

§ 422.312

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]

42 CFR Ch. IV (10–1–24 Edition)

§ 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