

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

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an enrollee for basic benefits as defined in § 422.100(c)(1), and is calculated as described at § 422.262.

MA monthly MSA premium means the amount of the plan premium for coverage of basic benefits as defined in § 422.100(c)(1) through an MSA plan, as set forth at § 422.254(e).

MA monthly prescription drug beneficiary premium is the MA-PD plan base beneficiary premium, defined at section 1860D–13(a)(2) of the Act, as adjusted to reflect the difference between the plan's bid and the national average bid (as described in § 422.256(c)) less the amount of rebate the MA-PD plan elects to apply, as described at § 422.266(b)(2).

MA monthly supplemental beneficiary premium is the portion of the plan bid attributable to mandatory and/or optional supplemental health care benefits described under § 422.102, less the amount of beneficiary rebate the plan elects to apply to a mandatory supplemental benefit, as described at § 422.266(b)(1).

MA-PD plan means an MA local or regional plan that provides prescription drug coverage under Part D of Title XVIII of the Social Security Act.

Monthly aggregate bid amount means the total monthly plan bid amount for coverage of an MA eligible beneficiary with a nationally average risk profile for the factors described in § 422.308(c), and this amount is comprised of the following:

(1) The unadjusted MA statutory non-drug monthly bid amount for coverage of basic benefits as defined in § 422.100(c)(1).

(2) The amount for coverage of basic prescription drug benefits under Part D (if any).

(3) The amount for provision of supplemental health care benefits (if any).

New MA plan means a MA contract offered by a parent organization that has not had another MA contract in the previous 3 years. For purposes of 2022 quality bonus payments based on 2021 Star Ratings only, new MA plan means an MA contract offered by a parent organization that has not had another MA contract in the previous 4 years.

Plan basic cost sharing means cost sharing that would be charged by a

plan for basic benefits as defined in § 422.100(c)(1) before any reductions resulting from mandatory supplemental benefits.

Unadjusted MA area-specific non-drug monthly benchmark amount means, for local MA plans serving one county, the county capitation rate CMS publishes annually that reflects the nationally average risk profile for the risk factors CMS applies to payment calculations as set forth at § 422.308(c) of this part, (that is, a standardized benchmark). For local MA plans serving multiple counties it is the weighted average of county rates in a plan's service area, weighted by the plan's projected enrollment per county. The rules for determining county capitation rates are specific to a time period, as set forth at § 422.258(a). Effective 2012, the MA area-specific non-drug monthly benchmark amount is called the blended benchmark amount, and is determined according to the rules set forth under § 422.258(d) of this part.

Unadjusted MA region-specific non-drug monthly benchmark amount means, for MA regional plans, the amount described at § 422.258(b).

Unadjusted MA statutory non-drug monthly bid amount means a plan's estimate of its average monthly required revenue to provide coverage of basic benefits as defined in § 422.100(c)(1) to an MA eligible beneficiary with a nationally average risk profile for the risk factors CMS applies to payment calculations as set forth at § 422.308(c).

[63 FR 35085, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005; 76 FR 21564, Apr. 15, 2011; 84 FR 15832, Apr. 16, 2019; 85 FR 19290, Apr. 6, 2020; 86 FR 6098, Jan. 19, 2021; 87 FR 27895, May 9, 2022]

§ 422.254 Submission of bids.

(a) *General rules.* (1) Not later than the first Monday in June, each MA organization must submit to CMS an aggregate monthly bid amount for each MA plan (other than an MSA plan) the organization intends to offer in the upcoming year in the service area (or segment of such an area if permitted under § 422.262(c)(2)) that meets the requirements in paragraph (b) of this section. With each bid submitted, the MA organization must provide the information required in paragraph (c) of this