

§ 422.309

the same geographic area or State or in the United States, or on the basis of other appropriate data.

[63 FR 35093, June 26, 1998; 63 FR 52614, Oct. 1, 1998]

§ 422.309 Incorrect collections of premiums and cost-sharing.

(a) *Definitions.* As used in this section—

(1) *Amounts incorrectly collected*

(i) Means amounts that:

(A) Exceed the limits imposed by § 422.308;

(B) In the case of a M+C private fee-for-service plan, exceed the M+C monthly basic beneficiary premium or the M+C monthly supplemental premium submitted under § 422.306; and

(C) In the case of a M+C MSA plan, exceed the M+C monthly supplemental premium submitted under § 422.306 and the deductible for basic benefits; and

(ii) Includes amounts collected from an enrollee who was believed not entitled to Medicare benefits but was later found to be entitled.

(2) *Other amounts due* are amounts due for services that were—

(i) Emergency, urgently needed services, or other services obtained outside the M+C plan; or

(ii) Initially denied but, upon appeal, found to be services the enrollee was entitled to have furnished by the M+C organization.

(b) *Basic commitments.* An M+C organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf.

(c) *Refund methods*—(1) *Lump-sum payment.* The M+C organization must use lump-sum payments for the following:

(i) Amounts incorrectly collected that were not collected as premiums.

(ii) Other amounts due.

(iii) All amounts due if the M+C organization is going out of business or terminating its M+C contract for an M+C 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 M+C organi-

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zation 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 M+C organization must make the refund in accordance with State law.

(d) *Reduction by HCFA.* If the M+C 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 an enrollee, HCFA reduces the premium the M+C organization is allowed to charge an M+C plan enrollee by the amounts incorrectly collected or otherwise due. In addition, the M+C organization would be subject to sanction under subpart O for failure to refund amounts incorrectly collected from M+C plan enrollees.

§ 422.310 Adjusted community rate (ACR) approval process.

(a) *General rule.* (1) Except with respect to M+C MSA plans, each M+C organization must compute a separate ACR for each M+C coordinated care or private fee-for-service plan offered to Medicare beneficiaries. In computing the ACR, the M+C organization calculates an initial rate (for years after 1999, using the methods described in paragraph (b), for 1999, under § 417.594(b)) that represents the “commercial premium” the M+C organization would charge its general non-Medicare eligible enrollment population for the basic benefits, and any mandatory supplemental benefits covered under the M+C plan. The M+C organization should also calculate a separate initial rate (using the same approach) for each optional supplemental benefit package it offers under an M+C plan. For years after 1999 the M+C organization then either adjusts that rate by the factors specified in paragraph (c) of this section or requests that HCFA adjust the rate in accordance with the procedures specified in paragraph (c)(6) of this section. For 1999, adjustments are made under section 417.594(c). All data submitted as part of the ACR process is subject to