

statements required by paragraph (b)(3) of this section must display in separate columns the financial information for the MA organization and each of the parties in interest.

(2) Inter-entity transactions must be eliminated in the consolidated column.

(3) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(4) Upon written request from an MA organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this paragraph (c) with respect to a particular entity.

(d) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an MA organization in its offerings, the MA organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular MA organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The MA organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA.

(e) *Loan information.* Each organization must notify CMS of any loans or other special financial arrangements it makes with contractors, subcontractors and related entities.

(f) *Enrollee access to information.* Each MA organization must make the information reported to CMS under § 422.502(f)(1) available to its enrollees upon reasonable request.

(g) *Data validation.* Each Part C sponsor must subject information collected under paragraph (a) of this section to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.

[63 FR 35099, June 26, 1998, as amended at 75 FR 19812, Apr. 15, 2010]

#### § 422.520 Prompt payment by MA organization.

(a) *Contract between CMS and the MA organization.* (1) The contract between

CMS and the MA organization must provide that the MA organization will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

(2) The MA organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B).

(3) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

(b)(1) *Contracts between MA organizations and providers and suppliers.* Contracts or other written agreements between MA organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA organization and the relevant provider.

(2) The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider.

(c) *Failure to comply.* If CMS determines, after giving notice and opportunity for hearing, that an MA organization has failed to make payments in accordance with paragraph (a) of this section, CMS may provide—

(1) For direct payment of the sums owed to providers, or MA private fee-for-service plan enrollees; and

(2) For appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

(d) A CMS decision to not conduct a hearing under paragraph (c) of this section does not disturb any potential remedy under State law for 1866(a)(1)(O) of the Act.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 70 FR 4738, Jan. 28, 2005]

#### § 422.521 Effective date of new significant regulatory requirements.

CMS will not implement, other than at the beginning of a calendar year, requirements under this part that impose a new significant cost or burden on MA

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organizations or plans, unless a different effective date is required by statute.

[68 FR 50858, Aug. 22, 2003]

### § 422.524 Special rules for RFB societies.

In order to participate as an MA organization, an RFB society—

(a) May not impose any limitation on membership based on any factor related to health status; and

(b) Must offer, in addition to the MA RFB plan, health coverage to individuals who are members of the church or convention or group of churches with which the society is affiliated, but who are not entitled to receive benefits from the Medicare program.

### § 422.527 Agreements with Federally qualified health centers.

The contract between the MA organization and CMS must specify that—

(a) The MA organization must pay a Federally qualified health center (FQHC) a similar amount to what it pays other providers for similar services.

(b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(c) Financial incentives, such as risk pool payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under § 422.316(a).

[70 FR 4738, Jan. 28, 2005]

### § 422.530 Plan crosswalks.

(a) *General rules*—(1) *Definition of crosswalk*. A crosswalk is the movement of enrollees from one plan (or plan benefit package (PBP)) to another plan (or PBP) under a contract between the MA organization and CMS. To crosswalk enrollees from one PBP to another is to change the enrollment from the first PBP to the second.

(2) *Prohibitions*. Except as described in paragraph (c) of this section, crosswalks are prohibited between different contracts or different plan types (for example, HMO to PPO).

(3) *Compliance with renewal/non-renewal rules*. The MA organization must comply with renewal and non-

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renewal rules in §§ 422.505 and 422.506 in order to complete plan crosswalks.

(4) *Eligibility*. Enrollees must be eligible for enrollment under §§ 422.50 through 422.54 in order to be moved from one PBP to another PBP.

(5) *Types of MA plans*. For purposes of crosswalk policy in this section, CMS considers the following plans as different plan types:

(i) Health maintenance organizations coordinated care plans.

(ii) Provider-sponsored organizations coordinated care plans.

(iii) Regional or local preferred provider organizations coordinated care plans.

(iv) Special needs plans.

(v) Private Fee-for-service plans.

(vi) MSA plans.

(b) *Allowable crosswalk types*—(1) *All MA plans*. An MA organization may perform a crosswalk in the following circumstances:

(i) *Renewal*. A plan in the following contract year that links to a current contract year plan and retains the entire service area from the current contract year. The following contract year plan must retain the same plan ID as the current contract year plan.

(ii) *Consolidated renewal*. A plan in the following contract year that combines 2 or more complete current contract year plans of the same plan type but not including when a current PBP is split among more than one PBP for the following contract year. The plan ID for the following contract year must be the same as one of the current contract year plan IDs.

(iii) *Renewal with a service area expansion (SAE)*. A plan in the following contract year that links to a current contract year plan and retains all of its plan service area from the current contract year, but also adds one or more new counties. The following year contract plan must retain the same plan ID as the current contract year plan.

(iv) *Renewal with a service area reduction (SAR)*. (A) A plan in the following contract year that links to a current contract year plan and only retains a portion of its plan service area. The following contract year plan must retain the same plan ID as the current contract year plan. The crosswalk is