

(i) The enrolled individual is eligible to enroll in the MA plan; and

(ii) The MA-PD plan into which individuals are transitioned describes changes to MA-PD benefits and provides information about the MA-PD plan in the Annual Notice of Change, which must be sent consistent with § 422.111(a), (d), and (e).

(3) For the purpose of approving a MA organization to transition enrollment under this paragraph (e), CMS determines whether a non-SNP MA plan would meet the criteria in paragraph (d)(2) of this section by adding the cohort of individuals identified by the MA organization for enrollment in a non-SNP MA plan to the April enrollment of such plan and calculating the resulting percentage of dual eligible enrollment.

(4) In cases where an MA organization does not transition current enrollees under paragraph (e)(1) of this section, the MA organization must send a written notice to enrollees who are not transitioned, consistent with § 422.506(a)(2).

(f) *Special considerations.* Actions taken pursuant to paragraph (d) of this section warrant special consideration to exempt affected MA organizations from the denial of an application for a new contract or service area expansion in accordance with §§ 422.502(b)(3) and (4), 422.503(b)(6) and (7), 422.506(a)(3) and (4), 422.508(c) and (d), and 422.512(e)(1) and (2).

(g) *Applicability to segments.* The rules under paragraphs (d) through (f) of this section also apply to segments of the MA plan as provided for local MA plans under § 422.262(c)(2).

(h) *Rule on dual eligible special needs plans in relation to Medicaid managed care.*

(1) Beginning in 2027, where an MA organization offers a dual eligible special needs plan and the MA organization, its parent organization, or any entity that shares a parent organization with the MA organization also contracts with a State as a Medicaid managed care organization (MCO) (as defined in § 438.2) that enrolls full-benefit dual eligible individuals as defined in § 423.772, during the effective dates and in the same service area (even if there is only partial overlap of the

service areas) of that Medicaid MCO contract, the MA organization—

(i) May only offer, or have a parent organization or share a parent organization with another MA organization that offers, one D-SNP for full-benefit dual eligible individuals, except as permitted in paragraph (h)(3) of this section; and

(ii) Must limit new enrollment in the D-SNP to individuals enrolled in, or in the process of enrolling in, the Medicaid MCO.

(2) Beginning in 2030, such D-SNPs may only enroll (or continue to cover) individuals enrolled in (or in the process of enrolling in) the Medicaid MCO, except that such D-SNPs may continue to implement deemed continued eligibility requirements as described in § 422.52(d).

(3)(i) If a State Medicaid agency's contract(s) with the MA organization differentiates enrollment into D-SNPs by age group or to align enrollment in each D-SNP with the eligibility or benefit design used in the State's Medicaid managed care program(s) (as defined in § 438.2), the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization may offer one or more additional D-SNPs for full-benefit dual eligible individuals in the same service area in accordance with the group (or groups) eligible for D-SNPs based on provisions of the contract with the State Medicaid agency under § 422.107.

(ii) If the MA organization, its parent organization, or an entity that shares a parent organization with the MA organization offers both HMO D-SNP(s) and PPO D-SNP(s), and one or more of the—

(A) HMO D-SNPs is subject to paragraph (h)(1) of this section, the PPO D-SNP(s) not subject to paragraph (h)(1) of this section may continue if they no longer accept new enrollment of full-benefit dual eligible individuals in the same service area as the plan (or plans) subject to paragraph (h)(1) of this section.

(B) PPO D-SNPs is subject to paragraph (h)(1) of this section, the HMO D-SNP(s) not subject to paragraph (h)(1) of this section may continue if they no longer accept new enrollment of full-benefit dual eligible individuals in the

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same service area as the plan (or plans) subject to paragraph (h)(1) of this section.

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§ 422.516 Validation of Part C reporting requirements.

(a) *Required information.* Each MA organization must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the provider-patient relationship, information with respect to the following:

- (1) The cost of its operations.
- (2) The procedures related to and utilization of its services and items.
- (3) The availability, accessibility, and acceptability of its services.
- (4) To the extent practical, developments in the health status of its enrollees.
- (5) Information demonstrating that the MA organization has a fiscally sound operation.
- (6) Other matters that CMS may require.

(b) *Significant business transactions.* Each MA organization must report to CMS annually, within 120 days of the end of its fiscal year (unless for good cause shown, CMS authorizes an extension of time), the following:

- (1) A description of significant business transactions (as defined in § 422.500) between the MA organization and a party in interest.
- (2) With respect to those transactions—
 - (i) A showing that the costs of the transactions listed in paragraph (c) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or
 - (ii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.
- (3) A combined financial statement for the MA organization and a party in

interest if either of the following conditions is met:

(i) Thirty-five percent or more of the costs of operation of the MA organization go to a party in interest.

(ii) Thirty-five percent or more of the revenue of a party in interest is from the MA organization.

(c) *Requirements for combined financial statements.* (1) The combined financial statements required by paragraph (b)(3) of this section must display in separate columns the financial information for the MA organization and each of the parties in interest.

(2) Inter-entity transactions must be eliminated in the consolidated column.

(3) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(4) Upon written request from an MA organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this paragraph (c) with respect to a particular entity.

(d) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an MA organization in its offerings, the MA organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular MA organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The MA organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA.

(e) *Loan information.* Each organization must notify CMS of any loans or other special financial arrangements it makes with contractors, subcontractors and related entities.

(f) *Enrollee access to information.* Each MA organization must make the information reported to CMS under § 422.502(f)(1) available to its enrollees upon reasonable request.

(g) *Data validation.* Each Part C sponsor must subject information collected under paragraph (a) of this section to a yearly independent audit to determine