

public, give CMS written notice of the deficiency.

(5) Within 10 days of CMS’s notice of withdrawal of approval, give written notice of the withdrawal to all accredited Part D sponsors.

(6) On an annual basis, provide summary data specified by CMS that relate to the past year’s accreditation activities and trends.

(d) *Continuing Federal oversight of approved accreditation organizations.* Specific criteria and procedures for continuing oversight and for withdrawing approval of an accreditation organization include the following:

(1) *Equivalency review.* CMS compares the accreditation organization’s standards and its application and enforcement of those standards to the comparable CMS requirements and processes when—

- (i) CMS imposes new requirements or changes its survey process;
- (ii) An accreditation organization proposes to adopt new standards or changes in its survey process; or
- (iii) The term of an accreditation organization’s approval expires.

(2) *Validation review.* CMS or its agent may conduct a survey of an accredited organization, examine the results of the accreditation organization’s own survey, or attend the accreditation organization’s survey to validate the organization’s accreditation process. At the conclusion of the review, CMS identifies any accreditation programs for which validation survey results indicate—

- (i) A 20 percent rate of disparity between certification by the accreditation organization and certification by CMS or its agent on standards that do not constitute immediate jeopardy to patient health and safety if unmet;
- (ii) Any disparity between certification by the accreditation organization and certification by CMS or its agent on standards that constitute immediate jeopardy to patient health and safety if unmet; or
- (iii) That, regardless of the rate of disparity, there are widespread or systematic problems in an organization’s accreditation process that accreditation no longer provides assurance that the Medicare requirements are met or exceeded.

(3) *Onsite observation.* CMS may conduct an onsite inspection of the accreditation organization’s operations and offices to verify the organization’s representations and assess the organization’s compliance with its own policies and procedures. The onsite inspection may include, but is not limited to the following:

- (i) Reviewing documents.
- (ii) Auditing meetings concerning the accreditation process.
- (iii) Evaluating survey results or the accreditation status decision-making process.
- (iv) Interviewing the organization’s staff.

(4) *Notice of intent to withdraw approval.* If an equivalency review, validation review, onsite observation, or CMS’s daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this subpart, CMS gives the organization written notice of its intent to withdraw approval.

(5) *Withdrawal of approval.* CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

- (i) Deeming, based on accreditation, no longer guarantees that the Part D sponsor meets the requirements for offering qualified prescription drug coverage, and failure to meet those requirements may jeopardize the health or safety of Medicare enrollees and constitute a significant hazard to the public health; or
- (ii) The accreditation organization has failed to meet its obligations under this section or under § 423.165 or § 423.171.

(6) *Reconsideration of withdrawal of approval.* An accreditation organization dissatisfied with a determination to withdraw CMS approval may request a reconsideration of that determination in accordance with subpart D of part 488 of this chapter.

§ 423.171 Procedures for approval of accreditation as a basis for deeming compliance.

(a) *Required information and materials.* A private, national accreditation organization applying for approval must

furnish to CMS all of the following information and materials (when reapplying for approval, the organization need furnish only the particular information and materials requested by CMS):

(1) The types of Part D plans and sponsors that it reviews as part of its accreditation process.

(2) A detailed comparison of the organization's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).

(3) Detailed information about the organization's survey process, including the following:

(i) Frequency of surveys and whether surveys are announced or unannounced.

(ii) Copies of survey forms, and guidelines and instructions to surveyors.

(iii) Descriptions of—

(A) The survey review process and the accreditation status decision making process;

(B) The procedures used to notify accredited Part D sponsors of deficiencies and to monitor the correction of those deficiencies; and

(C) The procedures used to enforce compliance with accreditation requirements.

(4) Detailed information about the individuals who perform surveys for the accreditation organization, including the—

(i) Size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

(ii) Education and experience requirements surveyors must meet;

(iii) Content and frequency of the in-service training provided to survey personnel;

(iv) Evaluation systems used to monitor the performance of individual surveyors and survey teams; and

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

(5) 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.

(6) 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.

(7) A description of the organization's policies and procedures for the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

(8) A description of all types (for example, full or partial) and categories (for example, provisional, conditional, or 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 serve as a basis for accreditation if CMS approves the accreditation organization.

(9) A list of all currently accredited Part D sponsors and MA organizations and the type, category, and expiration date of the accreditation held by each of them.

(10) A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by CMS.

(11) The name and address of each person with an ownership or control interest in the accreditation organization.

(b) *Required supporting documentation.* A private, national accreditation organization applying or reapplying for approval also must submit the following supporting documentation—

(1) A written presentation that demonstrates its ability to furnish CMS with electronic data in CMS compatible format.

(2) A resource analysis that demonstrates that its staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(3) A statement acknowledging that, as a condition for approval, it agrees to comply with the ongoing responsibility requirements of § 423.168(c).

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(c) *Additional information.* If CMS determines that it needs additional information for a determination to grant or deny the accreditation organization's request for approval, it notifies the organization and allows time for the organization to provide the additional information.

(d) *Onsite visit.* CMS may visit the accreditation organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff.

(e) *Notice of determination.* CMS gives the accreditation organization, within 210 days of receipt of its completed application, a formal notice that—

- (1) States whether the request for approval is granted or denied;
- (2) Gives the rationale for any denial; and
- (3) Describes the reconsideration and reapplication procedures.

(f) *Withdrawal.* An accreditation organization may withdraw its application for approval at any time before it receives the formal notice specified in paragraph (e) of this section.

(g) *Reconsideration of adverse determination.* An accreditation organization that has received a notice of denial of its request for approval may request a reconsideration in accordance with subpart D of part 488 of this chapter.

(h) *Request for approval following denial.* (1) Except as provided in paragraph (h)(2) of this section, an accreditation organization that has received notice of denial of its request for approval may submit a new request if it—

- (i) Has revised its accreditation program to correct the deficiencies on which the denial was based.
- (ii) Can demonstrate that the Part D sponsors that it has accredited meet or exceed applicable Medicare requirements; and
- (iii) Resubmits the application in its entirety.

(2) An accreditation organization that has requested reconsideration of CMS' denial of its request for approval may not submit a new request until the reconsideration is administratively final.

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Subpart E [Reserved]

Subpart F—Submission of Bids and Monthly Beneficiary Premiums; Plan Approval

§ 423.251 Scope.

This section sets forth the requirements and limitations on submission, review, negotiation and approval of competitive bids for prescription drug plans and MA-PD plans; the calculation of the national average bid amount; and the determination of enrollee premiums.

§ 423.258 Definitions.

For the purposes of this subpart, the following definitions apply:

Full risk plan means a prescription drug plan that is not a limited risk plan or a fallback prescription drug plan.

Limited risk plan means a prescription drug plan that provides basic prescription drug coverage and for which the PDP sponsor includes a modification of risk level described in § 423.265(d) in its bid submitted for the plan. This term does not include a fallback prescription drug plan.

Standardized bid amount means, for a prescription drug plan that provides basic prescription drug coverage, the PDP approved bid; for a prescription drug plan that provides supplemental prescription drug coverage, the portion of the PDP approved bid that is attributable to basic prescription drug coverage; for a MA-PD plan, the portion of the accepted bid amount that is attributable to basic prescription drug coverage.

§ 423.265 Submission of bids and related information.

(a) *Eligibility for bidding.* An applicant may submit a bid to become a Part D plan sponsor.

(b) *Bid submission*—(1) *General.* Not later than the first Monday in June, each potential Part D sponsor must submit bids and supplemental information described in this section for each Part D plan it intends to offer in the subsequent calendar year.