

# Medicare Advantage Deeming



## CMS has Broad Authority to Expand & Save Tax Dollars

The Centers for Medicare & Medicaid Services (CMS) can improve of Medicare Advantage (MA) oversight by maximizing use of private accreditors' plan reviews. "Deeming" accredited plans:

- Reduces plan burden,
- Saves taxpayer dollars, and
- Lets CMS focus on poor performing plans that tend to not seek accreditation.

The bipartisan Balanced Budget Act of 1997 authorized CMS to deem privately accredited MA plans as meeting requirements in six MA categories: Access, Advance Directives, Anti-discrimination, Confidentiality and Accuracy of Enrollee Records, Provider Participation and Quality Improvement. Congress expressly did this to reduce redundancy in MA plan oversight. Deeming for health plans and other entities – including most recently dialysis centers – enjoys bipartisan support because it enhances oversight and minimizes plan burden.

The National Committee for Quality Assurance (NCQA) deemed plans in all six categories from 2000 to 2015. NCQA's Health Plan Accreditation program is the most widely used in the country, covering nearly 170 million Americans, including 11.2 million in MA plans, or 63% of all enrollees. NCQA reviews actual case files to verify compliance, scores the quality of clinical care and patient experience, and requires strict auditing for accuracy.

### CMS Statutory Authority for Deeming

Unfortunately, deeming lapsed in 2015 because CMS audits drifted from the six categories to target coverage determinations and appeals. NCQA Accreditation also focuses heavily on coverage determinations and appeals, but CMS has not deemed coverage determinations and appeals. Without deeming of coverage determinations and appeals, accredited plans must undergo redundant coverage determinations and appeals oversight. Beneficiaries also lack needed oversight on key protections like privacy and anti-discrimination that CMS deemed but are not now covered in CMS audits. NCQA also approves MA Special Needs Plans (SNPs) Models of Care (MOCs) that describe how SNPs will meet their special population's unique needs. However, CMS has not deemed how SNPs actually implement the MOCs.

That is why NCQA asked former CMS General Counsel Sheree Kanner to assess CMS' legal authority for MA deeming. Kanner found that CMS has broad authority to define what activities qualify as Quality Improvement and it can deem. CMS may deem appeal and coverage determination and SNP MOC requirements because those requirements may be "considered part of a quality improvement program," and "treated as relating to access to services."

- 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."

Kanner further found that CMS may consider the six statutory categories a floor, not a ceiling, on its authority. CMS can deem appeals, grievances, coverage determinations and SNP MOCs, even if they were outside the six listed categories. Congress also made clear in a conference report 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."

- This makes sense, as NCQA-Accredited Medicare Advantage plans perform better on important quality measures like asthma and diabetes care and nutrition and exercise counseling.
- Deeming thus lets CMS focus scarce plan oversight resources on non-accredited plans more likely to have problems.