasons. First, CMS has authority to treat appeals, grievances, organization and coverage determinations and SNP MOCs as fitting within the six categories of MAO requirements for which Congress mandated that CMS deem MAOs in compliance. Second, even if CMS were to conclude that appeals, grievances, organization and coverage determinations and SNP MOCs are outside the six listed categories, we believe that CMS has authority to consider those six categories a floor, not a ceiling, on CMS's deeming authority.

As explained below, deeming plans compliant with requirements related to appeals, grievances, organization and coverage determinations and SNP MOCs based on accreditation by NCQA would be consistent not only with the statute, but also with its legislative history and CMS's past practice. Congress plainly expressed its desire to "reduce redundancy" in the oversight of MA plans through the use of accrediting organizations. Permitting NCQA to accredit plans' compliance with these requirements, which are a major focus of CMS audits, would further that goal. Moreover, CMS has previously deemed MAOs compliant in areas not specifically listed in the statute, including appeals and grievances.

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[1] SNPs are MA coordinated care plans specifically designed to provide targeted care and limit enrollment to special needs individuals. MOCs describe the basic framework under which SNPs meet the needs of each of their enrollees. CMS, SNP MOC, *available at* https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.html (last modified Aug. 23, 2016).

Finally, in addition to giving CMS authority to deem SNPs compliant with requirements for implementing their MOCs based on NCQA accreditation, we believe that the statute gives CMS separate authority to allow NCQA to approve SNPs as effectively implementing their MOCs.[2]

I. BACKGROUND

Quality Assurance and Improvement Program – Social Security Act § 1852(e)

Social Security Act (SSA) § 1852(e), and its deeming authority, were initially enacted in the Balanced Budget Act of 1997 (BBA),[3] which established the MA program (then called Medicare+Choice).[4] Thus, CMS's deeming authority has existed from the inception of the MA program.

Section 1852(e)(1), as enacted in the BBA, required each MAO to "have arrangements, consistent with any regulation, for an ongoing *quality assurance program* for health care services it provides."[5] Section 1852(e)(2) listed 12 elements for a quality assurance program.[6]

Under section 1852(e)(4) CMS was required to deem an MAO to meet the quality assurance program requirements if the plan was

> accredited (and periodically reaccredited) by a private organization under a process that [CMS] has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856[7] to carry out the respective requirements.[8]

CMS implemented section 1852(e)(4) in 1998 by stating it would deem an MAO compliant with "quality assessment and performance improvement requirements," when private accrediting

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[2] We note that NCQA already offers MAOs certification in "utilization management," which NCQA defines to include standards that relate to appeals, grievances and organization and coverage determinations. *See* NCQA, Certification in Utilization Management, *available at* http://www.ncqa.org/Programs/Certification/Utilization-Management-and-Credentialing-UM-CR/Utilization-Management-UM. NCQA will begin offering health plans accreditation for utilization management later this year. *See* NCQA, 2018 Utilization Management Accreditation, *available at* http://www.ncqa.org/programs/accreditation/2018-utilization-management-um.

[3] Pub. L. No. 105-33, § 4001, 111 Stat. 251, 291-93 (codified as amended at 42 U.S.C. 1395w–22(e)).

[4] While the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 renamed Medicare+Choice as Medicare Advantage, the statute continues to refer to Medicare+Choice in places. *See* Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176 (codified as amended at 42 U.S.C. § 1395w–21).

[5] SSA § 1852(e)(1) (1997) (emphasis added).

[6] SSA § 1852(e)(2) (1997). The elements included, among others, collection, analysis, and reporting of data and evaluating the effectiveness of ongoing efforts.

[7] Section 1856 refers to CMS's general authority to establish standards under the MA program. *See* SSA § 1856(b)(1) ("[CMS] shall establish by regulation other standards . . . for [MA] organizations and plans consistent with, and to carry out, this part.").

[8] SSA § 1852(e)(4) (1997). The statute also gave CMS authority to deem MAOs compliant with "confidentiality of records" requirements.

organizations applied and enforced standards that were at least as stringent as the CMS requirements.[9] CMS included "appeals, grievances, and other complaints" among the "quality assessment and performance improvement requirements."

Section 1852(e) was amended for the first time by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA).[10] Specifically, section 1852(e)(4) was amended to state, in part:

> (A) IN GENERAL.—[CMS] shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that [CMS] has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.
>
> (B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:
>
> (i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).
> (ii) Subsection (b) (relating to antidiscrimination).
> (iii) Subsection (d) (relating to access to services).
> (iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).
> (v) Subsection (i) (relating to information on advance directives).
> (vi) Subsection (j) (relating to provider participation rules).

The BBRA conference report explained that that Congress intended for these provisions to "put[] in place incentives for [MA] plans to seek higher standards achievable through accreditation and [to] reduce redundancy in the oversight process."[11] The conference report also noted that "[CMS] will continue to have broad authority to establish the actual standards that the accrediting bodies enforce."[12] Finally, the conference report "emphasize[d] that the intent of Congress in 1997 was clear that private accreditation procedures should be utilized in the [MA] program" and that Congress's "intent in this regard ha[d] not changed."[13]

These provisions addressing MAO accreditation (sections 1852(e)(4)(A)-(B)) have not been amended since enactment of the BBRA in 1999; however, other provisions in section 1852(e) were amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[14] The MA "quality assurance program" was retitled the MA "quality improvement program" and section 1852(e)(1) was amended to require each MAO to "have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees." Section 1852(e)(2) was

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9 63 Fed. Reg. 24,968, 34,998 (June 26, 1998).

10 Pub. L. No. 106-113, § 518, 113 Stat. 1501, 1501A-384-86 (codified as amended at 42 U.S.C. § 1395w–22(e)).

11 H.R. Rep. No. 106-479, at 903 (1999) (Conf. Rep.).

12 *Id*.

13 *Id*.

14 Pub. L. No. 108-173, § 722, 117 Stat. at 2347-48 (codified as amended at 42 U.S.C. 1395w–22(e)).

amended to remove the list of 12 quality assurance program elements and replace it with a general requirement for MA plans to have a "chronic care improvement program."

While section 1852(e)(1) is now titled the "quality *improvement* program," Congress neglected to make a corresponding change to the respective statutory deeming authority at section 1852(e)(4)(B)(i), which continues to refer to "quality *assurance* programs." However, the MMA conference committee report makes clear that Congress intended to give CMS authority to deem MAOs in compliance with quality *improvement* program standards through the use of private accrediting organizations:

> MA organizations are deemed to meet the quality improvement program requirements as [CMS] determines to be appropriate if the MA organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that [CMS] has determined ensures that the accrediting organization applies and enforces standards that meet or exceed the standards established by [CMS].[15]

CMS has also expressly confirmed in regulation that "quality improvement" is a requirement with which it deems an MAO to be in compliance on the basis of accreditation.[16]

Access to Services Requirement – SSA § 1852(d)

In addition to adding 1852(e) to the SSA, the BBA added section 1852(d), which includes an MAO requirement for enrollee access to services.[17] As noted, access to services is one of the six statutory categories with which CMS must deem a plan in compliance based on accreditation.[18]

Under section 1852(d)(1)(A), an MAO must ensure that "benefits [are] available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits." CMS has promulgated regulations implementing section 1852(d) that establish specific requirements for access to MAO services.[19] For instance, MAOs must have written policies and procedures that "allow for individual medical necessity determinations,"[20] and, with respect to drugs, MAOs are required to "[i]ssue the determination and authorize or provide the benefit . . . in accordance with the requirements [that relate to appeals, grievances and organization and coverage determinations], as appropriate, when a party requests a coverage determination."[21]

NCQA SNP Approval – SSA § 1859(f)(7)

In 2010, the Affordable Care Act amended section 1859(f) of the SSA, which describes requirements for approval of SNPs, by adding paragraph (7), which states: "For 2012 and subsequent years,

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15 H.R. Rep. No. 108-391, at 731 (2003) (Conf. Rep.).
16 42 C.F.R. § 422.156(b)(1) (2005); 70 Fed. Reg. 4724 (Jan. 28, 2005).
17 Pub. L. No. 105-33, § 4001, 111 Stat. at 289-91.
18 SSA § 1852(e)(4)(B)(iii).
19 42 C.F.R. § 422.112.
20 42 C.F.R. § 422.112(a)(6)(ii).
21 42 C.F.R. § 422.112(b)(7)(ii).

[CMS] shall require that a[n MAO] offering a specialized MA plan for special needs individuals be approved by [NQCA] (based on standards established by [CMS]).”[22]

In implementing section 1859(f)(7), CMS initially proposed that NCQA review all SNP quality improvement program plans and MOCs using standards developed by CMS.[23] In its final regulations, however, CMS stated that, as part of SNP approval, NCQA would review only SNP MOCs. Although CMS declined to make review of quality improvement program plans part of the NCQA section 1859(f)(7) approval process, the agency made clear that it maintained “broad discretion regarding the development of the SNP approval process.”[24]

II. ANALYSIS

CMS Is Permitted to Deem MAOs Compliant with Appeal, Grievance, Organization and Coverage Determination and SNP MOC Requirements Through the Use of Private Accrediting Organizations Because Those Requirements May Be Considered Part of a Quality Improvement Program

The quality improvement program[25] is one of the six specified statutory categories with which CMS must deem an MAO compliant if the MAO is accredited by a private accrediting organization.[26] However, CMS can, and previously has, deemed MAOs to be in compliance with quality improvement program standards that are not specifically listed in the statute.

As originally enacted in 1997, section 1852(e)(1) required MAOs to have arrangements for quality assurance programs “consistent with any regulation.”[27] Thus, at the beginning of the quality assurance program, CMS had broad regulatory authority to establish MA quality assurance standards. Also in 1997, CMS was given authority under section 1852(e)(4) to deem MAOs compliant with those standards.[28] Section 1852(e)(4) provided that an MAO

> is deemed to meet [quality assurance program] requirements if the [MAO] is accredited (and periodically reaccredited) by a private organization under a process that [CMS] has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under [CMS’s general authority to establish standards] to carry out the respective requirements.[29]

In 1998, CMS issued its first set of regulations to implement section 1852(e). In the preamble discussion to that interim final rule, CMS stated that it “believe[d] that all of the [quality assurance

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22 Pub. L. No. 111-148, § 3205(c), 124 Stat. 119, 458 (2010) (codified at 42 U.S.C. § 1395w–28(f)(7)).

23 75 Fed. Reg. 71,189, 71,199 (Nov. 22, 2010).

24 76 Fed. Reg. 21,431, 21,446-48 (Apr. 15, 2011).

25 As discussed above, while section 1852(e)(1) is currently titled the “quality *improvement* program,” the statutory deeming authority at section 1852(e)(4)(B)(i) still refers to the quality *assurance* program,” the name of the program until the enactment of the MMA in 2003.

26 SSA § 1852(e)(4)(B)(i).

27 SSA § 1852(e)(1) (1997).

28 SSA § 1852(e)(4) (1997).

29 *Id*.

program] requirements in section 1852(e) are geared toward improving quality, not simply monitoring it" and, therefore, the agency referred to the requirements as the "quality assessment and performance improvement program."[30] As part of this program, CMS established in regulation certain clinical and non-clinical services that were required to be addressed by MAOs through "performance improvement projects."[31] Specifically, CMS included "[a]ppeals, grievances, and other complaints" in non-clinical performance improvement projects under 42 C.F.R. § 422.152(d)(5)(i)."[32] Moreover, in 42 C.F.R. § 422.156(b)(1), CMS stated that the "performance improvement requirements of § 422.152" were "deemable" by a private accrediting organization.[33] Taken together, sections 422.152(d)(5)(i) and 422.156(b)(1) allowed CMS to deem an MAO in compliance with appeals and grievance requirements through accreditation by a private accrediting organization.

While the current version of section 1852(e) no longer includes the "consistent with any regulation" language from the BBA, its removal does not diminish CMS's rulemaking authority. Even after the statute was amended, CMS maintained broad authority to establish standards for the MA program.[34]

Additionally, deletion of a portion of a statute does not alter the statute's meaning if a change in meaning would be inconsistent with Congress's intent.[35] Here, when Congress amended the statute in 1999 to add the six statutory categories for which CMS was required to deem an MAO in compliance with MA program requirements, it reiterated that it intended CMS to "continue to have broad authority to establish the actual standards that the accrediting bodies enforce."[36] This statement is particularly significant given its timing: Only one year earlier, CMS had included appeals and grievances in MA performance improvement projects and said that "[a]n [MAO] accredited by an approved accreditation organization may be deemed to meet [the quality assessment and performance improvement] requirements, depending on the specific requirements for which its accreditation organization's request for approval was granted."[37] In saying that it wished CMS "to continue to have broad authority" to define what is "deemable" by MA accrediting organizations, Congress essentially ratified CMS's authority to treat appeals and grievances as "deemable" requirements under the quality improvement program.

As with appeals and grievances, CMS could exercise its "broad deeming authority" to include organization and coverage determinations and SNP MOCs as quality improvement program standards with which the agency may deem an MAO in compliance through an accrediting organization. Like appeals and grievances, organization and coverage determinations are decisions made by MAOs that determine whether an enrollee receives an item or service. Organization and

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30 63 Fed. Reg. at 34,992 (June 26, 1998).

31 *Id*. at 34,994.

32 42 C.F.R. § 422.152(d)(5)(i) (1998); 63 Fed. Reg. at 34,994.

33 42 C.F.R. § 422.156(b)(1) (1998); 63 Fed. Reg. at 34,998.

34 SSA § 1856(b)(1) ("[CMS] shall establish by regulation other standards . . . for [MAOs] and plans consistent with, and to carry out, this part."); SSA § 1871(a)(1) ("[CMS] shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title."); Wis. Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 497 n. 13 (2002) ("We have long noted Congress' delegation of extremely broad regulatory authority to [CMS].").

35 United States v. Wilson, 503 U.S. 333, 336 (1992) (attributing no significance to the deletion of a reference to the Attorney General, because a change in meaning would be inconsistent with congressional intent).

36 H.R. Rep. No. 106-479, at 903-04 (1999) (Conf. Rep.).

37 63 Fed. Reg. at 34,998.

coverage determinations therefore relate directly to the quality of care beneficiaries receive. To improve the quality of care, it would be natural for CMS to consider organization and coverage determinations among the quality improvement standards with which the agency could deem an MAO compliant through accreditation.[38]

CMS also could exercise its broad deeming authority to include implementation of SNP MOC, which "provides the basic framework under which the SNP [meets] the needs of each of its enrollees" and is "a vital quality improvement tool."[39] As CMS has already explicitly stated that SNP MOCs are a "quality improvement tool," CMS would be well within its statutory authority under section 1852(e) to include implementation of SNP MOCs as a quality improvement standard within the agency's deeming authority.

CMS Is Also Permitted to Deem MAOs Compliant with Appeal, Grievance, Organization and Coverage Determination and SNP MOC Requirements Through the Use of Private Accrediting Organizations Because Those Requirements May Be Treated as Relating to Access to Services

Like the quality improvement program, access to services is one of the six specified statutory categories with which CMS must deem an MAO compliant if it is accredited by a private accrediting organization.[40] Additionally, CMS has authority to designate the specific standards MAOs must meet as part of the access to services requirement. Appeals, grievances. organization and coverage determinations, and SNP MOCs may be included among those standards.

An MAO is required to ensure that its enrollees have access to services by making "benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits."[41] As explained above, appeals, and grievances and organization and coverage determinations are all decisions made by MAOs that determine whether an enrollee receives an item or service. Consequently, if such decisions are not made properly and promptly, an MAO will have failed to assure continuity in the provision of benefits. Thus, appeals, grievances and organization and coverage determinations all could be interpreted by CMS to fall under the access to services requirement.

Indeed, the current CMS access to services regulations include standards suggesting that appeals, grievances and organization and coverage determinations are already incorporated in the access to

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38 CMS has also acknowledged the importance of appeals and organization and coverage determinations in MA star ratings, which CMS has described as "driving improvements in Medicare quality." CMS, 2017 Start Ratings (Oct. 12, 2016), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-12.html. There are currently four star rating appeals measures. CMS, MA and Part D Calendar Year 2018 Call Letter, at 87(Apr. 3, 2017), *available at* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf. Moreover, CMS reduces a MA contract's measure rating to 1 star, the lowest rating, if there are "errors in processing coverage determinations/exceptions or organization determinations." *Id*. at 86.

39 CMS, SNP MOC, *available at* https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.html (last modified Aug. 23, 2016).

40 SSA § 1852(e)(4)(B)(iii).

41 SSA § 1852(d)(1)(A).

services requirement. For instance, the regulations explicitly require MAOs to have written policies and procedures related to "medical necessity determinations."[42] Coverage and organization determinations, appeals, and grievances all utilize medical necessity determinations as a basis for determining enrollees' eligibility for items and services.[43] Moreover, the access to services regulations also require, when a party requests a coverage determination for drugs, that the MAO "[i]ssue the determination and authorize or provide the benefit" in accordance with the, appeal, grievance and organization and coverage determination requirements.[44]

Additionally, as previously noted, SNP MOCs describe the basic framework under which SNPs meet the needs of each of their enrollees.[45] The current MOC scoring guidelines, which are published by NCQA based on standards and scoring criteria established by CMS, include references related to access to services.[46] For instance, a SNP is instructed to include in its MOC "[s]pecific goals for improving access . . . of the healthcare needs . . . for the SNP population."[47] The MOC must also "describe [the SNP's] process for partnering with providers within the community to *deliver needed services* to its most vulnerable members, including the type of specialized resources and services provided and how the organization works with its partners to facilitate member or caregiver *access* and *maintain continuity of services*."[48]

Therefore, based upon the statute and consistent with CMS's implementation of the access to services requirement, CMS could include appeal, grievance, organization and coverage determination and SNP MOC standards, and deem MAOs in compliance with those standards and others within the access to services requirement, through accreditation.

CMS May Treat the Six Statutory Categories Listed in Section 1852(e) as a Floor and Not a Ceiling on the Requirements with Which the Agency May Deem a Plan in Compliance

As explained above, CMS's "broad authority" to determine the requirements that MA accrediting bodies enforce allows the agency to include, appeals, grievances, organization and coverage determinations and SNP MOCs. But we also note that nothing in the statute expressly limits CMS's "deeming authority" to the six specified statutory categories.

Section 1852(e)(4)(A) states that "[CMS] shall provide that a[n MA] organization is deemed to meet all the [specified categories] if the organization is accredited (and periodically reaccredited) by a private accrediting organization." Notably, the statute does not state that CMS may deem MAOs compliant in only the six specified categories. Nor does the legal maxim "expressio unius est exclusio alterius" (the mention of one thing implies the exclusion of another) require such an interpretation. Courts have emphasized that the maxim is "not always correct" and "the maxim's force in particular situations depends *entirely on context*," such as whether the expression of one

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42 42 C.F.R. § 422.112(a)(6)(ii).

43 *See* 42 C.F.R. §§ 422.562(a)(4), 423.562(a)(5).

44 42 C.F.R. § 422.112(b)(7)(ii).

45 CMS, SNP MOC, *available at* https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.html (last modified Aug. 23, 2016).

46 NCQA, Model of Care Scoring Guidelines CY 2018 (Jan. 10, 2017), *available at* http://snpmoc.ncqa.org/wp-content/uploads/MOC-Scoring-Guidelines_CY-2018.pdf.

47 *Id*. at 15.

48 *Id*. at 3 (emphases added).

thing "does really necessarily . . . imply the preclusion of alternatives."[49] Here, the context suggests that Congress intended the specified categories to represent a floor and not a ceiling on the requirements that are "deemable."

As previously discussed, when Congress amended the statute as part of the BBRA in 1999 to list six requirements, it stated that CMS would "continue to have broad authority to establish the actual standards that the accrediting bodies enforce."[50]

Moreover, in enacting the BBRA, Congress also stated that it amended section 1852(e) to "reduce redundancy in the oversight process" and that it intended "that private accreditation procedures should be utilized in the [MA] program."[51] CMS audits today no longer focus on the six categories specified in the statute. Instead, CMS now uses audits to monitor MAO compliance in program areas like appeals, grievances, organization and coverage determinations and SNP MOCs.[52] This has created a significant redundancy in the current oversight process, because even when MAOs are accredited in the six statutory categories, they remain subject to CMS audits.

Additionally, because of the lack of overlap between the six specified statutory categories and CMS audits, MAOs no longer have an incentive to receive private accreditation. Thus, congressional intent is undermined. Permitting private accrediting organizations to enforce MAO requirements that go beyond those specifically listed in the statute – that is, to enforce the requirements that are actually the focus of CMS audits – would be consistent with Congress's goal "that private accreditation procedures should be utilized in the [MA] program."[53]

CMS Is Permitted to Allow NCQA to Evaluate Whether SNPs Effectively Implement Their MOCs as Part of the Approval Process Required by SSA § 1859(f)(7)

In addition to its deeming authority under section 1852(e), CMS also has broad authority to establish the standards for which NCQA approves SNPs under SSA § 1859(f)(7). Section 1859(f)(7) requires that SNPs be approved by NCQA, and that such approval be "based on standards established by [CMS])." While CMS's standards currently restrict NCQA's approval to only an evaluation of whether SNP MOCs include descriptions that meet certain clinical and non-clinical elements,[54] nothing in the statute requires NCQA's approval to be so limited. Indeed, CMS's initial proposal for implementing section 1859(f) makes this clear. CMS initially proposed that SNP approval include NCQA review and approval of SNP quality improvement program plans.[55] CMS has also acknowledged that the statute gives it "broad discretion regarding the development of the SNP approval process."[56] Although the agency ultimately did not include NCQA review of MOC implementation in SNP approval, CMS did not say or suggest that it lacked statutory authority to do so. Rather, it was a policy choice. Therefore, CMS is permitted to extend the SNP approval process beyond NCQA

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49 *In re* Sealed Case No. 97-3112, 181 F.3d 128, 132 (D.C. Cir. 1999) (emphasis added).

50 H.R. Rep. No. 106-479, at 903-04 (1999) (Conf. Rep.).

51 *Id*.

52 CMS, 2016 Part C and Part D Program Audit and Enforcement Report, at 5 (May 9, 2017), *available at* https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2016_Program_Audit_Enforcement_Report.pdf.

53 H.R. Rep. No. 106-479, at 903 (1999) (Conf. Rep.).

54 CMS, Medicare Managed Care Manual, ch. 5, § 20.2 (rev. 117, Aug. 8, 2014).

55 75 Fed. Reg. at 71,199.

56 76 Fed. Reg. at 21,447.

approval of SNP MOC descriptions to include NCQA evaluation of whether SNPs properly implement their MOCs. Allowing NCQA to make this determination would appear to be sound policy: No longer would the SNP approval process be based solely on promises made by SNPs; instead it would also be based on whether SNPs fulfill their promises.