

are or were enrolled in Medicare, that is included on the preclusion list because of a felony conviction will remain on the preclusion list for a 10-year period, beginning on the date of the felony conviction, unless CMS determines that a shorter length of time is warranted. Factors that CMS considers in making such a determination are as follows:—

(A) The severity of the offense.

(B) When the offense occurred.

(C) Any other information that CMS deems relevant to its determination.

(iv) In cases where an individual or entity is excluded by the OIG, the individual or entity must remain on the preclusion list until the expiration of the CMS-imposed preclusion list period or reinstatement by the OIG, whichever occurs later.

(6) CMS has the discretion not to include a particular individual or entity on (or if warranted, remove the individual or entity from) the preclusion list should it determine that exceptional circumstances exist regarding beneficiary access to MA items, services, or drugs. In making a determination as to whether such circumstances exist, CMS takes into account:

(i) The degree to which beneficiary access to MA items, services, or drugs would be impaired; and

(ii) Any other evidence that CMS deems relevant to its determination.

(b) An MA organization that does not comply with paragraph (a) of this section may be subject to sanctions under § 422.750 and termination under § 422.510.

[83 FR 16733, Apr. 16, 2018, as amended at 84 FR 15831, Apr. 16, 2019]

**§ 422.224 Payment to individuals and entities excluded by the OIG or included on the preclusion list.**

(a) An MA organization may not pay, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee by any individual or entity that is excluded by the Office of the Inspector General (OIG) or is included on the preclusion list, defined in § 422.2.

(b) If an MA organization receives a request for payment by, or on behalf of, an individual or entity that is excluded by the OIG or an individual or entity that is included on the preclusion list, defined in § 422.2, the MA organization

must notify the enrollee and the excluded individual or entity or the individual or entity included on the preclusion list in writing, as directed by contract or other direction provided by CMS, that payments will not be made. Payment may not be made to, or on behalf of, an individual or entity that is excluded by the OIG or is included on the preclusion list.

[83 FR 16733, Apr. 16, 2018]

**Subpart F—Submission of Bids, Premiums, and Related Information and Plan Approval**

SOURCE: 70 FR 4725, Jan. 28, 2005, unless otherwise noted.

**§ 422.250 Basis and scope.**

This subpart is based largely on section 1854 of the Act, but also includes provisions from sections 1853 and 1858 of the Act, and is also based on section 1106 of the Act. It sets forth the requirements for the Medicare Advantage bidding payment methodology, including CMS' calculation of benchmarks, submission of plan bids by Medicare Advantage (MA) organizations, establishment of beneficiary premiums and rebates through comparison of plan bids and benchmarks, negotiation and approval of bids by CMS, and the release of MA bid submission data.

[81 FR 80556, Nov. 15, 2016]

**§ 422.252 Terminology.**

*Annual MA capitation rate* means a county payment rate for an MA local area (county) for a calendar year. The terms “per capita rate” and “capitation rate” are used interchangeably to refer to the annual MA capitation rate.

*Low enrollment contract* means a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees to reliably measure the performance of the health plan.

*MA local area* means a payment area consisting of county or equivalent area specified by CMS.

*MA monthly basic beneficiary premium* means the premium amount (if any) an MA plan (except an MSA plan) charges