Medicare Advantage Deeming

CMS has Broad Authority to Maximize Benefits to Taxpayers & Plan Members

The Benefits of Medicare Advantage Deeming

The Centers for Medicare & Medicaid Services (CMS) can improve Medicare Advantage (MA) oversight by leveraging the deeming authority first included in the bipartisan Balanced Budget Act of 1997. The law authorized CMS to deem privately accredited MA plans as meeting certain program requirements, provided the accreditor's standards were ""no less stringent than the applicable Medicare requirements."

Deeming authority extended to six areas: (1) Quality assessment & improvement; (2) Confidentiality & accuracy; (3) Anti-discrimination; (4) Access to services; (5) Information on advance directives; and (6) Provider participation rules.

Congress expressly established deeming authority to reduce redundancy in MA plan oversight for those plans that have *already subjected themselves to a rigorous, third-party accreditation review*. In the conference committee report, Congress also made clear that it intended for deeming to establish "incentives for MA plans to seek higher standards achievable through accreditation and reduce redundancy in the oversight process."

Subsequently, the concept of deeming for health plans and other entities – including, most recently, dialysis centers – has enjoyed bipartisan support because it enhances oversight, minimizes plan burden and recognizes the value of utilizing non-governmental resources to ensure high-quality care.

Deeming accredited plans:

- Reduces duplicative reporting requirements
- Saves taxpayer dollars by leveraging the expertise of non-governmental entities
- Helps CMS focus limited oversight resources on lower-performing plans

Recent History

Between 2000 and 2015, the National Committee for Quality Assurance (NCQA) deemed hundreds of MA plans. Currently, NCQA-accredited plans cover nearly 170 million Americans, including 11.2 million in MA plans, or 63% of all enrollees. As part of its accreditation process, NCQA reviews actual case files to verify compliance, scores the quality of clinical care and patient experience, and requires strict auditing for accuracy.

CMS has not approved third-party accreditors like NCQA for MA deeming since 2015, citing a lack of overlap between CMS audits (primarily focused on coverage determinations and appeals) and their interpretation of statutorily deemable areas. Without deeming, accredited plans undergo redundant coverage determinations and appeals oversight and CMS staff duplicates many of the oversight functions already performed by accreditors. And beneficiaries lose out on protections in key areas that CMS has previously deemed but is not now covering in MA audits. Other opportunities to leverage accreditation, such as in review of Special Needs Plans (SNP) performance, are also stymied by a narrow reading of deeming authority.

CMS Statutory Authority for Deeming

A recent legal opinion from former CMS General Counsel Sheree Kanner found that CMS has broad authority to deem appeal and coverage determination requirements under the "Quality assessment & improvement" category included in the original deeming statute. Kanner also determined that the implementation of a SNP's Models of Care (MOCs) may be considered part of a quality improvement program, making then deemable under the "Access to services" category.

- Coverage determinations meet both categories' criteria because CMS regulations define access to include appeals, grievances and coverage determinations, and coverage determinations directly relate to the enrollees' quality of care.
- SNP MOCs meet both categories' criteria because CMS explicitly states that SNP MOCs are a "quality improvement tool." CMS instructs SNPs to include in MOCs "specific goals for improving access."