(i) Amounts incorrectly collected that were not collected as premiums.
(ii) Other amounts due.
(iii) All amounts due if the MA organization is going out of business or terminating its MA contract for an MA plan(s).

(2) Premium adjustment or lump-sum payment, or both. If the amounts incorrectly collected were in the form of premiums, or included premiums as well as other charges, the MA organization may refund by adjustment of future premiums or by a combination of premium adjustment and lump-sum payments.

(3) Refund when enrollee has died or cannot be located. If an enrollee has died or cannot be located after reasonable effort, the MA organization must make the refund in accordance with State law.

(d) Reduction by CMS. If the MA organization does not make the refund required under this section by the end of the contract period following the contract period during which an amount was determined to be due to an enrollee, CMS will reduce the premium the MA organization is allowed to charge an MA plan enrollee by the amounts incorrectly collected or otherwise due. In addition, the MA organization would be subject to sanction under subpart O of this part for failure to refund amounts incorrectly collected from MA plan enrollees.

Subpart G—Payments to Medicare Advantage Organizations

SOURCE: 70 FR 4729, Jan. 28, 2005, unless otherwise noted.

§422.300 Basis and scope.

This subpart is based on sections 1833, 1854, and 1858 of the Act. It sets forth the rules for making payments to Medicare Advantage (MA) organizations offering local and regional MA plans, including calculation of MA capitation rates and benchmarks, conditions under which payment is based on plan bids, adjustments to capitation rates (including risk adjustment), and other payment rules.

See §422.458 in subpart J for rules on risk sharing payments to MA regional organizations.

§422.304 Monthly payments.

(a) General rules. Except as provided in paragraph (b) of this section, CMS makes advance monthly payments of the amounts determined under paragraphs (a)(1) and (a)(2) of this section for coverage of original fee-for-service benefits for an individual in an MA payment area for a month.

(1) Payment of bid for plans with bids below benchmark. For MA plans that have average per capita monthly savings (as described at §422.264(b) for local plans and §422.264(d) for regional plans), CMS pays:

(i) The unadjusted MA statutory non-drug monthly bid amount defined in §422.252, risk-adjusted as described at §422.308(c) and adjusted (if applicable) for variations in rates within the plan’s service area (described at §422.258(a)(2)) and for the effects of risk adjustment on beneficiary premiums under §422.262; and

(ii) The amount (if any) of the rebate described in paragraph (a)(3) of this section.

(2) Payment of benchmark for plans with bids at or above benchmark. For MA plans that do not have average per capita monthly savings (as described at §422.264(b) for local plans and §422.264(d) for regional plans), CMS pays the unadjusted MA area-specific non-drug monthly benchmark amount specified at §422.258, risk-adjusted as described at §422.308(c) and adjusted (if applicable) for variations in rates within the plan’s service area (described at §422.258(a)(2)) and for the effects of risk adjustment on beneficiary premiums under §422.262.

(3) Payment of rebate for plans with bids below benchmarks. The rebate amount under paragraph (a)(1)(ii) of this section is the amount of the monthly rebate computed under §422.266(a) for that plan, less the amount (if any) applied to reduce the Part B premium, as provided under §422.266(b)(3)).

(b) Separate payment for Federal drug subsidies. In the case of an enrollee in an MA-PD plan, defined at §422.252, the