

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; 89 FR 30822, Apr. 23, 2024]

§ 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 provided by MA organizations under § 422.254.

(2) The bid amount and proportions reasonably and equitably reflects the plan's estimated revenue requirements for providing the benefits under that plan, as the term revenue requirements is used for purposes of section 1302(8) of the Public Health Service Act.

(3) *Limitation on enrollee cost sharing.* For coordinated care plans (including regional MA plans and specialized MA plans) and private fee-for-service plans:

(i) The actuarial value of plan basic cost sharing, reduced by any supplemental benefits, may not exceed—

(ii) The actuarial value of deductibles, coinsurance, and copayments that would be applicable for the benefits to individuals entitled to benefits under Part A and enrolled under Part B in the plan's service area with a national average risk profile for the factors described in § 422.308(c) if they

were not members of an MA organization for the year, except that cost sharing for non-network Medicare services in a regional MA plan is not counted under the amount described in paragraph (b)(2)(i) of this section.

(c) *Negotiation process.* The negotiation process may include the resubmission of information to allow MA organizations to modify their initial bid submissions to account for the outcome of CMS' regional benchmark calculations required under § 422.258(c) and the outcome of CMS' calculation of the national average monthly bid amount required under section 1860D–13(a)(4) of the Act.

(d) *Exception for private fee-for-service plans.* For private fee-for-service plans defined at § 422.4(a)(3), CMS will not review, negotiate, or approve the bid amount, proportions of the bid, or the amounts of the basic beneficiary premium and supplemental premium.

(e) *Exception for MSA plans.* CMS does not review, negotiate, or approve amounts submitted with respect to MA MSA plans, except to determine that the deductible does not exceed the statutory maximum, defined at § 422.103(d).

[63 FR 35085, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005; 70 FR 76198, Dec. 23, 2005; 75 FR 19806, Apr. 15, 2010; 76 FR 21564, Apr. 15, 2011; 83 FR 16733, Apr. 16, 2018]

§ 422.258 Calculation of benchmarks.

(a) The term “MA area-specific non-drug monthly benchmark amount” means, for a month in a year:

(1) For MA local plans with service areas entirely within a single MA local area:

(i) For years before 2007, one-twelfth of the annual MA capitation rate (described at § 422.306) for the area, adjusted as appropriate for the purpose of risk adjustment.

(ii) For years 2007 through 2010, one-twelfth of the applicable amount determined under section 1853(k)(1) of the Act for the area for the year, adjusted as appropriate for the purpose of risk adjustment.

(iii) For 2011, one-twelfth of the applicable amount determined under 1853(k)(1) for the area for 2010.

(iv) Beginning with 2012, one-twelfth of the blended benchmark amount described in paragraph (d) of this section,

subject to paragraph (d)(8) of this section and adjusted as appropriate for the purpose of risk adjustment.

(2) For MA local plans with service areas including more than one MA local area, an amount equal to the weighted average of amounts described in paragraph (a)(1) of this section for the year for each local area (county) in the plan's service area, using as weights the projected number of enrollees in each MA local area that the plan used to calculate the bid amount, and adjusted as appropriate for the purpose of risk adjustment.

(b) For MA regional plans, the term “MA region-specific non-drug monthly benchmark amount” is:

(1) The sum of two components: the statutory component (based on a weighted average of local benchmarks in the region, as described in paragraph (c)(3) of this section; and the plan bid component (based on a weighted average of regional plan bids in the region as described in paragraph (c)(4) of this section).

(2) Announced before November 15 of each year, but after CMS has received the plan bids.

(c) *Calculation of MA regional non-drug benchmark amount.* CMS calculates the monthly regional non-drug benchmark amount for each MA region as follows:

(1) *Reference month.* For all calculations that follow, CMS will determine the number of MA eligible individuals in each local area, in each region, and nationally as of the reference month, which is a month in the previous calendar year CMS identifies.

(2) *Statutory market share.* CMS will determine the statutory national market share percentage as the proportion of the MA eligible individuals nationally who were not enrolled in an MA plan.

(3) *Statutory component of the region-specific benchmark.* (i) CMS calculates the unadjusted region-specific non-drug amount by multiplying the amount determined under paragraph (a) of this section for the year by the county's share of the MA eligible individuals residing in the region (the number of MA eligible individuals in the county divided by the number of MA eligible individuals in the region),

and then adding all the enrollment-weighted county rates to a sum for the region.

(ii) CMS then multiplies the unadjusted region-specific non-drug amount from paragraph (c)(3)(i) of this section by the statutory market share to determine the statutory component of the regional benchmark.

(4) *Plan-bid component of the region-specific benchmark.* For each regional plan offered in a region, CMS will multiply the plan's unadjusted region-specific non-drug bid amount by the plan's share of enrollment (as determined under paragraph (c)(5) of this section) and then sum these products across all plans offered in the region. CMS then multiplies this by 1 minus the statutory market share to determine the plan-bid component of the regional benchmark.

(5) *Plan's share of enrollment.* CMS will calculate the plan's share of MA enrollment in the region as follows:

(i) In the first year that any MA regional plan is being offered in an MA region, and more than one MA regional plan is being offered, CMS will determine each regional plan's share of enrollment based on one of two possible approaches. CMS may base this factor on equal division among plans, so that each plan's share will be 1 divided by the number of plans offered. Alternatively, CMS may base this factor on each regional plan's estimate of projected enrollment. Plan enrollment projections are subject to review and adjustment by CMS to assure reasonableness.

(ii) If two or more regional plans are offered in a region and were offered in the reference month: The plan's share of enrollment will be the number of MA eligible individuals enrolled in the plan divided by the number of MA eligible individuals enrolled in all of the plans in the region, as of the reference month.

(iii) If a single regional plan is being offered in the region: The plan's share of enrollment is equal to 1.

(d) *Determination of the blended benchmark amount—(1) General rules.* For the purpose of paragraphs (a) and (b) of this section, the term blended benchmark amount for an area for a year means the sum of two components: the applicable amount determined under

section 1853(k)(1) of the Act and the specified amount determined under section 1853(n)(2) of Act. The weights for each component are based on the phase-in period assigned each area, as described in paragraphs (d)(8) and (d)(9) of this section. At the conclusion of an area's phase-in period, the blended benchmark for an area for a year equals the section 1853(n)(2) of the Act specified amount described in paragraph (d)(2) of this section. The blended benchmark amount for an area for a year (which takes into account paragraph (d)(8) of this section), cannot exceed the applicable amount described in paragraph (d)(2) of this section that would be in effect but for the application of this paragraph.

(2) *Applicable amount.* For the purpose of paragraphs (a) and (b) of this section, the applicable amount determined under section 1853(k)(1) of the Act for a year is—

(i) In a rebasing year (described at § 422.306(b)(2), an amount equal to the greater of the average FFS expenditure amount at § 422.306(b)(2) for an area for a year and the minimum percentage increase rate at § 422.306(a) for an area for a year.

(ii) In a year when the amounts at § 422.306(b)(2) are not rebased, the minimum percentage increase rate at § 422.306(a) for the area for the year.

(iii) In no case the blended benchmark amount for an area for a year, determined taking into account paragraph (d)(8) of this section, be greater than the applicable amount at paragraph (d)(2) of this section for an area for a year.

(iv) Paragraph (d) of this section does not apply to the PACE program under section 1894 of Act.

(3) *Specified amount.* For the purpose of paragraphs (a) and (b) of this section, the specified amount under section 1853(n)(2) of the Act is the product of the base payment amount for an area for a year (adjusted as required under § 422.306(c) and (d)) multiplied by the applicable percentage described in paragraph (d)(5) of this section for an area for a year.

(4) *Base payment amount.* The base payment amount is as follows:

(i) For 2012, the average FFS expenditure amount specified in § 422.306(b)(2), determined for 2012.

(ii) For subsequent years, the average FFS expenditure amount specified in § 422.306(b)(2).

(5) *Applicable percentage.* Subject to paragraph (d)(7) of this section, the applicable percentage is one of four values assigned to an area based on Secretary's determination of the quartile ranking of the area's average FFS expenditure amount (described at § 422.306(b)(2) and adjusted as required at § 422.306(c) and (d)), relative to this amount for all areas.

(i) For the 50 States or the District of Columbia, a county with an average FFS expenditure amount adjusted under § 422.306(c) and (d) that falls in the—

(A) Highest quartile of such rates for all areas for the previous year receives an applicable percentage of 95 percent;

(B) Second highest quartile of such rates for all areas for the previous year receives an applicable percentage of 100 percent;

(C) Third highest quartile of such rates for all areas for the previous year receives an applicable percentage of 107.5 percent; or

(D) Lowest quartile of such rates for all areas for the previous year receives an applicable percentage of 115 percent.

(ii) To determine the applicable percentages for a territory, the Secretary ranks such areas for a year based on the level of the area's § 422.306(b)(2) amount adjusted under § 422.306(c) and (d), relative to the quartile rankings computed under paragraph (d)(5)(i) of this section.

(6) *Additional rules for determining the applicable percentage.* (i) In a contract year when the average FFS expenditure amounts from the previous year were rebased (according to the periodic rebasing requirement at § 422.306(b)(2)), the Secretary must determine an area's applicable percentage based on a quartile ranking of the previous year's rebased FFS amounts adjusted under § 422.306(c) and (d).

(ii) If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year's ranking, the applicable percentage for the area in the year must be

the average of the applicable percentage for the previous year and the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision.

(7) *Increases to the applicable percentage for quality.* Beginning with 2012, the blended benchmark under paragraphs (a) and (b) of this section will reflect the level of quality rating at the plan or contract level, as determined by the Secretary. The quality rating for a plan is determined by the Secretary according to a 5-star rating system (based on the data collected under section 1852(e) of the Act) specified in subpart D of this part 422. Specifically, the applicable percentage under paragraph (d)(5) of this section must be increased according to criteria in paragraphs (d)(7)(i) through (v) of this section if the plan or contract is determined to be a qualifying plan or a qualifying plan in a qualifying county for the year.

(i) *Qualifying plan.* Beginning with 2012, a qualifying plan means a plan that had a quality rating of 4 stars or higher based on the most recent data available for such year. For a qualifying plan, the applicable percentage at paragraph (d)(5) of this section must be increased as follows:

(A) For 2012, by 1.5 percentage points.

(B) For 2013, by 3.0 percentage points.

(C) For 2014 and subsequent years, by 5.0 percentage points.

(ii) *Qualifying county.* (A) A *qualifying county* means a county that meets the following three criteria:

(1) Has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) of the Act for a Metropolitan Statistical Area with a population of more than 250,000.

(2) Of the MA-eligible individuals residing in the county, at least 25 percent of such individuals were enrolled in MA plans as of December 2009.

(3) Has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the Original Medicare fee-for-service program for the year.

(B) Beginning with 2012, for a qualifying plan serving a qualifying county, the increase to the applicable percentage described at paragraph (d)(7)(i) of

this section must be doubled for the qualifying county.

(iii) MA organizations that fail to report data as required by the Secretary must be counted as having a rating of fewer than 3.5 stars at the plan or contract level, as determined by the Secretary.

(iv) *Application of applicable percentage increases to low enrollment contracts.* (A) For 2012, for an MA plan that the Secretary determines is unable to have a quality rating because of low enrollment, the Secretary treats this plan as a qualifying plan under paragraph (d)(7)(i) of this section.

(B) For 2013 and subsequent years, the Secretary develops a methodology to apply to MA plans with low enrollment (as defined by the Secretary) to determine whether a low enrollment contract is a qualifying plan.

(v) *Application of increases in applicable percentage to new MA plans.* A new MA plan (as defined at § 422.252) that meets criteria specified by the Secretary must be treated as a qualifying plan under paragraph (d)(7)(i) of this section, except that the applicable percentage must be increased as follows:

(A) For 2012, by 1.5 percentage points.

(B) For 2013, by 2.5 percentage points.

(C) For 2014 and subsequent years, by 3.5 percentage points.

(8) *Determination of phase-in period for the blended benchmark amount.* For 2012 through 2016, the blended benchmark amount for an area for a year depends on the phase-in period assigned to that area. The Secretary assigns one of three phase-in periods to each area: 2-year, 4 year, or 6 year. The phase-in period assigned to an area is based on the size of the difference between the 2010 applicable amount at paragraph (d)(2) of this section and the projected 2010 benchmark amount defined at paragraph (d)(8)(i) of this section.

(i) The projected 2010 benchmark amount is calculated once for the purpose of determining the phase-in period for an area. It is equal to one-half of the 2010 applicable amount at paragraph (d)(2) of this section and one-half of the specified amount at paragraph (d)(3) modified to apply to 2010 (as described in (d)(8)(ii) of this section).

(ii) To assign a phase-in period to an area, the specified amount is modified

as if it applies to 2010, and is the product of—

(A) The 2010 base payment amount adjusted as required under § 422.306(c) of this part; and

(B) The applicable percentage determined as if the reference to the “previous year” at paragraph (d)(5) of this section were deemed a reference to 2010 and increased as follows:

(1) The increase at paragraph (d)(7)(i) of this section for a qualifying plan in the area is applied as if the reference to a qualifying plan for 2012 were deemed a reference for 2010; and

(2) The increase at paragraph (d)(7)(ii) of this section is applied as if the determination of a qualifying county were made for 2010.

(iii) *Two-year phase-in.* An area is assigned the 2-year phase-in period if the difference between the applicable amount at paragraph (d)(2) of this section and the projected 2010 benchmark amount at paragraph (d)(8)(i) of this section is less than \$30.

(iv) *Four-year phase-in.* An area is assigned the 4-year phase-in period if the difference between the applicable amount at paragraph (d)(2) of this section and the projected 2010 benchmark amount at paragraph (d)(8)(i) of this section is at least \$30 but less than \$50.

(v) *Six-year phase-in.* An area is assigned the 6-year phase-in period if the difference between the applicable amount at paragraph (d)(2) of this section and the projected 2010 benchmark amount at paragraph (d)(8)(i) of this section is at least \$50.

(9) *Impact of phase-in period on calculation of the blended benchmark amount—(i) Weighting for the 2-year phase-in.* (A) For 2012, the blended benchmark is the sum of one-half of the applicable amount at paragraph (d)(2) of this section and one-half of the specified amount at paragraph (d)(3) of this section.

(B) For 2013 and subsequent years, the blended benchmark equals the specified amount.

(ii) *Weighting for the 4-year phase-in.* The blended benchmark is the sum of the applicable amount at paragraph (d)(2) of this section and the specified amount at paragraph (d)(3) of this section in the following proportions: