This document is scheduled to be published in the
Federal Register on 03/10/2026 and available online at
https://federalregister.gov/d/2026-04593, and on https://govinfo.gov

[Billing code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4216-PN]

Medicare Program; Request for Renewal of Deeming Authority of the National Committee for Quality Assurance (NCQA) for Medicare Advantage Health Maintenance Organizations and Preferred Provider Organizations

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice with request for comment.

SUMMARY: This notice announces that the Centers for Medicare & Medicaid Services is considering granting approval of the National Committee for Quality Assurance's renewal application for Medicare Advantage "deeming authority" of Health Maintenance Organizations and Preferred Provider Organizations to continue participation in the Medicare program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than **[Insert date 30 days after date of publication in the Federal Register.]**

ADDRESSES: In commenting, refer to file code CMS-4216-PN.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the "Submit a comment" instructions.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-4216-PN,

P.O. Box 8010

Baltimore, MD 21244-8010

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-4216-PN,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

FOR FURTHER INFORMATION CONTACT:

Dawn Johnson Scott, (410) 786-3159 or Katie Schenck, (410) 786-0628.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that website to view public comments. CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post

acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a Medicare Advantage (MA) organization that contracts with the Center for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met for a Medicare Advantage organization (MAO) to enter into a contract with CMS are located at 42 CFR 422.503(b). These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to enter into an MA contract with CMS. Other relevant provisions of the Act include Parts A and B of Title XVIII and Parts A and E of Title XI of the Act pertaining to the provision of services by Medicare-certified providers and suppliers. Generally, for an entity to be an MAO, the organization must be licensed by the state as a risk bearing organization, as set forth in 42 CFR 422.400.

As a method of assuring compliance with certain Medicare requirements, an MAO may choose to become accredited by a CMS-approved accreditation organization (AO). By virtue of its accreditation by a CMS-approved AO, the MAO may be "deemed" compliant in one or more requirements set forth in section 1852(e)(4)(B) of the Act. For CMS to recognize an AO's accreditation program as establishing an MA plan's compliance with our requirements, the AO must, as set forth in § 422.157(a)(1), prove to CMS that their standards are at least as stringent as Medicare requirements for MAOs. MAOs that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and are accredited by an approved AO may receive, at their request, "deemed" status for CMS requirements for the deemable areas. These areas include Quality Improvement, Anti-Discrimination, Confidentiality and Accuracy of Enrollee Records, Information on Advance Directives, and Provider Participation Rules.

At this time, CMS does not recognize accreditation of the following areas: Access to

Services set out in § 422.156(b)(3) or the Part D areas of review set out at § 423.165(b) as part of the MA deeming program. Accreditation organizations that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As we specify at § 422.157(b)(2)(ii), the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must apply to CMS to renew their deeming authority for a subsequent approval period.

The National Committee for Quality Assurance (NCQA) was previously approved by CMS as an AO for MA deeming of HMOs and PPOs for a term from December 30, 2020, to December 30, 2026. On December 19, 2025, NCQA submitted its initial application to renew its deeming authority, including materials requested by CMS that included information intended to address the requirements set out in regulations at § 422.158(a) and (b) that are prerequisites for receiving approval of its accreditation program from CMS.

II. Provisions of the Proposed Notice

This proposed notice notifies the public of NCQA's request to renew its MA deeming authority for HMOs and PPOs. The renewal application was submitted on December 19, 2025, and NCQA submitted all the necessary materials (including its standards and monitoring protocol) as part of their application; and CMS has determined the application is complete. Under section 1852(e)(4) of the Act and § 422.158 our review and evaluation of NCQA will be conducted as discussed below.

A. Components of the Review Process

The review of NCQA's renewal application for approval of MA deeming authority includes, but is not limited to, the following components:

- The types of MA plans that it would review as part of its accreditation process.
- A detailed comparison of NCQA's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk) in the following five deemable areas: Quality Improvement, Anti-Discrimination, Confidentiality and Accuracy of Enrollee Records,

Information on Advance Directives, and Provider Participation Rules.

● Detailed information about the organization's survey process, including—

++ Frequency of surveys and whether surveys are announced or unannounced.

++ Copies of survey forms, and guidelines and instructions to surveyors.

++ Descriptions of—

-- The survey review process and the accreditation status decision making process.

-- The procedures used to notify accredited MAOs of deficiencies and to monitor the correction of those deficiencies; and

-- The procedures used to enforce compliance with accreditation requirements.

● Detailed information about the individuals who perform surveys for the AO, including—

++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

++ The education and experience requirements surveyors must meet;

++ The content and frequency of the in-service training provided to survey personnel;

++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

++ The organization's policies and practice for participation, in surveys or in the accreditation decision process, by an individual who is professionally or financially affiliated with the entity being surveyed.

● A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

● A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

- A description of the organization's policies and procedures for the withholding or removal of accreditation for failure to meet the AO's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.
- A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the AO.
- A list of all currently accredited MAOs and the type, category, and expiration date of the accreditation held by each of them.
- A list of all full and partial accreditation surveys scheduled to be performed by the AO.
- The name and address of each person with an ownership or control interest in the AO.
- CMS will also consider NCQA's past performance in the deeming program and results of recent deeming validation reviews or equivalency reviews conducted as part of continuing federal oversight of the deeming program under § 422.157(d).

B. Notice Upon Completion of Evaluation

Upon completion of our evaluation, including a review of comments received as a result of this proposed notice, we will publish a notice in the **Federal Register** announcing the result of our evaluation. Section 1852(e)(4)(C) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days after the date of receipt of a completed application to complete our survey activities and application review process. Within the 210-day period, we will publish an approval or denial of the application in the **Federal Register**.

III. Collection of Information Requirements

This document does not impose new or revised collection of information requirements or burden. Consequently, there is no need for review by the Office of Management and Budget

under the authority of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*). With respect to the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Mehmet Oz, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register.**

Vanessa Garcia

Federal Register Liaison,

Centers for Medicare & Medicaid Services.

[FR Doc. 2026-04593 Filed: 3/9/2026 8:45 am; Publication Date: 3/10/2026]