

§ 422.322

(2) During the time the hospice election is in effect, CMS' monthly capitation payment to the MA organization is reduced to the sum of—

(i) An amount equal to the beneficiary rebate for the MA plan, as described in § 422.304(a)(3) or to zero for plans with no beneficiary rebate, described at § 422.304(a)(2); and

(ii) The amount of the monthly prescription drug payment described in § 423.315 (if any).

(3) In addition, CMS pays through the original Medicare program (subject to the usual rules of payment)—

(i) The hospice program for hospice care furnished to the Medicare enrollee; and

(ii) The MA organization, provider, or supplier for other Medicare-covered services to the enrollee.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

§ 422.322 Source of payment and effect of MA plan election on payment.

(a) *Source of payments.* (1) Payments under this subpart for original fee-for-service benefits to MA organizations or MA MSAs are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. CMS determines the proportions to reflect the relative weight that benefits under Part A, and benefits under Part B represents of the actuarial value of the total benefits under title XVIII of the Act.

(2) Payments to MA-PD organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(3) Payments under subpart C of part 495 of this chapter for meaningful use of certified EHR technology are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. In applying section 1848(o) of the Act under sections 1853(l) and 1886(n)(2) of the Act under section 1853(m) of the Act, CMS determines the amount to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable for services furnished by professionals and hospitals

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under Parts B and A, respectively, under title XVIII of the Act.

(b) *Payments to the MA organization.* Subject to §§ 412.105(g), 413.76, and 495.204 of this chapter and §§ 422.109, 422.316, and 422.320, CMS' payments under a contract with an MA organization (described in § 422.304) with respect to an individual electing an MA plan offered by the organization are instead of the amounts which (in the absence of the contract) would otherwise be payable under original Medicare for items and services furnished to the individual.

(c) *Only the MA organization entitled to payment.* Subject to §§ 422.314, 422.316, 422.318, 422.320, and 422.520 and sections 1886(d)(11) and 1886(h)(3)(D) of the Act, only the MA organization is entitled to receive payment from CMS under title XVIII of the Act for items and services furnished to the individual.

(d) *FFS payment for expenses for kidney acquisitions.* Paragraphs (b) and (c) of this section do not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i) of the Act.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005; 75 FR 44654, July 28, 2010; 85 FR 33908, June 2, 2020; 85 FR 72909, Nov. 16, 2020]

§ 422.324 Payments to MA organizations for graduate medical education costs.

(a) MA organizations may receive direct graduate medical education payments for the time that residents spend in non-hospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(b) MA organizations may receive direct graduate medical education payments if all of the following conditions are met:

(1) The resident spends his or her time assigned to patient care activities.

(2) The MA organization incurs "all or substantially all" of the costs for the training program in the non-hospital setting as defined in § 413.75(b) of this chapter.

(3) There is a written agreement between the MA organization and the non-hospital site that indicates the MA

organization will incur the costs of the resident's salary and fringe benefits and provide reasonable compensation to the non-hospital site for teaching activities.

(c) An MA organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles specified in § 413.85(c) of this chapter, consist of—

(1) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(2) Reasonable compensation to the non-hospital site for teaching activities related to the training of medical residents.

(d) The direct graduate medical education payment is equal to the product of—

(1) The lower of—

(i) The MA organization's allowable costs per resident as defined in paragraph (c) of this section; or

(ii) The national average per resident amount; and

(2) Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the MA organization.

(e) Direct graduate medical education payments made to MA organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

[70 FR 4729, Jan. 28, 2005, as amended at 85 FR 72909, Nov. 16, 2020]

§ 422.326 Reporting and returning of overpayments.

(a) *Terminology.* For purposes of this section—

Applicable reconciliation occurs on the date of the annual final deadline for risk adjustment data submission described at § 422.310(g), which is announced by CMS each year.

Funds means any payment that an MA organization has received that is based on data submitted by the MA organization to CMS for payment purposes, including § 422.308(f) and § 422.310.

Overpayment means any funds that an MA organization has received or retained under title XVIII of the Act to which the MA organization, after appli-

cable reconciliation, is not entitled under such title.

(b) *General rule.* If an MA organization has identified that it has received an overpayment, the MA organization must report and return that overpayment in the form and manner set forth in this section.

(c) *Identified overpayment.* The MA organization has identified an overpayment when the MA organization has determined, or should have determined through the exercise of reasonable diligence, that the MA organization has received an overpayment.

(d) *Reporting and returning of an overpayment.* An MA organization must report and return any overpayment it received no later than 60 days after the date on which it identified it received an overpayment, unless otherwise directed by CMS for purposes of § 422.311.

(1) *Reporting.* An MA organization must notify CMS, of the amount and reason for the overpayment, using a notification process determined by CMS.

(2) *Returning.* An MA organization must return identified overpayments in a manner specified by CMS.

(e) *Enforcement.* Any overpayment retained by an MA organization is an obligation under 31 U.S.C. 3729(b)(3) if not reported and returned in accordance with paragraph (d) of this section.

(f) *Look-back period.* An MA organization must report and return any overpayment identified for the 6 most recent completed payment years.

[79 FR 29958, May 23, 2014]

§ 422.330 CMS-identified overpayments associated with payment data submitted by MA organizations.

(a) *Definitions.* For purposes of this section—

Applicable reconciliation date occurs on the date of the annual final deadline for risk adjustment data submission described at § 422.310(g)(2)(ii).

Erroneous payment data means payment data that should not have been submitted either because the data submitted are inaccurate or because the data are inconsistent with Medicare Part C requirements.

Payment data means data submitted by an MA organization to CMS and used for payment purposes, including