

(A) A beneficiary makes any plan change (regardless of the parent organization) within the first three months of enrollment (known as rapid disenrollment), except as provided in paragraph (d)(5)(iii) of this section.

(B) Any other time period a beneficiary is not enrolled in a plan, but the plan paid compensation based on that time period.

(iii) Rapid disenrollment compensation recovery does not apply when:

(A) A beneficiary enrolls effective October 1, November 1, or December 1 and subsequently uses the Annual Election Period to change plans for an effective date of January 1.

(B) A beneficiary's enrollment change is not in the best interests of the Medicare program, including for the following reasons:

(1) Other creditable coverage (for example, an employer plan).

(2) Moving into or out of an institution.

(3) Gain or loss of employer/union sponsored coverage.

(4) Plan termination, non-renewal, or CMS imposed sanction.

(5) To coordinate with Part D enrollment periods or the State Pharmaceutical Assistance Program.

(6) Becoming LIS or dually eligible for Medicare and Medicaid.

(7) Qualifying for another plan based on special needs.

(8) Due to an auto, facilitated, or passive enrollment.

(9) Death.

(10) Moving out of the service area.

(11) Non-payment of premium.

(12) Loss of entitlement or retroactive notice of entitlement.

(13) Moving into a 5-star plan.

(14) Moving from an LPI plan into a plan with three or more stars.

(iv)(A) When rapid disenrollment compensation recovery applies, the entire compensation must be recovered.

(B) For other compensation recovery, plans must recover a pro-rated amount of compensation (whether paid for an initial enrollment year or renewal year) from an agent or broker equal to the number of months not enrolled.

(1) If a plan has paid full initial compensation, and the enrollee disenrolls prior to the end of the enrollment year, the total number of months not en-

rolled (including months prior to the effective date of enrollment) must be recovered from the agent or broker.

(2) Example: A beneficiary enrolls upon turning 65 effective April 1 and disenrolls September 30 of the same year. The plan paid full initial enrollment year compensation. Recovery is equal to 6/12ths of the initial enrollment year compensation (for January through March and October through December).

(e) *Payments other than compensation (administrative payments).* (1) For contract years through contract year 2024, payments made for services other than enrollment of beneficiaries (for example, training, customer service, agent recruitment, operational overhead, or assistance with completion of health risk assessments) must not exceed the value of those services in the marketplace.

(2) Beginning with contract year 2025, administrative payments are included in the calculation of enrollment-based compensation.

(f) *Payments for referrals.* Payments may be made to individuals for the referral (including a recommendation, provision, or other means of referring beneficiaries) to an agent, broker or other entity for potential enrollment into a plan. The payment may not exceed \$100 for a referral into an MA or MA-PD plan and \$25 for a referral into a PDP plan.

(g) *TPMO oversight.* In addition to any applicable FDR requirements under § 422.504(i), when doing business with a TPMP, either directly or indirectly through a downstream entity, MA plans must implement the following as a part of their oversight of TPMOs:

(1) When a TPMP is not otherwise an FDR, the MA organization is responsible for ensuring that the TPMP adheres to any requirements that apply to the MA plan.

(2) Contracts, written arrangements, and agreements between the TPMP and an MA plan, or between the TPMP and an MA plan's FDR, must ensure the TPMP:

(i) Discloses to the MA organization any subcontracted relationships used for marketing, lead generation, and enrollment.

(ii) Record all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology, in their entirety.

(iii) Reports to plans monthly any staff disciplinary actions or violations of any requirements that apply to the MA plan associated with beneficiary interaction to the plan.

(iv) Uses the TPMO disclaimer as required under § 422.2267(e)(41).

(3) Ensure that the TPMO, when conducting lead generating activities, either directly or indirectly for an MA organization, must, when applicable:

(i) Disclose to the beneficiary that his or her information will be provided to a licensed agent for future contact. This disclosure must be provided as follows:

(A) Verbally when communicating with a beneficiary through telephone.

(B) In writing when communicating with a beneficiary through mail or other paper.

(C) Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.

(ii) Disclose to the beneficiary that he or she is being transferred to a licensed agent who can enroll him or her into a new plan.

(4) Beginning October 1, 2024, personal beneficiary data collected by a TPMO for marketing or enrolling them into an MA plan may only be shared with another TPMO when prior express written consent is given by the beneficiary. Prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.

[86 FR 6112, Jan. 19, 2021, as amended at 87 FR 27899, May 9, 2022; 88 FR 22337, Apr. 12, 2023; 89 FR 30829, Apr. 23, 2024; 89 FR 63827, Aug. 6, 2024]

#### **§ 422.2276 Employer group retiree marketing.**

MA organizations may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits

through the MA organization, and furnish these materials only to the group members. These materials are not subject to CMS prior review and approval.

### **Subpart W [Reserved]**

### **Subpart X—Requirements for a Minimum Medical Loss Ratio**

SOURCE: 78 FR 31307, May 23, 2013, unless otherwise noted.

#### **§ 422.2400 Basis and scope.**

This subpart is based on sections 1857(e)(4), 1860D–12(b)(3)(D), and 1106 of the Act, and sets forth medical loss ratio requirements for Medicare Advantage organizations, financial penalties and sanctions against MA organizations when minimum medical loss ratios are not achieved by MA organizations, and release of medical loss ratio data to entities outside of CMS.

[81 FR 80557, Nov. 15, 2016]

#### **§ 422.2401 Definitions.**

*Non-claims costs* means those expenses for administrative services that are not—

(1) Incurred claims (as provided in § 422.2420(b)(2) through (4));

(2) Expenditures on quality improving activities (as provided in § 422.2430);

(3) Licensing and regulatory fees (as provided in § 422.2420(c)(2)(i));

(4) State and Federal taxes and assessments (as provided in § 422.2420(c)(2)(ii) and (iii)).

[78 FR 31307, May 23, 2013; 78 FR 43821, July 22, 2013]

#### **§ 422.2410 General requirements.**

(a) For contracts beginning in 2014 or later, an MA organization (defined at § 422.2) is required to report the information required under § 422.2460 for each contract under this part for each contract year.

(b) *MLR requirement.* If CMS determines for a contract year that an MA organization has an MLR for a contract that is less than 0.85, the MA organization has not met the MLR requirement and must remit to CMS an amount equal to the product of the following:

## § 422.2420

## 42 CFR Ch. IV (10–1–24 Edition)

(1) The total revenue of the MA contract for the contract year.

(2) The difference between 0.85 and the MLR for the contract year.

(c) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 3 or more consecutive contract years, CMS does not permit the enrollment of new enrollees under the contract for coverage during the second succeeding contract year.

(d) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS terminates the contract per § 422.510(b)(1) and (d) effective as of the second succeeding contract year.

[78 FR 31307, May 23, 2013, as amended at 83 FR 16736, Apr. 16, 2018]

### § 422.2420 Calculation of the medical loss ratio.

(a) *Determination of MLR.* (1) The MLR for each contract under this part is the ratio of the numerator (as defined in paragraph (b) of this section) to the denominator (as defined in paragraph (c) of this section). An MLR may be increased by a credibility adjustment according to the rules at § 422.2440, or subject to an adjustment determined by CMS to be warranted based on exceptional circumstances for areas outside the 50 states and the District of Columbia.

(2) The MLR for an MA contract—

(i) Not offering Medicare prescription drug benefits must only reflect costs and revenues related to the benefits defined at § 422.100(c); and

(ii) That includes MA–PD plans (defined at § 422.2) must also reflect costs and revenues for benefits described at § 423.104(d) through (f) of this chapter.

(b) *Determining the MLR numerator.*

(1) For a contract year, the numerator of the MLR for an MA contract (other than an MSA contract) must equal the sum of paragraphs (b)(1)(i) through (iii) of this section, and the numerator of the MLR for an MSA contract must equal the sum of paragraphs (b)(1)(i), (iii), and (iv) of this section. The numerator must be determined in accordance with paragraphs (b)(5) and (6) of this section.

(i) Incurred claims for all enrollees, as defined in paragraphs (b)(2) through (4) of this section.

(ii) The amount of the reduction, if any, in the Part B premium for all MA plan enrollees under the contract for the contract year.

(iii) The expenditures under the contract for activities that improve health care quality, as defined in § 422.2430.

(iv) The amount of the annual deposit into the medical savings account described at § 422.4(a)(2).

(2) *Incurred claims for clinical services and prescription drug costs.* Incurred claims must include the following:

(i) Amounts that the MA organization pays (including under capitation contracts) for covered services, described at paragraph (a)(2) of this section, provided to all enrollees under the contract.

(ii) For an MA contract that includes MA–PD plans (described in paragraph (a)(2) of this section), drug costs provided to all enrollees under the contract, as defined at § 423.2420(b)(2)(i) of this chapter.

(iii) Unpaid claims reserves for the current contract year, including claims reported in the process of adjustment.

(iv) Percentage withholds from payments made to contracted providers.

(v) Incurred but not reported claims based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

(vi) Changes in other claims-related reserves.

(vii) Claims that are recoverable for anticipated coordination of benefits.

(viii) Claims payments recoveries received as a result of subrogation.

(ix) [Reserved]

(x) Reserves for contingent benefits and the medical claim portion of lawsuits.

(xi) The amount of incentive and bonus payments made to providers.

(3) Adjustments that must be deducted from incurred claims include the following:

(i) Overpayment recoveries received from providers.

(4) *Exclusions from incurred claims.* The following amounts must not be included in incurred claims:

(i) Non-claims costs, as defined in § 422.2401, which include the following:

(A) Amounts paid to third party vendors for secondary network savings.

(B) Amounts paid to third party vendors for any of the following:

(1) Network development.

(2) Administrative fees.

(3) Claims processing.

(4) Utilization management.

(C) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, such as the following:

(1) Medical record copying costs.

(2) Attorneys' fees.

(3) Subrogation vendor fees.

(4) Bona fide service fees.

(5) Compensation to any of the following:

(i) Paraprofessionals.

(ii) Janitors.

(iii) Quality assurance analysts.

(iv) Administrative supervisors.

(v) Secretaries to medical personnel.

(vi) Medical record clerks.

(ii) Amounts paid to CMS as a remittance under § 422.2410(b).

(5) Incurred claims under this part for policies issued by one MA organization and later assumed by another entity must be reported by the assuming organizations for the entire MLR reporting year during which the policies were assumed and no incurred claims under this part for that contract year must be reported by the ceding MA organization.

(6) Reinsured incurred claims for a block of business that was subject to indemnity reinsurance and administrative agreements effective before March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(c) *Determining the MLR denominator.* For a contract year, the denominator of the MLR for an MA contract must equal the total revenue under the contract. Total revenue under the contract is as described in paragraph (c)(1) of this section, net of deductions described in paragraph (c)(2) of this section,

taking into account the exclusions described in paragraph (c)(3) of this section, and in accordance with paragraphs (c)(4) and (c)(5) of this section.

(1) CMS' payments to the MA organization for all enrollees under a contract, reported on a direct basis, including the following:

(i) Payments under § 422.304(a)(1) through (3) and (c).

(ii) The amount applied to reduce the Part B premium, as provided under § 422.266(b)(3).

(iii) Payments under § 422.304(b)(1), as reconciled per § 423.329(c)(2)(ii) of this chapter.

(iv) All premiums paid by or on behalf of enrollees to the MA organization as a condition of receiving coverage under an MA plan, including CMS' payments for low income premium subsidies under § 422.304(b)(2).

(v) All unpaid premium amounts that an MA organization could have collected from enrollees in the MA plan(s) under the contract.

(vi) All changes in unearned premium reserves.

(vii) Payments under § 423.315(e) of this chapter.

(2) The following amounts must be deducted from total revenue in calculating the MLR:

(i) *Licensing and regulatory fees.* (A) Statutory assessments to defray the operating expenses of any State or Federal department, such as the "user fee" described in section 1857(e)(2) of the Act.

(B) Examination fees in lieu of premium taxes as specified by State law.

(ii) *Federal taxes and assessments.* All Federal taxes and assessments allocated to health insurance coverage.

(iii) *State taxes and assessments.* State taxes and assessments such as the following:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly.

(B) Guaranty fund assessments.

(C) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(D) State income, excise, and business taxes other than premium taxes.

(iv) *Community benefit expenditures.* Community benefit expenditures are payments made by a Federal income tax-exempt MA organization for community benefit expenditures as defined in paragraph (c)(2)(iv)(A) of this section, limited to the amount defined in paragraph (c)(2)(iv)(B) of this section, and allocated to a contract as required under paragraph (d)(1) of this section.

(A) Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden.

(B) Such payment may be deducted up to the limit of either 3 percent of total revenue under this part or the highest premium tax rate in the State for which the Part D sponsor is licensed, multiplied by the Part D sponsor's earned premium for the contract.

(3) The following amounts must not be included in total revenue:

(i) The amount of unpaid premiums for which the MA organization can demonstrate to CMS that it made a reasonable effort to collect.

(ii) The following EHR payments and adjustments:

(A) EHR incentive payments for meaningful use of certified electronic health records by qualifying MAOs, MA EPs and MA-affiliated eligible hospitals that are administered under 42 CFR part 495 subpart C.

(B) EHR payment adjustments for a failure to meet meaningful use requirements that are administered under 42 CFR part 495 subpart C.

(iii) Coverage Gap Discount Program payments under § 423.2320 of this chapter.

(4) Total revenue (as defined at § 422.2420(c)) for policies issued by one MA organization and later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year during which the policies were assumed and no revenue under this part for that contract year must be reported by the ceding MA organization.

(5) Total revenue (as defined at § 422.2420(c)) that is reinsured for a block of business that was subject to

indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(d) *Allocation of expense*—(1) *General requirements.* (i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses.

(ii) Expenditures that benefit multiple contracts, or contracts other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.

(2) *Description of the methods used to allocate expenses.* (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories in paragraph (b) or (c) of this section will generally be the most accurate method.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contracts incurring the expense.

(iii)(A) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

(B) Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

[78 FR 31307, May 23, 2013; 78 FR 43821, July 22, 2013; 83 FR 16736, Apr. 16, 2018; 85 FR 33908, June 2, 2020]

**§ 422.2430 Activities that improve health care quality.**

(a) *Activity requirements.* (1) Activities conducted by an MA organization to improve quality must either—

(i) Fall into one of the categories in paragraph (a)(2) of this section and meet all of the requirements in paragraph (a)(3) of this section; or

(ii) Be listed in paragraph (a)(4) of this section.

(2) *Categories of quality improving activities.* The activity must be designed to achieve one or more of the following:

(i) To improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage.

(ii) To prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.

(iii) To improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage.

(iv) To promote health and wellness.

(v) To enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Such activities, such as Health Information Technology (HIT) expenses, are required to accomplish the activities that improve health care quality and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, and are consistent with meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance cur-

rent quality improving activities or make new quality improvement initiatives possible.

(3) The activity must be designed for all of the following:

(i) To improve health quality.

(ii) To increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) To be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) To be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(4)(i) For an MA contract that includes MA-PD plans (described in § 422.2420(a)(2)), Medication Therapy Management Programs meeting the requirements of § 423.153(d) of this chapter.

(ii) Fraud reduction activities, including fraud prevention, fraud detection, and fraud recovery.

(b) *Exclusions.* Expenditures and activities that must not be included in quality improving activities include, but are not limited to, the following:

(1) Those that are designed primarily to control or contain costs other than those that are related to fraud reduction.

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.

(3) Those which otherwise meet the definitions for quality improving activities but which were paid for with grant money or other funding separate from premium revenue.

(4) Those activities that can be billed or allocated by a provider for care delivery and that are reimbursed as clinical services.

(5) Establishing or maintaining a claims adjudication system, including

costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities (and that are not related to fraud reduction activities under paragraph (a)(4)(ii) of this section) or to meet regulatory requirements for processing claims, including ICD–10 implementation costs in excess of 0.3 percent of total revenue under this part, and maintenance of ICD–10 code sets adopted in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended.

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.

(7) All retrospective and concurrent utilization review.

(8) [Reserved]

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.

(10) Provider credentialing.

(11) Marketing expenses.

(12) Costs associated with calculating and administering individual enrollee or employee incentives.

(13) That portion of prospective utilization review that does not meet the definition of activities that improve health quality.

(14) Any function or activity not expressly permitted by CMS under this part.

[78 FR 31307, May 23, 2013, as amended at 83 FR 16736, Apr. 16, 2018]

**§ 422.2440 Credibility adjustment.**

(a) An MA organization may add the credibility adjustment specified under paragraph (e) of this section to a contract's MLR if the contract's experience is partially credible, as defined in paragraph (d)(1) of this section.

(b) An MA organization may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as defined in paragraph (d)(2) of this section.

(c) For those contract years for which a contract has non-credible experience, as defined in paragraph (d)(3) of this section, sanctions under § 422.2410(b) through (d) will not apply.

(d)(1) A contract's experience is partially credible if it is based on the experience of at least 2,400 member months and fewer than or equal to 180,000 member months.

(2) A contract's experience is fully credible if it is based on the experience of more than 180,000 member months.

(3) A contract's experience is non-credible if it is based on the experience of fewer than 2,400 member months.

(e)(1) The credibility adjustment for a partially credible MA contract, other than an MSA contract, is equal to the base credibility factor determined under paragraph (f) of this section.

(2) The credibility adjustment for a partially credible MA MSA contract is the product of the base credibility factor, as determined under paragraph (f) of this section, multiplied by the deductible factor, as determined under paragraph (g) of this section.

(f) The base credibility factor for partially credible experience is determined based on the number of member months for all enrollees under the contract and the factors shown in Table 1 of this section. When the number of member months used to determine credibility exactly matches a member month category listed in Table 1 of this section, the value associated with that number of member months is the base credibility factor. The base credibility factor for a number of member months between the values shown in Table 1 of this section is determined by linear interpolation.

(g) The deductible factor is based on the enrollment-weighted average deductible for all MSA plans under the MA MSA contract, where the deductible for each plan under the contract is weighted by the plan's portion of the total number of member months for all plans under the contract. When the weighted average deductible exactly matches a deductible category listed in Table 2 of this section, the value associated with that deductible is the deductible factor. The deductible factor for a weighted average deductible between the values shown in Table 2 of section is determined by linear interpolation.

TABLE 1 TO § 422.2440—BASE CREDIBILITY FACTORS FOR MA CONTRACTS

Member months	Base credibility factor (additional percentage points)
<2,400 .....	N/A (Non-credible).
2,400 .....	8.4%.
6,000 .....	5.3%.
12,000 .....	3.7%.
24,000 .....	2.6%.
60,000 .....	1.7%.
120,000 .....	1.2%.
180,000 .....	1.0%.
>180,000 .....	0.0% (Fully credible).

TABLE 2 TO § 422.2440—DEDUCTIBLE FACTORS FOR MA MSA CONTRACTS

Weighted average deductible	Deductible factor
<\$2,500 .....	1.000
\$2,500 .....	1.164
\$5,000 .....	1.402
≥\$10,000 .....	1.736

[85 FR 33908, June 2, 2020]

**§ 422.2450 [Reserved]****§ 422.2460 Reporting requirements.**

(a) Except as provided in paragraph (b) of this section, for each contract year, each MA organization must submit to CMS, in a timeframe and manner specified by CMS, a report that includes the data needed by the MA organization to calculate and verify the medical loss ratio (MLR) and remittance amount, if any, for each contract under this part, including the amount of incurred claims for original Medicare covered benefits, supplemental benefits, and prescription drugs; total revenue; expenditures on quality improving activities; non-claims costs; taxes; licensing and regulatory fees; and any remittance owed to CMS under § 422.2410.

(b) For contract years 2018 through 2022, each MA organization must submit to CMS, in a timeframe and manner specified by CMS, the following information:

(1) *Fully credible and partially credible contracts.* For each contract under this part that has fully credible or partially credible experience, as determined in accordance with § 422.2440(d), the MA organization must report to CMS the MLR for the contract and the amount of any remittance owed to CMS under § 422.2410.

(2) *Non-credible contracts.* For each contract under this part that has non-credible experience, as determined in accordance with § 422.2440(d), the MA organization must report to CMS that the contract is non-credible.

(c) Total revenue included as part of the MLR calculation must be net of all projected reconciliations.

(d) Subject to paragraph (e) of this section, the MLR is reported once, and is not reopened as a result of any payment reconciliation processes.

(e) With respect to an MA organization that has already submitted to CMS the MLR report or MLR data required under paragraph (a) or (b) of this section, respectively, for a contract for a contract year, paragraph (d) of this section does not prohibit resubmission of the MLR report or MLR data for the purpose of correcting the prior MLR report or data submission. Such resubmission must be authorized or directed by CMS, and upon receipt and acceptance by CMS, is regarded as the contract's MLR report or data submission for the contract year for purposes of this subpart.

[83 FR 16736, Apr. 16, 2018, as amended at 87 FR 27899, May 9, 2022]

**§ 422.2470 Remittance to CMS if the applicable MLR requirement is not met.**

(a) *General requirement.* For each contract year, an MA organization must provide a remittance to CMS if the contract's MLR does not meet the minimum MLR requirement required by § 422.2410(b) of this subpart.

(b) *Amount of remittance.* For each contract that does not meet the MLR requirement for a contract year, the MA organization must remit to CMS the amount by which the MLR requirement exceeds the contract's actual MLR multiplied by the total revenue of the contract, as provided in § 422.2420(c), for the contract year.

(c) *Timing of remittance.* CMS deducts the remittance from plan payments in a timely manner after the MLR is reported, on a schedule determined by CMS.

(d) *Treatment of remittance.* Payment to CMS must not be included in the numerator or denominator of any year's MLR.