CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 58 **Date: AUGUST 13, 2004**

I. SUMMARY OF CHANGES:

NEW/REVISED MATERIAL - EFFECTIVE DATE: August 13, 2004

Section 35.1 - Terminology - Modified definition of fully accredited status

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new\revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	5 / 35 / 35.1 / Terminology

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

35.1 - Terminology

(Rev. 58, 08-13-04)

Deeming Authority

The authority granted by CMS to private, national accrediting organizations to determine, on CMS' behalf, whether an M+C organization evaluated by the accrediting organization is in compliance with corresponding Medicare regulations.

Deemed Status

Designation that an M+C organization has been reviewed and determined "fully accredited" by a CMS-approved private, national accrediting organization for those standards within the deeming categories that the accrediting organization has the authority to deem.

Accreditation

An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

Fully Accredited

Designation that all the elements within all the accreditation standards for which the accreditation organization has been approved by CMS have been surveyed and determined to be fully met or otherwise acceptable without significant findings, recommendations, or corrective actions. Each AO defines fully accredited differently. Currently CMS has entered an agreement with NCQA, JCAHO, and AAAHC to be deeming accrediting organizations. Below describes each AO's fully accredited status levels.

NCQA

Health plans may earn the following NCQA Accreditation status levels based on their compliance with NCQA's rigorous requirements and their performance on HEDIS® and CAHPS®:

- ***Excellent:*** *NCQA's highest accreditation status is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality*

improvement. Plans earning this accreditation level must also achieve HEDIS results that are in the highest range of national or regional performance.

- ***Commendable:*** *This accreditation level is awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. The 'Commendable' designation is equivalent to NCQA's former 'Full Accreditation' designation.*

- ***Accredited:*** *Health plans that earn the "Accredited" designation must meet most of NCQA's basic requirements for consumer protection and quality improvement. "Accredited" is equivalent to the former "One-Year" designation.*

Joint Commission Accreditation Health Organization

Accreditation with Requirements for Improvement (previously Accreditation with Type I Recommendations) *is awarded to a health care organization that demonstrates satisfactory compliance with applicable JCAHO standards in most performance areas, but has deficiencies in one or more performance areas or in meeting accreditation policy requirements which require resolution within a specified time period.*

Provisional Accreditation *is awarded to a previously unaccredited health care organization that demonstrates satisfactory compliance with a subset of standards during a preliminary on-site evaluation. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately 6 months later.*

AAAHC

AAAHC has five types of accreditation decisions resulting from an initial accreditation survey, re-accreditation survey (survey following 3-year term) or a re-survey (survey following one-year or 6-month provisional term of accreditation or a 6-month deferral).

Three Years *– The Accreditation Committee awards an organization accreditation for 3 years when it concludes that the organization is in substantial compliance with the standards, and the committee supports the accuracy of the findings and the organization's commitment to continue providing high-quality medical care and services as reflected in the standards.*

One Year *– The Accreditation Committee awards an organization accreditation for 1-year when a limited portion of the organization's operations require action to meet some standards and the organization requires sufficient time to achieve compliance.*

Six Month Provisional *– The Accreditation Committee awards an organization a provisional 6-month term of accreditation when it concludes that the organization is in substantial compliance with the standards but it is not eligible for a 3-year term of accreditation because the organization does not meet specific requirements , e.g., the organization has not been operational for 6 months. The Accreditation Committee also awards provisional accreditation to organizations that are in compliance with the standards but the organization's demonstration of continued compliance with the standards is not sufficiently established to grant a longer term of accreditation.*

Private, National Accrediting Organization

Organizations that seek deeming authority must be private, national accrediting organizations. To meet CMS' definition of a private, national accrediting organization, the entity must demonstrate the following:

- It has accredited and re-accredited managed care organizations in multiple States;
- It is recognized as an accrediting body by the managed care industry and relevant national associations;
- It contracts with or employs staff that are appropriately trained and have experience with monitoring managed care plans for compliance with the AO specific accrediting standards; and
- It contracts with or employs sufficient staff to provide accreditation services nationwide.

Accreditation Cycle for M+C Deeming

The duration of CMS' recognition of the validity of an accrediting organization's determination that an M+C organization is "fully accredited." CMS will continue to perform the biennial monitoring audit. In the M+C deeming program, an accrediting organization may use its usual cycle, as long as re-accreditation occurs at least every three years.

Unit of Analysis for Deeming

For deeming, CMS will recognize the deemed status of M+C organizations if they are accredited at the same jurisdictional level (whether contract, state, or multi-state) that CMS would have used if it, rather than the accrediting organization, had conducted the survey.

Accrediting Organizations' Enforcement of Compliance with Standards that Relate to M+C Organization Requirements

Accrediting organizations with deeming authority will be responsible for enforcing compliance in accredited M+C organizations by initiating a corrective action process with respect to deficiencies found in those areas where deemed status applies. In their application for deeming authority, an accrediting organization must be able to demonstrate that when they find areas of noncompliance, they (the accrediting organization) will implement a process that is at least as stringent as the process CMS uses to correct areas of noncompliance with similar Medicare requirements.
