

apply all or some portion of the rebate for a plan toward payment for supplemental drug coverage described at § 423.104(f)(1)(ii), which may include reduction in cost sharing and coverage of drugs not covered under Part D. The rebate, or portion of rebate, applied toward supplemental benefits may only be applied to a mandatory supplemental benefit, and cannot be used to fund an optional supplemental benefit.

(2) *Payment of premium for prescription drug coverage.* MA organizations that offer a prescription drug benefit may credit some or all of the rebate toward reduction of the MA monthly prescription drug beneficiary premium.

(3) *Payment toward Part B premium.* MA organizations may credit some or all of the rebate toward reduction of the Medicare Part B premium (determined without regard to the application of subsections (b), (h), and (i) of section 1839 of the Act).

(c) *Disclosure relating to rebates.* MA organizations must disclose to CMS information on the amount of the rebate provided, as required at § 422.254(d). MA organizations must distinguish, for each MA plan, the amount of rebate applied to enhance original Medicare benefits from the amount of rebate applied to enhance Part D benefits. [70 FR 4725, Jan. 28, 2005, as amended at 76 FR 21567, Apr. 15, 2011]

**§ 422.270 Incorrect collections of premiums and cost-sharing.**

(a) *Definitions.* As used in this section—

(1) Amounts incorrectly collected—

(i) Means amounts that—

(A) Exceed the limits approved under § 422.262;

(B) In the case of an MA private fee-for-service plan, exceed the MA monthly basic beneficiary premium or the MA monthly supplemental premium submitted under § 422.262; and

(C) In the case of an MA MSA plan, exceed the MA monthly beneficiary supplemental premium submitted under § 422.262, or exceed permissible cost sharing amounts after the deductible has been met per § 422.103; and

(ii) Includes amounts collected from an enrollee who was believed to be entitled to Medicare benefits but was later found not to be entitled.

(2) *Other amounts due* are amounts due for services that were—

(i) Emergency, urgently needed services, or other services obtained outside the MA plan; or

(ii) Initially denied but, upon appeal, found to be services the enrollee was entitled to have furnished by the MA organization.

(b) *Basic commitments.* An MA organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf.

(c) *Refund methods*—(1) *Lump-sum payment.* The MA organization must use lump-sum payments for the following:

(i) Amounts incorrectly collected that were not collected as premiums.

(ii) Other amounts due.

(iii) All amounts due if the MA organization is going out of business or terminating its MA contract for an MA plan(s).

(2) *Premium adjustment or lump-sum payment, or both.* If the amounts incorrectly collected were in the form of premiums, or included premiums as well as other charges, the MA organization may refund by adjustment of future premiums or by a combination of premium adjustment and lump-sum payments.

(3) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort, the MA organization must make the refund in accordance with State law.

(d) *Reduction by CMS.* If the MA organization does not make the refund required under this section by the end of the contract period following the contract period during which an amount was determined to be due to an enrollee, CMS will reduce the premium the MA organization is allowed to charge an MA plan enrollee by the amounts incorrectly collected or otherwise due. In addition, the MA organization would be subject to sanction under subpart O of this part for failure to refund amounts incorrectly collected from MA plan enrollees.

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### § 422.272 Release of MA bid pricing data.

(a) *Terminology.* For purposes of this section, the term “MA bid pricing data” means the following information that MA organizations must submit for each MA plan bid for the annual bid submission:

(1) The pricing-related information described at § 422.254(a)(1); and

(2) The information required for MSA plans, described at § 422.254(e).

(b) *Release of MA bid pricing data.* Subject to paragraph (c) of this section and to the annual timing identified in paragraph (d) of this section, CMS will release to the public MA bid pricing data for MA plan bids accepted or approved by CMS for a contract year under § 422.256. The annual release will contain MA bid pricing data from the final list of MA plan bids accepted or approved by CMS for a contract year that is at least 5 years prior to the upcoming calendar year.

(c) *Exclusions from release of MA bid pricing data.* For the purpose of this section, the following information is excluded from the data released under paragraph (b) of this section:

(1) For an MA plan bid that includes Part D benefits, the information described at § 422.254(b)(1)(ii), (c)(3)(ii), and (c)(7).

(2) Additional information that CMS requires to verify the actuarial bases of the bids for MA plans for the annual bid submission, as follows:

(i) Narrative information on base period factors, manual rates, cost-sharing methodology, optional supplement benefits, and other required narratives.

(ii) Supporting documentation.

(3) Any information that could be used to identify Medicare beneficiaries or other individuals.

(4) Bid review correspondence and reports.

(d) *Timing of data release.* CMS will release MA bid pricing data as provided in paragraph (b) of this section on an annual basis after the first Monday in October.

[81 FR 80556, Nov. 15, 2016]

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### Subpart G—Payments to Medicare Advantage Organizations

SOURCE: 70 FR 4729, Jan. 28, 2005, unless otherwise noted.

#### § 422.300 Basis and scope.

This subpart is based on sections 1106, 1128J(d), 1852, 1853, 1854, and 1858 of the Act. It sets forth the requirements for making payments to MA organizations offering local and regional MA policies, including calculation of MA capitation rates and benchmarks, conditions under which payment is based on plan bids, adjustments to capitation rates (including risk adjustment), collection of risk adjustment data, conditions for use and disclosure of risk adjustment data, collection of improper payments and other payment rules. Section 422.458 specifies the requirements for risk sharing payments to MA regional organizations.

[88 FR 6665, Feb. 1, 2023]

#### § 422.304 Monthly payments.

(a) *General rules.* Except as provided in paragraph (b) of this section, CMS makes advance monthly payments of the amounts determined under paragraphs (a)(1) and (a)(2) of this section for coverage of original fee-for-service benefits for an individual in an MA payment area for a month.

(1) *Payment of bid for plans with bids below benchmark.* For MA plans that have average per capita monthly savings (as described at § 422.264(b) for local plans and § 422.264(d) for regional plans), CMS pays:

(i) The unadjusted MA statutory non-drug monthly bid amount defined in § 422.252, risk-adjusted as described at § 422.308(c) and adjusted (if applicable) for variations in rates within the plan’s service area (described at § 422.258(a)(2)) and for the effects of risk adjustment on beneficiary premiums under § 422.262; and

(ii) The amount (if any) of the rebate described in paragraph (a)(3) of this section.

(2) *Payment of benchmark for plans with bids at or above benchmark.* For MA plans that do not have average per capita monthly savings (as described at

§ 422.264(b) for local plans and § 422.264(d) for regional plans), CMS pays the unadjusted MA area-specific non-drug monthly benchmark amount specified at § 422.258, risk-adjusted as described at § 422.308(c) and adjusted (if applicable) for variations in rates within the plan's service area (described at § 422.258(a)(2)) and for the effects of risk adjustment on beneficiary premiums under § 422.262.

(3) *Payment of rebate for plans with bids below benchmarks.* The rebate amount under paragraph (a)(1)(ii) of this section is the amount of the monthly rebate computed under § 422.266(a) for that plan, less the amount (if any) applied to reduce the Part B premium, as provided under § 422.266(b)(3)).

(b) *Separate payment for Federal drug subsidies.* In the case of an enrollee in an MA-PD plan, defined at § 422.252, the MA organization offering such a plan also receives—

(1) Direct and reinsurance subsidy payments for qualified prescription drug coverage, described at section 1860D–15(a) and (b) of the Act (other than payments for fallback prescription drug plans described at section 1860D–11(g)(5) of the Act); and

(2) Reimbursement for premium and cost sharing reductions for low-income individuals, described at section 1860D–14 of the Act.

(c) *Special rules—(1) Enrollees with end-stage renal disease.* (i) For enrollees determined to have end-stage renal disease (ESRD), CMS establishes special rates that are actuarially equivalent to rates in effect before the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(ii) CMS publishes annual changes in these capitation rates no later than the first Monday in April each year, as provided in § 422.312.

(iii) CMS applies appropriate adjustments when establishing the rates, including risk adjustment factors.

(iv) CMS reduces the payment rate for each renal dialysis treatment by the same amount that CMS is authorized to reduce the amount of each composite rate payment for each treatment as set forth in section 1881(b)(7) of the Act. These funds are to be used to help

pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

(2) *MSA enrollees.* In the case of an MSA plan, CMS pays the unadjusted MA area-specific non-drug monthly benchmark amount for the service area, determined in accordance with § 422.314(c) and subject to risk adjustment as set forth at § 422.308(c), less  $\frac{1}{2}$  of the annual lump sum amount (if any) CMS deposits to the enrollee's MA MSA.

(3) *RFB plan enrollees.* For RFB plan enrollees, CMS adjusts the capitation payments otherwise determined under this subpart to ensure that the payment level is appropriate for the actuarial characteristics and experience of these enrollees. That adjustment can be made on an individual or organization basis.

(d) *Payment areas—(1) General rule.* Except as provided in paragraph (e) of this section—

(i) An MA payment area for an MA local plan is an MA local area defined at § 422.252.

(ii) An MA payment area for an MA regional plan is an MA region, defined at § 422.455(b)(1).

(2) *Special rule for ESRD enrollees.* For ESRD enrollees, the MA payment area is a State or other geographic area specified by CMS.

(e) *Geographic adjustment of payment areas for MA local plans—(1) Terminology.* “Metropolitan Statistical Area” and “Metropolitan Division” mean any areas so designated by the Office of Management and Budget in the Executive Office of the President.

(2) *State request.* A State's chief executive may request, no later than February 1 of any year, a geographic adjustment of the State's payment areas for MA local plans for the following calendar year. The chief executive may request any of the following adjustments to the payment area specified in paragraph (c)(1)(i) of this section:

(i) A single statewide MA payment area.

(ii) A metropolitan-based system in which all non-metropolitan areas within the State constitute a single payment area and any of the following constitutes a separate MA payment area:

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(A) All portions of each single Metropolitan Statistical Area within the State.

(B) All portions of each Metropolitan Statistical Area within each Metropolitan Division within the State.

(iii) A consolidation of noncontiguous counties.

(3) *CMS response.* In response to the request, CMS makes the payment adjustment requested by the chief executive. This adjustment cannot be requested or made for payments to regional MA plans.

(4) *Budget neutrality adjustment for geographically adjusted payment areas.* If CMS adjusts a State's payment areas in accordance with paragraph (d)(2) of this section, CMS at that time, and each year thereafter, adjusts the capitation rates so that the aggregate Medicare payments do not exceed the aggregate Medicare payments that would have been made to all the State's payments areas, absent the geographic adjustment.

(f) *Separate payment for meaningful use of certified EHRs.* In the case of qualifying MA organizations, as defined in § 495.200 of this chapter, entitled to MA EHR incentive payments per § 495.204 of this chapter, such payments are made in accordance with sections 1853(l) and (m) of the Act and subpart C of part 495 of this chapter.

[70 FR 4729, Jan. 28, 2005, as amended at 75 FR 44564, July 28, 2010; 85 FR 72909, Nov. 16, 2020]

### § 422.306 Annual MA capitation rates.

Subject to adjustments at §§ 422.308(b) and (g), the annual capitation rate for each MA local area is determined under paragraph (a) of this section for 2005 and each succeeding year, except for years when CMS announces under § 422.312(b) that the annual capitation rates will be determined under paragraph (b) of this section, and is then adjusted to exclude the applicable phase-in percentage of the standardized costs for payments under section 1886(d)(5)(B) of the Act in the area for the year under paragraph (c) of this section and costs for kidney acquisitions in the area for the year under paragraph (d) of this section.

(a) *Minimum percentage increase rate.* The annual capitation rate for each

MA local area is equal to the minimum percentage increase rate, which is the annual capitation rate for the area for the preceding year increased by the national per capita MA growth percentage (defined at § 422.308(a)) for the year, but not taking into account any adjustment under § 422.308(b) for a year before 2004.

(b) *Greater of the minimum percentage increase rate or local area fee-for-service costs.* The annual capitation rate for each MA local area is the greater of—

(1) The minimum percentage increase rate under paragraph (a) of this section; or

(2) The amount determined, no less frequently than every 3 years, to be the adjusted average per capita cost for the MA local area, as determined under section 1876(a)(4) of the Act, based on 100 percent of fee-for-service costs for individuals who are not enrolled in an MA plan for the year, with the following adjustments:

(i) Adjusted as appropriate for the purpose of risk adjustment;

(ii) Adjusted to exclude costs attributable to payments under section 1886(h) of the Act for the costs of direct graduate medical education;

(iii) Adjusted to include CMS' estimate of the amount of additional per capita payments that would have been made in the MA local area if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs; and

(iv) Adjusted to exclude costs attributable to payments under sections 1848(o) and 1886(n) of the Act of Medicare FFS incentive payments for meaningful use of electronic health records.

(c) *Phase-out of the indirect costs of medical education from MA capitation rates.* Beginning with 2010, after the annual capitation rate for each MA local area is determined under paragraph (a) or (b), the amount is adjusted in accordance with section 1853(k)(4) of the Act to exclude from such amount the estimated costs for payments under section 1886(d)(5)(B) of the Act in the area for the year.

(d) *Exclusion of costs for kidney acquisitions from MA capitation rates.* Beginning with 2021, after the annual capitation rate for each MA local area is determined under paragraph (a) or (b) of this section, the amount is adjusted in accordance with section 1853(k)(5) of the Act to exclude the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d) of the Act) in the area for the year.

[70 FR 4729, Jan. 28, 2005, as amended at 73 FR 54250, Sept. 18, 2008; 75 FR 19806, Apr. 15, 2010; 75 FR 44564, July 28, 2010; 85 FR 33907, June 2, 2020]

**§ 422.308 Adjustments to capitation rates, benchmarks, bids, and payments.**

CMS performs the following calculations and adjustments to determine rates and payments:

(a) *National per capita growth percentage.* (1) The national per capita growth percentage for a year, applied under § 422.306, is CMS' estimate of the rate of growth in per capita expenditures under this title for an individual entitled to benefits under Part A and enrolled under Part B. CMS may make separate estimates for aged enrollees, disabled enrollees, and enrollees who have ESRD.

(2) The amount calculated in paragraph (a)(1) of this section must exclude expenditures attributable to sections 1848(a)(7) and (o) and sections 1886(b)(3)(B)(ix) and (n) of the Act.

(b) *Adjustment for over or under projection of national per capita growth percentages.* CMS will adjust the minimum percentage increase rate at § 422.306(a)(2) and the adjusted average per capita cost rate at § 422.306(b)(2) for the previous year to reflect any differences between the projected national per capita growth percentages for that year and previous years, and the current estimates of those percentages for those years. CMS will not make this adjustment for years before 2004.

(c) *Risk adjustment—(1) General rule.* CMS will adjust the payment amounts under § 422.304(a)(1), (a)(2), and (a)(3) for age, gender, disability status, institu-

tional status, and other factors CMS determines to be appropriate, including health status, in order to ensure actuarial equivalence. CMS may add to, modify, or substitute for risk adjustment factors if those changes will improve the determination of actuarial equivalence.

(2) *Risk adjustment: Health status—(i) Data collection.* To adjust for health status, CMS applies a risk factor based on data obtained in accordance with § 422.310.

(ii) *Implementation.* CMS applies a risk factor that incorporates inpatient hospital and ambulatory risk adjustment data. This factor is phased as follows:

(A) 100 percent of payments for ESRD MA enrollees in 2005 and succeeding years.

(B) 75 percent of payments for aged and disabled enrollees in 2006.

(C) 100 percent of payments for aged and disabled enrollees in 2007 and succeeding years.

(3) *Uniform application.* Except as provided for MA RFB plans under § 422.304(c)(3), CMS applies this adjustment factor to all types of plans.

(4) *Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals.* (i) *Application of payment rules.* For plan year 2011 and subsequent plan years, in the case of a plan described in paragraph (c)(4)(ii) of this section, the Secretary may apply the payment rules under section 1894(d) of the Act (other than paragraph (3) of that section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(ii) *Plan described.* A plan described in this paragraph is a fully integrated dual-eligible special needs plan, as defined at § 422.2, and has a similar average level of frailty (as determined by the Secretary) as the PACE program.

(5) *Application of coding adjustment.* (i) In applying the adjustment under paragraph (c)(1) of this section for health status to payment amounts, the Secretary ensures that such adjustment

reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between MA plans and providers under Part A and B to the extent that the Secretary has identified such differences.

(ii) In order to ensure payment accuracy, the Secretary annually conducts an analysis of the differences described in paragraph (c)(5)(i) of this section.

(A) The Secretary completes such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years.

(B) In conducting such analysis, the Secretary uses data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(iii) In calculating each year's adjustment, the adjustment factor is as follows:

(A) For 2014, not less than the adjustment factor applied for 2010, plus 1.3 percentage points.

(B) For each of the years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage points.

(C) For 2019 and each subsequent year, not less than 5.7 percent.

(iv) Such adjustment is applied to risk scores until the Secretary implements risk adjustment using MA diagnostic, cost, and use data.

(6) *Improvements to risk adjustment for special needs individuals with chronic health conditions*—(i) *General rule*. For 2011 and subsequent years, for purposes of the adjustment under paragraph (c)(1) of this section with respect to individuals described in paragraph (c)(6)(ii) of the section, the Secretary uses a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score is used instead of the default risk score for new enrollees in MA plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Act).

(ii) *Individuals described*. An individual described in this clause is a special needs individual described in section 1859(b)(6)(B)(iii) of the Act who enrolls in a specialized MA plan for spe-

cial needs individuals on or after January 1, 2011.

(iii) *Evaluation*. For 2011 and periodically thereafter, the Secretary evaluates and revises the risk adjustment system under this paragraph in order to, as accurately as possible, account for—

(A) Higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness; and

(B) Costs that may be associated with higher concentrations of beneficiaries with the conditions specified in paragraph (c)(6)(iii)(A) of this section.

(iv) *Publication of evaluation and revisions*. The Secretary publishes, as part of an announcement under section 1853(b) of the Act, a description of any evaluation conducted under paragraph (c)(6)(iii) of this section during the preceding year and any revisions made under paragraph (c)(6)(iii) of this section as a result of such evaluation.

(d) *Adjustment for intra-area variations*. CMS makes the following adjustments to payments.

(1) *Intra-regional variations*. For payments for an MA regional plan for an MA region, CMS will adjust the payment amount specified at § 422.304(a)(1) and (a)(2) to take into account variations in local payment rates among the different MA local areas included in the region.

(2) *Intra-service area variations*. For payments to an MA local plan with a service area covering more than one MA local area (county), CMS will adjust the payment amount specified in § 422.304(a)(1) and (a)(2) to take into account variations in local payment rates among the different MA local areas included in the plan's service area.

(e) *Adjustment relating to risk adjustment: the government premium adjustment*. CMS will adjust payments to an MA plan as necessary to ensure that the sum of CMS' monthly payment made under § 422.304(a) and the plan's monthly basic beneficiary premium equals the unadjusted MA statutory non-drug bid amount, adjusted for risk and for intra-area or intra-regional payment variation.

(f) *Adjustment of payments to reflect number of Medicare enrollees—(1) General rule.* CMS adjusts payments retroactively to take into account any difference between the actual number of Medicare enrollees and the number on which it based an advance monthly payment.

(2) *Special rules for certain enrollees.* (i) Subject to paragraph (f)(2)(ii) of this section, CMS may make adjustments, for a period (not to exceed 90 days) that begins when a beneficiary elects a group health plan (as defined in § 411.1010) offered by an MA organization, and ends when the beneficiary is enrolled in an MA plan offered by the MA organization.

(ii) CMS does not make an adjustment unless the beneficiary certifies that, at the time of enrollment under the MA plan, he or she received from the organization the disclosure statement specified in § 422.111.

(g) *Adjustment for national coverage determination (NCD) services and legislative changes in benefits.* If CMS determines that the cost of furnishing an NCD service or legislative change in benefits is significant, as defined in § 422.109, CMS will adjust capitation rates, or make other payment adjustments, to account for the cost of the service or legislative change in benefits. Until the new capitation rates are in effect, the MA organization will be paid for the significant cost NCD service or legislative change in benefits on a fee-for-service basis as provided under § 422.109(b).

(h) *Adjustments to payments to regional MA plans for purposes of risk corridor payments.* For the purpose of calculation of risk corridors under § 422.458, MA organizations offering regional MA plans in 2006 and/or 2007 must submit, after the end of a contract year and before a date CMS specifies, the following information:

(1) Actual allowable costs (defined in § 422.458(a)) for the previous contract year.

(2) The portion of the costs attributable to administrative expenses incurred in providing these benefits.

(3) The total costs for providing rebatable integrated benefits (as defined in § 422.458(a)) and the portion of the costs that is attributable to admin-

istrative expenses in addition to the administrative expenses described in paragraph (h)(2) of this section.

[70 FR 4729, Jan. 28, 2005, as amended at 75 FR 44564, July 28, 2010; 76 FR 21567, Apr. 15, 2011]

#### § 422.310 Risk adjustment data.

(a) *Definition of risk adjustment data.* Risk adjustment data are all data that are used in the development and application of a risk adjustment payment model.

(b) *Data collection: Basic rule.* Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.

(c) *Sources and extent of data.* (1) To the extent required by CMS, risk adjustment data must account for the following:

(i) Items and services covered under the original Medicare program.

(ii) Medicare covered items and services for which Medicare is not the primary payer.

(iii) Other additional or supplemental benefits that the MA organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the original Medicare program, even if they participate jointly in the same service.

(d) *Other data requirements.* (1) MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. CMS may specify abbreviated formats for data submission required of MA organizations.

(2) The data must be submitted electronically to the appropriate CMS contractor.

(3) MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician,

or other practitioner that furnished the item or service.

(4) MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

(5) For data described in paragraph (d)(1) of this section as data equivalent to Medicare fee-for-service data, which is also known as MA encounter data, MA organizations must submit a NPI in a billing provider field on each MA encounter data record, per CMS guidance.

(e) *Validation of risk adjustment data.* MA organizations and their providers and practitioners are required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data. MA organizations must remit improper payments based on RADV audits, in a manner specified by CMS. For RADV audits, CMS may extrapolate RADV Contract-Level audit findings for payment year 2018 and subsequent payment years.

(f) *Use and release of data*—(1) *CMS use of data.* CMS may use the data described in paragraphs (a) through (d) of this section for the following purposes:

(i) To determine the risk adjustment factors used to adjust payments, as required under §§ 422.304(a) and (c);

(ii) To update risk adjustment models;

(iii) To calculate Medicare DSH percentages;

(iv) To conduct quality review and improvement activities;

(v) For Medicare coverage purposes;

(vi) To conduct evaluations and other analysis to support the Medicare and Medicaid programs (including demonstrations) and to support public health initiatives and other health care-related research;

(vii) For activities to support the administration of the Medicare and Medicaid programs;

(viii) For activities conducted to support program integrity; and

(ix) For purposes authorized by other applicable laws.

(2) *CMS release of data.* Regarding data described in paragraphs (a) through (d) of this section, CMS may release the minimum data it determines is necessary for one or more of the purposes listed in paragraph (f)(1) of this section to other HHS agencies, other Federal executive branch agencies, States, and external entities in accordance with the following:

(i) Applicable Federal laws;

(ii) CMS data sharing procedures;

(iii) Subject to the protection of beneficiary identifier elements and beneficiary confidentiality, including—

(A) A prohibition against public disclosure of beneficiary identifying information;

(B) Release of beneficiary identifying information to other HHS agencies, other Federal executive branch agencies, and States only when such information is needed; and

(C) Release of beneficiary identifying information to external entities only to the extent needed to link datasets.

(iv) Subject to the aggregation of dollar amounts reported for the associated encounter to protect commercially sensitive data.

(v) Risk adjustment data other than data described in paragraphs (f)(2)(iii) and (f)(2)(iv) of this section will be released without the redaction or aggregation described in paragraphs (f)(2)(iii) and (f)(2)(iv) of this section, respectively.

(3) Risk adjustment data will not become available for release under this paragraph (f) unless—

(i) The risk adjustment reconciliation for the applicable payment year has been completed;

(ii) CMS determines that data release is necessary under paragraph (f)(1)(vi) of this section for emergency preparedness purposes before reconciliation; or

(iii) CMS determines that extraordinary circumstances exist to release the data before reconciliation.

(iv) CMS determines that releasing aggregated data before reconciliation is necessary and appropriate to support activities or authorized uses under paragraph (f)(1)(vii) of this section.

(v) CMS determines that releasing data to State Medicaid agencies before



reconciliation for the purpose of coordinating care for dually eligible individuals is necessary and appropriate to support activities or authorized uses under paragraph (f)(1)(vii) of this section.

(g) *Deadlines for submission of risk adjustment data.* Risk adjustment factors for each payment year are based on risk adjustment data submitted for items and services furnished during the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate. CMS may adjust these deadlines, as appropriate.

(1) The annual deadline for risk adjustment data submission is the first Friday in September for risk adjustment data reflecting items and services furnished during the 12-month period ending the prior June 30, and the first Friday in March for data reflecting services furnished during the 12-month period ending the prior December 31.

(2) After the payment year is completed, CMS recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary.

(i) Prior to calculation of final risk factors for a payment year, CMS allows a reconciliation process to account for risk adjustment data submitted after the March deadline until the final risk adjustment data submission deadline in the year following the payment year.

(ii) After the final risk adjustment data submission deadline, which is a date announced by CMS that is no earlier than January 31 of the year following the payment year, an MA organization can submit data to correct overpayments but cannot submit diagnoses for additional payment.

(3) Submission of corrected risk adjustment data in accordance with overpayments after the final risk adjustment data submission deadline, as described in paragraph (g)(2) of this section,

must be made as provided in § 422.326.

[73 FR 48757, Aug. 19, 2008, as amended at 79 FR 29956, May 23, 2014; 79 FR 50358, Aug. 22, 2014; 80 FR 7960, Feb. 12, 2015; 83 FR 16733, Apr. 16, 2018; 88 FR 6665, Feb. 1, 2023; 88 FR 79539, Nov. 16, 2023; 89 FR 30822, Apr. 23, 2024]

#### § 422.311 RADV audit dispute and appeal processes.

(a) *Risk adjustment data validation (RADV) audits.* In accordance with §§ 422.2 and 422.310(e), the Secretary conducts RADV audits to ensure risk-adjusted payment integrity and accuracy.

(1) Recovery of improper payments from MA organizations is conducted in accordance with the Secretary's payment error extrapolation and recovery methodologies.

(2) CMS may apply extrapolation to audits for payment year 2018 and subsequent payment years.

(b) *RADV audit results.* (1) MA organizations that undergo RADV audits will be issued an audit report post medical record review that describes the results of the RADV audit as follows:

(i) Detailed enrollee-level information relating to confirmed enrollee HCC discrepancies.

(ii) The contract-level RADV payment error estimate in dollars.

(iii) The contract-level payment adjustment amount to be made in dollars.

(iv) An approximate timeframe for the payment adjustment.

(v) A description of the MA organization's RADV audit appeal rights.

(2) *Compliance date.* The compliance date for meeting RADV medical record submission requirements for the validation of risk adjustment data is the due date when MA organizations selected for RADV audit must submit medical records to the Secretary.

(c) *RADV audit appeals—(1) Appeal rights.* MA organizations that do not agree with their RADV audit results may appeal.

(2) *Issues eligible for RADV appeals—(i) General rules.* MA organizations may appeal RADV medical record review determinations and the Secretary's RADV payment error calculation. In order to be eligible for RADV appeal, MA organizations must adhere to the following:

(A) Established RADV audit procedures and requirements.

(B) RADV appeals procedures and requirements.

(ii) *Failure to follow RADV rules.* Failure to follow the Secretary's RADV audit procedures and requirements and the Secretary's RADV appeals procedures and requirements will render the MA organization's request for appeal invalid.

(iii) *RADV appeal rules.* The MA organization's written request for medical record review determination appeal must specify the following:

(A) The audited HCC(s) that the Secretary identified as being in error.

(B) A justification in support of the audited HCC selected for appeal.

(iv) *Number of medical records eligible for appeal.* For each audited HCC, MA organizations may appeal one medical record that has undergone RADV review. If an attestation was submitted to cure a signature or credential-related error, the attestation may be included in the HCC appeal.

(v) *Selection of medical record for appeal.* The MA organization must select the medical record that undergoes appeal.

(vi) *Written request for RADV payment error calculation appeal.* The written request for RADV payment error calculation appeal must clearly specify the following:

(A) The MA organization's own RADV payment error calculation.

(B) Where the Secretary's RADV payment error calculation was erroneous.

(3) *Issues ineligible for RADV appeals.*

(i) MA organizations' request for appeal may not include HCCs, medical records or other documents beyond the audited HCC, RADV-reviewed medical record, and any accompanying attestation that the MA organization chooses for appeal.

(ii) MA organizations may not appeal the Secretary's medical record review determination methodology or RADV payment error calculation methodology.

(iii) As part of the RADV payment error calculation appeal—MA organizations may not appeal RADV medical record review-related errors.

(iv) MA organizations may not appeal RADV errors that result from an MA

organization's failure to submit a medical record.

(4) *Burden of proof.* The MA organization bears the burden of proof by a preponderance of the evidence in demonstrating that the Secretary's medical record review determination(s) or payment error calculation was incorrect.

(5) *Manner and timing of a request for RADV appeal.* (i) At the time the Secretary issues its RADV audit report, the Secretary notifies audited MA organizations of the following:

(A) That they may appeal RADV HCC errors that are eligible for medical record review determination appeal.

(B) That they may appeal the Secretary's RADV payment error calculation.

(ii) MA organizations have 60 days from date of issuance of the RADV audit report to file a written request with CMS for RADV appeal. This request for RADV appeal must specify one of the following:

(A) Whether the MA organization requests medical record review determination appeal, the issues with which the MA organization disagrees, and the reasons for the disagreements.

(B) Whether the MA organization requests a payment error calculation appeal, the issues with which the MA organization disagrees, and the reasons for the disagreements. MA organizations will forgo their medical record review determination appeal if they choose to file only a payment error calculation appeal because medical record review determinations need to be final prior to adjudicating a payment error calculation appeal.

(iii) For MA organizations that intend to appeal both the medical record review determination and the RADV payment error calculation, an MA organization's request for appeal of its RADV payment error calculation may not be filed and will not be adjudicated until—

(A) The administrative appeal process for the RADV medical record review determinations filed by the MA organization has been exhausted; or

(B) The MA organization does not timely request a RADV medical record review determination appeal at the

hearing stage and/or the CMS Administrator review stage, as applicable.

(iv) An MA organization whose medical record review determination appeal has been completed as described in paragraph (c)(5)(iii) of this section has 60 days from the date of issuance of a revised RADV audit report, based on the final medical record review determination, to file a written request with CMS for a RADV payment error calculation appeal. This request for RADV payment error calculation appeal must clearly specify where the Secretary's RADV payment error calculation was erroneous, what the MA organization disagrees with, and the reasons for the disagreements.

(6) *Reconsideration stage*—(i) *Written request for medical record review reconsideration.* A MA organization's written request for medical record review determination reconsideration must specify the following:

(A) Any and all HCC(s) that the Secretary identified as being in error that the MA organization wishes to appeal.

(B) A justification in support of the audited HCC chosen for appeal.

(ii) *Written request for payment error calculation.* The MA organization's written request for payment error calculation reconsideration—

(A) Must include the MA organization's own RADV payment error calculation that clearly specifies where the Secretary's RADV payment error calculation was erroneous; and

(B) May include additional documentary evidence pertaining to the calculation of the payment error that the MA organization wishes the reconsideration official to consider.

(iii) *Conduct of the reconsideration.* (A) For medical record review determination reconsideration, a medical record review professional who was not involved in the initial medical record review determination of the disputed audited HCCs does the following:

(1) Reviews the medical record and accompanying dispute justification.

(2) Reconsiders the initial audited medical record review determination.

(B) For payment error calculation reconsideration, CMS ensures that a third party not involved in the initial RADV payment error calculation does the following:

(1) Reviews the Secretary's RADV payment error calculation.

(2) Reviews the MA organization's RADV payment error calculation;

(3) Recalculates the payment error in accordance with CMS's RADV payment error calculation procedures.

(iv) *Effect of the reconsideration official's decision.* (A) The reconsideration official issues a written reconsideration decision to the MA organization.

(B) The reconsideration official's decision is final unless it is reversed or modified by a final decision of the hearing officer as defined at § 422.311(c)(7)(x).

(C) If the MA organization disagrees with the reconsideration official's decision, they may request a hearing in accordance with paragraph (c)(7) of this section.

(v) *Computations based on reconsideration official's decision.* (A) Once the reconsideration official's medical record review determination decision is considered final in accordance with paragraph (c)(6)(iv)(B) of this section, the Secretary recalculates the MA organization's RADV payment error and issues a revised RADV audit report superseding all prior RADV audit reports to the appellant MA organization.

(B) For MA organizations appealing the RADV payment error calculation only, once the reconsideration official's payment error calculation decision is considered final in accordance with paragraph (c)(6)(iv)(B) of this section, the Secretary recalculates the MA organization's RADV payment error and issues a revised RADV audit report superseding all prior RADV audit reports to the appellant MA organization.

(7) *Hearing stage*—(i) *Errors eligible for hearing.* At the time the reconsideration official issues his or her reconsideration determination to the MA organization, the reconsideration official notifies the MA organization of any RADV HCC errors or payment error calculations that are eligible for RADV hearing.

(ii) *General hearing rules.* A MA organization that requests a RADV hearing must do so in writing in accordance with procedures established by CMS.

(iii) *Written request for hearing.* The written request for a hearing must be

filed with the Hearing Officer within 60 days of the date the MA organization receives the reconsideration officer's written reconsideration decision.

(A) If the MA organization appeals medical record review reconsideration determination, the written request for RADV hearing must—

(1) Include a copy of the written decision of the reconsideration official;

(2) Specify the audited HCCs that the reconsideration official confirmed as being in error; and

(3) Specify a justification why the MA organization disputes the reconsideration official's determination.

(B) If the MA organization appeals the RADV payment error calculation reconsideration determination, the written request for RADV hearing must include the following:

(1) A copy of the written decision of the reconsideration official.

(2) The MA organization's own RADV payment error calculation that clearly specifies where the Secretary's payment error calculation was erroneous.

(iv) *Designation of hearing officer.* A hearing officer will conduct the RADV hearing.

(v) *Disqualification of the hearing officer.* (A) A hearing officer may not conduct a hearing in a case in which he or she is prejudiced or partial to any party or has any interest in the matter pending for decision.

(B) A party to the hearing who objects to the designated hearing officer must notify that officer in writing at the earliest opportunity.

(C) The hearing officer must consider the objections, and may, at his or her discretion, either proceed with the hearing or withdraw.

(D) If the hearing officer withdraws, another hearing officer conducts the hearing.

(E) If the hearing officer does not withdraw, the objecting party may, after the hearing, present objections and request that the officer's decision be revised or a new hearing be held before another hearing officer. The objections must be submitted in writing to the Secretary.

(vi) *Hearing Officer review.* The hearing officer reviews the following:

(A) For a medical record review determination appeal, the hearing officer reviews all of the following:

(1) The RADV-reviewed medical record and any accompanying attestation that the MA organization selected for review.

(2) The reconsideration official's written determination.

(3) The written brief submitted by the MA organization or the Secretary in response to the reconsideration official's determination.

(B) For a payment error calculation appeal, the hearing officer reviews all of the following:

(1) The reconsideration official's written determination.

(2) Briefs addressing the reconsideration decision.

(vii) *Hearing procedures—(A) Authority of the Hearing Officer.* The hearing officer has full power to make rules and establish procedures, consistent with the law, regulations, and the Secretary rulings. These powers include the authority to dismiss the appeal with prejudice and take any other action which the hearing officer considers appropriate, including for failure to comply with such rules and procedures.

(B) *The hearing is on the record.* (1) Except as specified in paragraph (c)(viii)(B)(2) of this section, the hearing officer is limited to the review of the record.

(2)(i) Subject to the hearing officer's full discretion, the parties may request a live or telephonic hearing regarding some or all of the disputed medical records.

(ii) The hearing officer may, on his or her own-motion, schedule a live or telephonic hearing.

(3) The record is comprised of the following:

(i) *Written decisions* described at paragraphs (c)(6)(iv) and (7)(vi) of this section.

(ii) Written briefs from the MA organization explaining why they believe the reconsideration official's determination was incorrect.

(iii) The Secretary's optional brief that responds to the MA organization's brief—

(4) The hearing officer neither receives testimony nor accepts any new evidence that is not part of the record.

(5) Either the MA organization or the Secretary may ask the hearing officer to rule on a motion for summary judgment.

(viii) *Hearing Officer decision.* The hearing officer decides whether to uphold or overturn the reconsideration official's decision, and sends a written determination to CMS and the MA organization, explaining the basis for the decision.

(ix) *Computations based on Hearing Officer's decision.* (A) Once the hearing officer's medical record review determination decision is considered final in accordance with paragraph (c)(7)(x) of this section, the Secretary recalculates the MA organization's RADV payment error and issues a revised RADV audit report superseding all prior RADV audit reports to the appellant MA organization.

(B) For MA organizations appealing the RADV payment error calculation only, once the hearing officer's payment error calculation decision is considered final in accordance with paragraph (c)(7)(x) of this section, the Secretary recalculates the MA organization's RADV payment error and issues a revised RADV audit report superseding all prior RADV audit reports to the appellant MA organization.

(x) *Effect of the Hearing Officer's decision.* The hearing officer's decision is final unless the decision is reversed or modified by the CMS Administrator.

(8) *CMS Administrator review stage.* (i) A request for CMS Administrator review must be made in writing and filed with the CMS Administrator.

(ii) CMS or a MA organization that has received a hearing officer's decision and requests review by the CMS Administrator must do so within 60 days of receipt of the hearing officer's decision.

(iii) After reviewing a request for review, the CMS Administrator has the discretion to elect to review the hearing officer's decision or to decline to review the hearing officer's decision. If the CMS Administrator does not decline to review or does not elect to review within 90 days of receipt of either the MA organization or CMS's timely request for review (whichever is later), the hearing officer's decision becomes final.

(iv) If the CMS Administrator elects to review the hearing decision—

(A) The CMS Administrator acknowledges the decision to review the hearing decision in writing and notifies CMS and the MA organization of their right to submit comments within 15 days of the date of the issuance of the notification that the Administrator has elected to review the hearing decision; and

(B) [Reserved]

(v) The CMS Administrator renders his or her final decision in writing within 60 days of the date of the issuance of the notice acknowledging his or her decision to elect to review the hearing officer's decision.

(vi) The decision of the hearing officer is final if the CMS Administrator—

(A) Declines to review the hearing officer's decision; or

(B) Does not decline to review or elect to review within 90 days of the date of the receipt of either the MA organization or CMS's request for review (whichever is later); or

(C) Does not make a decision within 60 days of the date of the issuance of the notice acknowledging his or her decision to elect to review the hearing officer's decision.

(vii) *Computations based on CMS Administrator decision.* (A) Once the CMS Administrator's medical record review determination decision is considered final in accordance with paragraph (c)(8)(vi) of this section, the Secretary recalculates the MA organization's RADV payment error and issues a revised RADV audit report superseding all prior RADV audit reports to the appellant MA organization.

(B) For MA organizations appealing the RADV payment error calculation only, once the CMS Administrator's payment error calculation decision is considered final in accordance with paragraph (c)(8)(vi) of this section, the Secretary recalculates the MA organization's RADV payment error and issues a revised and final RADV audit report superseding all prior RADV audit reports to the appellant MA organization.

(9) *Final agency action.* In cases when an MA organization files a payment error calculation appeal subsequent to a medical record review determination

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appeal that has completed the administrative appeals process, the medical record review determination appeal final decision and the payment error calculation appeal final decision will not be considered a final agency action until the payment error calculation appeal has completed the administrative appeals process and a final revised audit report superseding all prior RADV audit reports has been issued to the appellant MA organization.

[75 FR 19806, Apr. 15, 2010; 75 FR 32859, June 10, 2010; as amended at 79 FR 29956, May 23, 2014; 88 FR 6665, Feb. 1, 2023; 89 FR 30822, Apr. 23, 2024]

## § 422.312 Announcement of annual capitation rate, benchmarks, and methodology changes.

(a) *Capitation rates*—(1) *Initial announcement*. Not later than the first Monday in April each year, CMS announces to MA organizations and other interested parties the following information for each MA payment area for the following calendar year:

(i) The annual MA capitation rate.

(ii) The risk and other factors to be used in adjusting those rates under § 422.308 for payments for months in that year.

(2) CMS includes in the announcement an explanation of assumptions used and a description of the risk and other factors.

(3) *Regional benchmark announcement*. Before the beginning of each annual, coordinated election period under § 422.62(a)(2), CMS will announce to MA organizations and other interested parties the MA region-specific non-drug monthly benchmark amount for the year involved for each MA region and each MA regional plan for which a bid was submitted under § 422.256.

(b) *Advance notice of changes in methodology*. (1) No later than 60 days before making the announcement under paragraph (a)(1) of this section, CMS notifies MA organizations of changes it proposes to make in the factors and the methodology it used in the previous determination of capitation rates.

(2) The MA organizations have 30 days to comment on the proposed changes.

[70 FR 4729, Jan. 28, 2005, as amended at 85 FR 33908, June 2, 2020]

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## § 422.314 Special rules for beneficiaries enrolled in MA MSA plans.

(a) *Establishment and designation of medical savings account (MSA)*. A beneficiary who elects coverage under an MA MSA plan—

(1) Must establish an MA MSA with a trustee that meets the requirements of paragraph (b) of this section; and

(2) If he or she has more than one MA MSA, designate the particular account to which payments under the MA MSA plan are to be made.

(b) *Requirements for MSA trustees*. An entity that acts as a trustee for an MA MSA must—

(1) Register with CMS;

(2) Certify that it is a licensed bank, insurance company, or other entity qualified, under sections 408(a)(2) or 408(h) of the Internal Revenue Code of 1986, to act as a trustee of individual retirement accounts;

(3) Agree to comply with the MA MSA provisions of section 138 of the Internal Revenue Code of 1986; and

(4) Provide any other information that CMS may require.

(c) *Deposit in the MA MSA*. (1) The payment is calculated as follows:

(i) The monthly MA MSA premium is compared with  $\frac{1}{12}$  of the annual capitation rate applied under this section for the.

(ii) If the monthly MA MSA premium is less than  $\frac{1}{12}$  of the annual capitation rate applied under this section for the area, the difference is the amount to be deposited in the MA MSA for each month for which the beneficiary is enrolled in the MSA plan.

(2) CMS deposits the full amount to which a beneficiary is entitled under paragraph (c)(1)(ii) of this section for the calendar year, beginning with the month in which MA MSA coverage begins.

(3) If the beneficiary's coverage under the MA MSA plan ends before the end of the calendar year, CMS recovers the amount that corresponds to the remaining months of that year.

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

## § 422.316 Special rules for payments to Federally qualified health centers.

If an enrollee in an MA plan receives a service from a Federally qualified

health center (FQHC) that has a written agreement with the MA organization offering the plan concerning the provision of this service (including the agreement required under section 1857(e)(3) of the Act and as codified in § 422.527)—

(a) CMS will pay the amount determined under section 1833(a)(3)(B) of the Act directly to the FQHC at a minimum on a quarterly basis, less the amount the FQHC would receive for the MA enrollee from the MA organization (which includes the cost sharing amount the FQHC may charge an enrollee, as established in the contract between the FQHC and the MA organization); and

(b) CMS will not reduce the amount of the monthly payments under this section as a result of the application of paragraph (a) of this section.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 76198, Dec. 23, 2005]

**§ 422.318 Special rules for coverage that begins or ends during an inpatient hospital stay.**

(a) *Applicability.* This section applies to inpatient services in a “subsection (d) hospital” as defined in section 1886(d)(1)(B) of the Act, a psychiatric hospital described in section 1886(d)(1)(B)(i) of the act, a rehabilitation hospital described in section 1886(d)(1)(B)(ii) of the Act, a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B) of the Act, or a long-term care hospital (described in section 1886(d)(1)(B)(iv)).

(b) *Coverage that begins during an inpatient stay.* If coverage under an MA plan offered by an MA organization begins while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—

(1) Payment for inpatient services until the date of the beneficiary’s discharge is made by the previous MA organization or original Medicare, as appropriate;

(2) The MA organization offering the newly-elected MA plan is not responsible for the inpatient services until the date after the beneficiary’s discharge; and

(3) The MA organization offering the newly-elected MA plan is paid the full

amount otherwise payable under this subpart.

(c) *Coverage that ends during an inpatient stay.* If coverage under an MA plan offered by an MA organization ends while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—

(1) The MA organization is responsible for the inpatient services until the date of the beneficiary’s discharge;

(2) Payment for those services during the remainder of the stay is not made by original Medicare or by any succeeding MA organization offering a newly-elected MA plan; and

(3) The MA organization that no longer provides coverage receives no payment for the beneficiary for the period after coverage ends.

**§ 422.320 Special rules for hospice care.**

(a) *Information.* An MA organization that has a contract under subpart K of this part must inform each Medicare enrollee eligible to select hospice care under § 418.24 of this chapter about the availability of hospice care (in a manner that objectively presents all available hospice providers, including a statement of any ownership interest in a hospice held by the MA organization or a related entity) if—

(1) A Medicare hospice program is located within the plan’s service area; or

(2) It is common practice to refer patients to hospice programs outside that area.

(b) *Enrollment status.* Unless the enrollee disenrolls from the MA plan, a beneficiary electing hospice continues his or her enrollment in the MA plan and is entitled to receive, through the MA plan, any benefits other than those that are the responsibility of the Medicare hospice.

(c) *Payment.* (1) No payment is made to an MA organization on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter, except for the portion of the payment attributable to the beneficiary rebate for the MA plan, described in § 422.266(b)(1) plus the amount of the monthly prescription drug payment described in § 423.315 (if any). This no-payment rule is effective from the first day of the month following the month

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of election to receive hospice care, until the first day of the month following the month in which the election is terminated.

(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

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the estimated amount in the aggregate that would be payable for services furnished by professionals and hospitals 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 re-

tained under title XVIII of the Act to which the MA organization, after applicable 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 enrollment data and data submitted under § 422.310.

(b) *Request to correct payment data.* (1) When CMS identifies erroneous payment data submitted by an MA organization (other than an error identified through the process described in § 422.311), CMS may send a data correction notice to the MA organization requesting that the MA organization correct the payment data.

(2) The notice will include or make reference to the specific payment data that need to be corrected, the reason why CMS believes that the payment data are erroneous, and the timeframe for correcting the payment data.

(c) *Payment offset.* (1) If the MA organization fails to submit the corrected payment data within the timeframe as requested in accordance with paragraph (b) of this section, CMS will conduct a payment offset against payments made to the MA organization if—

(i) The payment error affects payments for any of the 6 most recently completed payment years; and

(ii) The payment error for a particular payment year is identified after the applicable reconciliation date for that payment year.

(2) CMS will calculate the payment offset amount using the correct payment data and a payment algorithm that applies the payment rules for the applicable year.

(d) *Payment offset notification.* CMS will issue a payment offset notice to the MA organization that includes at least the following:

(1) The dollar amount of the offset from plan payments.

(2) An explanation of how the erroneous data were identified and used to calculate the payment offset amount.

(3) An explanation that, if the MA organization disagrees with the payment offset, it may request an appeal within 30 days of issuance of the payment offset notification.

(e) *Appeals process.* If an MA organization does not agree with the payment offset described in paragraph (c) of this section, it may appeal under the following three-level appeal process:

(1) *Reconsideration.* An MA organization may request reconsideration of the payment offset described in paragraph (c) of this section, according to the following process:

(i) *Manner and timing of request.* A written request for reconsideration must be filed within 30 days from the date that CMS issued the payment offset notice to the MA organization.

(ii) *Content of request.* The written request for reconsideration must specify the findings or issues with which the MA organization disagrees and the reasons for its disagreement. As part of its request for reconsideration, the MA organization may include any additional documentary evidence in support of its position. Any additional evidence must be submitted with the request for reconsideration. Additional information submitted after this time will be rejected as untimely.

(iii) *Conduct of reconsideration.* In conducting the reconsideration, the CMS reconsideration official reviews the underlying data that were used to determine the amount of the payment offset and any additional documentary evidence timely submitted by the MA organization.

(iv) *Reconsideration decision.* The CMS reconsideration official informs the MA organization of its decision on the reconsideration request.

(v) *Effect of reconsideration decision.* The decision of the CMS reconsideration official is final and binding unless a timely request for an informal hearing is filed in accordance with paragraph (e)(2) of this section.

(2) *Informal hearing.* An MA organization dissatisfied with CMS' reconsideration decision made under paragraph (e)(1) of this section is entitled to an informal hearing as provided for under paragraphs (e)(2)(i) through (e)(2)(v) of this section.

(i) *Manner and timing for request.* A request for an informal hearing must be made in writing and filed with CMS within 30 days of the date of CMS' reconsideration decision.

(ii) *Content of request.* The request for an informal hearing must include a copy of the reconsideration decision and must specify the findings or issues