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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

section and, for plans with rebates as described at § 422.266(a), the MA organization must provide the information required in paragraph (d) of this section.

(2) CMS has the authority to determine whether and when it is appropriate to apply the bidding methodology described in this section to ESRD MA enrollees.

(3) If the bid submission described in paragraphs (a)(1) and (2) of this section is not complete, timely, or accurate, CMS has the authority to impose sanctions under subpart O of this part or may choose not to renew the contract.

(4) CMS may decline to accept any or every otherwise qualified bid submitted by an MA organization or potential MA organization.

(b) *Bid requirements.* (1) The monthly aggregate bid amount submitted by an MA organization for each plan is the organization's estimate of the revenue required for the following categories for providing coverage to an MA eligible beneficiary with a national average risk profile for the factors described in § 422.308(c):

(i) The unadjusted MA statutory non-drug monthly bid amount, which is the MA plan's estimated average monthly required revenue for providing basic benefits as defined in § 422.100(c)(1).

(ii) The amount to provide basic prescription drug coverage, if any (defined at section 1860D-2(a)(3) of the Act).

(iii) The amount to provide supplemental health care benefits, if any.

(2) Each bid is for a uniform benefit package for the service area.

(3) Each bid submission must contain all estimated revenue required by the plan, including administrative costs and return on investment.

(i) MA plans offering additional telehealth benefits as defined in § 422.135(a) must exclude any capital and infrastructure costs and investments directly incurred or paid by the MA plan relating to such benefits from their bid submission for the unadjusted MA statutory non-drug monthly bid amount.

(ii) [Reserved]

(4) The bid amount is for plan payments only but must be based on plan assumptions about the amount of revenue required from enrollee cost-sharing. The estimate of plan cost-sharing

for the unadjusted MA statutory non-drug monthly bid amount for coverage of basic benefits as defined in § 422.100(c)(1) must reflect the requirement that the level of cost sharing MA plans charge to enrollees must be actuarially equivalent to the level of cost sharing (deductible, copayments, or coinsurance) charged to beneficiaries under the original Medicare fee-for-service program option. The actuarially equivalent level of cost sharing reflected in a regional plan's unadjusted MA statutory non-drug monthly bid amount does not include cost sharing for out-of-network Medicare benefits, as described at § 422.101(d).

(5) *Actuarial valuation.* The bid must be prepared in accordance with CMS actuarial guidelines based on generally accepted actuarial principles.

(i) A qualified actuary must certify the plan's actuarial valuation (which may be prepared by others under his or her direction or review).

(ii) To be deemed a qualified actuary, the actuary must be a member of the American Academy of Actuaries.

(iii) Applicants may use qualified outside actuaries to prepare their bids.

(c) *Information required for coordinated care plans and MA private fee-for-service plans.* MA organizations' submission of bids for coordinated care plans, including regional MA plans and specialized MA plans for special needs beneficiaries (described at § 422.4(a)(1)(iv)), and for MA private fee-for-service plans must include the following information:

(1) The plan type for each plan.

(2) The monthly aggregate bid amount for the provision of all items and services under the plan, as defined in § 422.252 and discussed in paragraph (a) of this section.

(3) The proportions of the bid amount attributable to-

(i) The provision of basic benefits as defined in § 422.100(c)(1);

(ii) The provision of basic prescription drug coverage (as defined at section 1860D-2(a)(3) of the Act; and

(iii) The provision of supplemental health care benefits (as defined § 422.102).

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(4) The projected number of enrollees in each MA local area used in calculation of the bid amount, and the enrollment capacity, if any, for the plan.

(5) The actuarial basis for determining the amount under paragraph (c)(2) of this section, the proportions under paragraph (c)(3) of this section, the amount under paragraph (b)(4) of this section, and additional information as CMS may require to verify actuarial bases and the projected number of enrollees.

(6) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of the deductibles, coinsurance, and copayments.

(7) For qualified prescription drug coverage, the information required under section 1860D–11(b) of the Act with respect to coverage.

(8) For the purposes of calculation of risk corridors under § 422.458, MA organizations offering regional MA plans in 2006 and/or 2007 must submit the following information developed using the appropriate actuarial bases.

(i) Projected allowable costs (defined in § 422.458(a)).

(ii) The portion of projected allowable costs attributable to administrative expenses incurred in providing these benefits.

(iii) The total projected costs for providing rebatable integrated benefits (as defined in § 422.458(a)) and the portion of costs that is attributable to administrative expenses.

(9) For regional plans, as determined by CMS, the relative cost factors for the counties in a plan's service area, for the purposes of adjusting payment under § 422.308(d) for intra-area variations in an MA organization's local payment rates.

(d) *Beneficiary rebate information.* In the case of a plan required to provide a monthly rebate under § 422.266 for a year, the MA organization offering the plan must inform CMS how the plan will distribute the beneficiary rebate among the options described at § 422.266(b).

(e) *Information required for MSA plans.* MA organizations intending to offer MA MSA plans must submit—

(1) The enrollment capacity (if any) for the plan;

(2) The amount of the MA monthly MSA premium for basic benefits (as defined in § 422.252);

(3) The amount of the plan deductible; and

(4) The amount of the beneficiary supplemental premium, if any.

(f) Separate bids must be submitted for Part A and Part B enrollees and Part B-only enrollees for each MA plan offered.

[63 FR 35085, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005; 75 FR 19806, Apr. 15, 2010; 76 FR 21564, Apr. 15, 2011; 83 FR 16733, Apr. 16, 2018; 84 FR 15833, Apr. 16, 2019]

§ 422.256 Review, negotiation, and approval of bids.

(a) *Authority.* Subject to paragraphs (a)(2), (d), and (e) of this section, CMS has the authority to review the aggregate bid amounts submitted under § 422.252 and conduct negotiations with MA organizations regarding these bids (including the supplemental benefits) and the proportions of the aggregate bid attributable to basic benefits, supplemental benefits, and prescription drug benefits and may decline to approve a bid if the plan sponsor proposes significant increases in cost sharing or decreases in benefits offered under the plan.

(1) When negotiating bid amounts and proportions, CMS has authority similar to that provided the Director of the Office of Personnel Management for negotiating health benefits plans under 5 U.S.C. chapter 89.

(2) *Noninterference.* (i) In carrying out Parts C and D under this title, CMS may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services.

(ii) CMS may not require a particular price structure for payment under such a contract, with the exception of payments to Federally qualified health centers as set forth at § 422.316.

(b) *Standards of bid review.* Subject to paragraphs (d) and (e) of this section, CMS can only accept bid amounts or proportions described in paragraph (a) of this section if CMS determines the following standards have been met:

(1) The bid amount and proportions are supported by the actuarial bases