

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.

## § 422.2480

## 42 CFR Ch. IV (10–1–24 Edition)

### § 422.2480 MLR review and non-compliance.

To ensure the accuracy of MLR reporting, CMS conducts selected review of data submitted under § 422.2460 to determine that the MLRs and remittance amounts under § 422.2410(b) and sanctions under § 422.2410(c) and (d), were accurately calculated, reported, and applied.

(a) The reviews include a validation of amounts included in both the numerator and denominator of the MLR calculation reported to CMS.

(b) MA organizations are required to maintain evidence of the amounts reported to CMS and to validate all data necessary to calculate MLRs.

(c)(1) Documents and records must be maintained for 10 years from the date such calculations were reported to CMS with respect to a given MLR reporting year.

(2) MA organizations must require any third party vendor supplying drug or medical cost contracting and claim adjudication services to the MA organization to provide all underlying data associated with MLR reporting to that MA organization in a timely manner, when requested by the MA organization, regardless of current contractual limitations, in order to validate the accuracy of MLR reporting.

(d) Data submitted under § 422.2460, calculations, or any other MLR submission required by this subpart found to be materially incorrect or fraudulent—

(1) Is noted by CMS;

(2) Appropriate remittance amounts are recouped by CMS; and

(3) Sanctions may be imposed by CMS as provided in § 422.752.

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

### § 422.2490 Release of Part C MLR data.

(a) *Terminology.* Subject to the exclusions in paragraph (b) of this section, Part C MLR data consists of the information submitted under § 422.2460.

(b) *Exclusions from Part C MLR data.* For the purpose of this section, the following items are excluded from Part C MLR data:

(1) Narrative descriptions that MA organizations submit to support the information reported to CMS pursuant to

the reporting requirements at § 422.2460, such as descriptions of expense allocation methods.

(2)(i) Information that is reported at the plan level, such as the number of member months associated with each plan under a contract, including information submitted for a contract consisting of only one plan.

(ii) Amounts that are reported as expenditures for a specific type of supplemental benefit, where the entire amount that is reported represents costs incurred by the only plan under the contract that offers that benefit.

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

(4) MLR review correspondence.

(5) Any information for a contract for those contract years for which the contract is determined to be non-credible, as defined in accordance with § 422.2440(d).

(c) *Data release.* CMS releases to the public Part C MLR data, for each contract for each contract year, no earlier than 18 months after the end of the applicable contract year.

[81 FR 80557, Nov. 15, 2016, as amended at 83 FR 16736, Apr. 16, 2018; 87 FR 27899, May 9, 2022]

## Subpart Y [Reserved]

## Subpart Z—Part C Recovery Audit Contractor Appeals Process

SOURCE: 79 FR 29961, May 23, 2014, unless otherwise noted.

### § 422.2600 Payment appeals.

If the Part C RAC did not apply its stated payment methodology correctly, an MA organization may appeal the findings of the applied methodology. The payment methodology itself is not subject to appeal.

### § 422.2605 Request for reconsideration.

(a) *Time for filing a request.* The request for reconsideration must be filed with the designated independent reviewer within 60 calendar days from the date of the demand letter received by the MA organization.

(b) *Content of request.* (1) The request for reconsideration must be in writing

and specify the findings or issues with which the MA organization disagrees.

(2) The MA organization must include with its request all supporting documentary evidence it wishes the independent reviewer to consider.

(i) This material must be submitted in the format requested by CMS.

(ii) Documentation, evidence, or substantiation submitted after the filing of the reconsideration request will not be considered.

(c) *CMS rebuttal*. CMS may file a rebuttal to the MA organization's reconsideration request.

(1) The rebuttal must be submitted within 30 calendar days of the review entity's notification to CMS that it has received the MA organization's reconsideration request.

(2) CMS sends its rebuttal to the MA organization at the same time it is submitted to the independent reviewer.

(d) *Review entity*. An independent reviewer conducts the reconsideration. The independent reviewer reviews the demand for repayment, the evidence and findings upon which it was based and any supporting documentation that the MA organization or CMS submitted in accordance with this section.

(e) *Notification of decision*. The independent reviewer informs the CMS and the MA organization of its decision in writing.

(f) *Effect of decision*. A reconsideration decision is final and binding unless the MA organization requests a hearing official review in accordance with § 422.2610.

(g) *Right to hearing official review*. An MA organization that is dissatisfied with the independent reviewer's reconsideration decision is entitled to a hearing official review as provided in § 422.2610.

#### § 422.2610 Hearing official review.

(a) *Time for filing a request*. A MA organization must file with CMS a request for a hearing official review within 30 calendar days from the date of the independent reviewer's issuance of a reconsideration determination.

(b) *Content of the request*. (1) The request must be in writing and must specify the findings or issues in the reconsideration decision with which the

MA organization disagrees and the reasons for the disagreements.

(2) The MA organization must submit with its request all supporting documentation, evidence, and substantiation that it wants to be considered.

(3) No new evidence may be submitted.

(4) Documentation, evidence, or substantiation submitted after the filing of the request will not be considered.

(c) *CMS rebuttal*. CMS may file a rebuttal to the MA organization's hearing official review request.

(1) The rebuttal must be submitted within 30 calendar days of the MA organization's submission of its hearing official review request.

(2) CMS sends its rebuttal to the MA organization at the same time it is submitted to the hearing official.

(d) *Conducting a review*. A CMS-designated hearing official conducts the hearing on the record.

(1) The hearing is not to be conducted live or via telephone unless the hearing official, in his or her sole discretion, requests a live or telephonic hearing.

(2) In all cases, the hearing official's review is limited to information that meets one or more of the following:

(i) The Part C RAC used in making its determinations.

(ii) The independent reviewer used in making its determinations.

(iii) The MA organization submits with its hearing request.

(iv) CMS submits in accordance with paragraph (c) of this section.

(3) Neither the MA organization nor CMS may submit new evidence.

(e) *Hearing official decision*. The CMS hearing official decides the case within 60 days and sends a written decision to the MA organization and CMS, explaining the basis for the decision.

(f) *Effect of hearing official decision*. The hearing official's decision is final and binding, unless the decision is reversed or modified by the CMS Administrator in accordance with § 422.2615.

#### § 422.2615 Review by the Administrator.

(a) *Request for review by Administrator*. If an MA organization is dissatisfied with the hearing official's decision, it may request that the CMS Administrator review the decision.