

(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