

Centers for Medicare & Medicaid Services, HHS

§ 422.528

their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.

[63 FR 35099, June 26, 1998, as amended at 75 FR 19812, Apr. 15, 2010; 89 FR 30825, Apr. 23, 2024]

§ 422.520 Prompt payment by MA organization.

(a) *Contract between CMS and the MA organization.* (1) The contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of the “clean claims” within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

(2) The MA organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B).

(3) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

(b)(1) *Contracts between MA organizations and providers and suppliers.* Contracts or other written agreements between MA organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA organization and the relevant provider.

(2) The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider.

(c) *Failure to comply.* If CMS determines, after giving notice and opportunity for hearing, that an MA organization has failed to make payments in accordance with paragraph (a) of this section, CMS may provide—

(1) For direct payment of the sums owed to providers, or MA private fee-for-service plan enrollees; and

(2) For appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

(d) A CMS decision to not conduct a hearing under paragraph (c) of this section does not disturb any potential

remedy under State law for 1866(a)(1)(O) of the Act.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 70 FR 4738, Jan. 28, 2005]

§ 422.521 Effective date of new significant regulatory requirements.

CMS will not implement, other than at the beginning of a calendar year, requirements under this part that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute.

[68 FR 50858, Aug. 22, 2003]

§ 422.524 Special rules for RFB societies.

In order to participate as an MA organization, an RFB society—

(a) May not impose any limitation on membership based on any factor related to health status; and

(b) Must offer, in addition to the MA RFB plan, health coverage to individuals who are members of the church or convention or group of churches with which the society is affiliated, but who are not entitled to receive benefits from the Medicare program.

§ 422.527 Agreements with Federally qualified health centers.

The contract between the MA organization and CMS must specify that—

(a) The MA organization must pay a Federally qualified health center (FQHC) a similar amount to what it pays other providers for similar services.

(b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(c) Financial incentives, such as risk pool payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under § 422.316(a).

[70 FR 4738, Jan. 28, 2005]

§ 422.528 Final settlement process and payment.

(a) *Notice of final settlement.* After the calculation of the final settlement amount, CMS sends the MA organization a notice of final settlement. The

§ 422.529

42 CFR Ch. IV (10–1–24 Edition)

notice of final settlement contains at least all of the following information:

(1) A final settlement amount, which may be either an amount due to the MA organization, or an amount due from the MA organization, or \$0 if nothing is due to or from the MA organization, for the contract that has been consolidated, nonrenewed, or terminated.

(2) Relevant banking and financial mailing instructions for MA organizations that owe CMS a final settlement amount.

(3) Relevant CMS contact information.

(4) A description of the steps for requesting an appeal of the final settlement amount calculation, in accordance with the requirements specified in § 422.529.

(b) *Request for an appeal.* An MA organization that disagrees with the final settlement amount has 15 calendar days from issuance of the notice of final settlement, as described in paragraph (a) of this section, to request an appeal of the final settlement amount under the process described in § 422.529.

(1) If an MA organization agrees with the final settlement amount, no response is required.

(2) If an MA organization disagrees with the final settlement amount but does not request an appeal within 15 calendar days from the date of the issuance of the notice of final settlement, CMS does not consider subsequent requests for appeal.

(c) *Actions if an MA organization does not request an appeal.* (1) For MA organizations that are owed money by CMS, CMS remits payment to the MA organization within 60 calendar days from the date of the issuance of the notice of final settlement.

(2) For MA organizations that owe CMS money, the MA organization is required to remit payment to CMS within 120 calendar days from issuance of the notice of final settlement. If the MA organization fails to remit payment within that 120-calendar-day period, CMS refers the debt owed to CMS to the Department of the Treasury for collection.

(d) *Actions following submission of a request for appeal.* If an MA organization responds to the notice of final settle-

ment disagreeing with the final settlement amount and requesting appeal, CMS conducts a review under the process described at § 422.529.

(e) *No additional payment adjustments.* After the final settlement amount is calculated and the notice of final settlement, as described under § 422.528(a), is issued to the MA organization, CMS no longer apply retroactive payment adjustments to the terminated, consolidated or nonrenewed contract and there are no adjustments applied to amounts used in the calculation of the final settlement amount.

[89 FR 30825, Apr. 23, 2024]

§ 422.529 Requesting an appeal of the final settlement amount.

(a) *Appeals process.* If an MA organization does not agree with the final settlement amount described in § 422.528(a), it may appeal under the following three-level appeal process:

(1) *Reconsideration.* An MA organization may request reconsideration of the final settlement amount described in § 422.528(a) according to the following process:

(i) *Manner and timing of request.* A written request for reconsideration must be filed within 15 calendar days from the date that CMS issued the notice of final settlement to the MA organization.

(ii) *Content of request.* The written request for reconsideration must do all of the following:

(A) Specify the calculation with which the MA organization disagrees and the reasons for its disagreement.

(B) Include evidence supporting the assertion that CMS' calculation of the final settlement amount is incorrect.

(C) Not include new reconciliation data or data that was submitted to CMS after the final settlement notice was issued. CMS does not consider information submitted for the purposes of retroactively adjusting a prior reconciliation.

(iii) *Conduct of reconsideration.* In conducting the reconsideration, the CMS reconsideration official reviews the calculations that were used to determine the final settlement amount and any additional evidence timely submitted by the MA organization.

(iv) *Reconsideration decision.* The CMS reconsideration official informs the MA organization of its decision on the reconsideration in writing.

(v) *Effect of reconsideration decision.* The decision of the CMS reconsideration official is final and binding unless a timely request for an informal hearing is filed in accordance with paragraph (a)(2) of this section.

(2) *Informal hearing.* An MA organization dissatisfied with CMS' reconsideration decision made under paragraph (a)(1) of this section is entitled to an informal hearing as provided for under paragraphs (a)(2)(i) through (a)(2)(iv) of this section.

(i) *Manner and timing of request.* A request for an informal hearing must be made in writing and filed with CMS within 15 calendar days of the date of CMS' reconsideration decision.

(ii) *Content of request.* The request for an informal hearing must include a copy of the reconsideration decision and must specify the findings or issues in the decision with which the MA organization disagrees and the reasons for its disagreement.

(iii) *Informal hearing procedures.* The informal hearing is conducted in accordance with the following:

(A) The CMS Hearing Officer provides written notice of the time and place of the informal hearing at least 30 days before the scheduled date.

(B) The CMS reconsideration official provides a copy of the record that was before CMS when CMS made its decision to the hearing officer.

(C) The hearing officer review is conducted by a CMS hearing officer who neither receives testimony nor accepts any new evidence. The CMS hearing officer is limited to the review of the record that was before CMS when CMS made its decision.

(iv) *Decision of the CMS hearing officer.* The CMS hearing officer decides the case and sends a written decision to the MA organization explaining the basis for the decision.

(v) *Effect of hearing officer's decision.* The hearing officer's decision is final and binding, unless the decision is reversed or modified by the CMS Administrator in accordance with paragraph (a)(3) of this section.

(3) *Review by the Administrator.* The Administrator's review is conducted in the following manner:

(i) *Manner and timing of request.* An MA organization that has received a hearing officer's decision may request review by the Administrator within 15 calendar days of the date of issuance of the hearing officer's decision under paragraph (a)(2)(iv) of this section. An MA organization may submit written arguments to the Administrator for review.

(ii) *Discretionary review.* After receiving a request for review, the Administrator has the discretion to elect to review the hearing officer's determination in accordance with paragraph (a)(3)(iii) of this section or to decline to review the hearing officer's decision within 30 calendar days of receiving the request for review. If the Administrator declines to review the hearing officer's decision, the hearing officer's decision is final and binding.

(iii) *Administrator's review.* If the Administrator elects to review the hearing officer's decision, the Administrator reviews the hearing officer's decision, as well as any information included in the record of the hearing officer's decision and any written argument submitted by the MA organization, and determine whether to uphold, reverse, or modify the hearing officer's decision.

(iv) *Effect of Administrator's decision.* The Administrator's decision is final and binding.

(b) *Matters subject to appeal and burden of proof.* (1) The MA organization's appeal is limited to CMS' calculation of the final settlement amount. CMS does not consider information submitted for the purposes of retroactively adjusting a prior reconciliation.

(2) The MA organization bears the burden of proof by providing evidence demonstrating that CMS' calculation of the final settlement amount is incorrect.

(c) *Stay of financial transaction until appeals are exhausted.* If an MA organization requests review of the final settlement amount, the financial transaction associated with the issuance or payment of the final settlement amount is stayed until all appeals are