

§ 422.264(b) for local plans and § 422.264(d) for regional plans), CMS pays the unadjusted MA area-specific non-drug monthly benchmark amount specified at § 422.258, risk-adjusted as described at § 422.308(c) and adjusted (if applicable) for variations in rates within the plan's service area (described at § 422.258(a)(2)) and for the effects of risk adjustment on beneficiary premiums under § 422.262.

(3) *Payment of rebate for plans with bids below benchmarks.* The rebate amount under paragraph (a)(1)(ii) of this section is the amount of the monthly rebate computed under § 422.266(a) for that plan, less the amount (if any) applied to reduce the Part B premium, as provided under § 422.266(b)(3)).

(b) *Separate payment for Federal drug subsidies.* In the case of an enrollee in an MA-PD plan, defined at § 422.252, the MA organization offering such a plan also receives—

(1) Direct and reinsurance subsidy payments for qualified prescription drug coverage, described at section 1860D–15(a) and (b) of the Act (other than payments for fallback prescription drug plans described at section 1860D–11(g)(5) of the Act); and

(2) Reimbursement for premium and cost sharing reductions for low-income individuals, described at section 1860D–14 of the Act.

(c) *Special rules—(1) Enrollees with end-stage renal disease.* (i) For enrollees determined to have end-stage renal disease (ESRD), CMS establishes special rates that are actuarially equivalent to rates in effect before the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(ii) CMS publishes annual changes in these capitation rates no later than the first Monday in April each year, as provided in § 422.312.

(iii) CMS applies appropriate adjustments when establishing the rates, including risk adjustment factors.

(iv) CMS reduces the payment rate for each renal dialysis treatment by the same amount that CMS is authorized to reduce the amount of each composite rate payment for each treatment as set forth in section 1881(b)(7) of the Act. These funds are to be used to help

pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

(2) *MSA enrollees.* In the case of an MSA plan, CMS pays the unadjusted MA area-specific non-drug monthly benchmark amount for the service area, determined in accordance with § 422.314(c) and subject to risk adjustment as set forth at § 422.308(c), less  $\frac{1}{2}$  of the annual lump sum amount (if any) CMS deposits to the enrollee's MA MSA.

(3) *RFB plan enrollees.* For RFB plan enrollees, CMS adjusts the capitation payments otherwise determined under this subpart to ensure that the payment level is appropriate for the actuarial characteristics and experience of these enrollees. That adjustment can be made on an individual or organization basis.

(d) *Payment areas—(1) General rule.* Except as provided in paragraph (e) of this section—

(i) An MA payment area for an MA local plan is an MA local area defined at § 422.252.

(ii) An MA payment area for an MA regional plan is an MA region, defined at § 422.455(b)(1).

(2) *Special rule for ESRD enrollees.* For ESRD enrollees, the MA payment area is a State or other geographic area specified by CMS.

(e) *Geographic adjustment of payment areas for MA local plans—(1) Terminology.* “Metropolitan Statistical Area” and “Metropolitan Division” mean any areas so designated by the Office of Management and Budget in the Executive Office of the President.

(2) *State request.* A State's chief executive may request, no later than February 1 of any year, a geographic adjustment of the State's payment areas for MA local plans for the following calendar year. The chief executive may request any of the following adjustments to the payment area specified in paragraph (c)(1)(i) of this section:

(i) A single statewide MA payment area.

(ii) A metropolitan-based system in which all non-metropolitan areas within the State constitute a single payment area and any of the following constitutes a separate MA payment area:

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(A) All portions of each single Metropolitan Statistical Area within the State.

(B) All portions of each Metropolitan Statistical Area within each Metropolitan Division within the State.

(iii) A consolidation of noncontiguous counties.

(3) *CMS response.* In response to the request, CMS makes the payment adjustment requested by the chief executive. This adjustment cannot be requested or made for payments to regional MA plans.

(4) *Budget neutrality adjustment for geographically adjusted payment areas.* If CMS adjusts a State's payment areas in accordance with paragraph (d)(2) of this section, CMS at that time, and each year thereafter, adjusts the capitation rates so that the aggregate Medicare payments do not exceed the aggregate Medicare payments that would have been made to all the State's payments areas, absent the geographic adjustment.

(f) *Separate payment for meaningful use of certified EHRs.* In the case of qualifying MA organizations, as defined in § 495.200 of this chapter, entitled to MA EHR incentive payments per § 495.204 of this chapter, such payments are made in accordance with sections 1853(l) and (m) of the Act and subpart C of part 495 of this chapter.

[70 FR 4729, Jan. 28, 2005, as amended at 75 FR 44564, July 28, 2010; 85 FR 72909, Nov. 16, 2020]

### § 422.306 Annual MA capitation rates.

Subject to adjustments at §§ 422.308(b) and (g), the annual capitation rate for each MA local area is determined under paragraph (a) of this section for 2005 and each succeeding year, except for years when CMS announces under § 422.312(b) that the annual capitation rates will be determined under paragraph (b) of this section, and is then adjusted to exclude the applicable phase-in percentage of the standardized costs for payments under section 1886(d)(5)(B) of the Act in the area for the year under paragraph (c) of this section and costs for kidney acquisitions in the area for the year under paragraph (d) of this section.

(a) *Minimum percentage increase rate.* The annual capitation rate for each

MA local area is equal to the minimum percentage increase rate, which is the annual capitation rate for the area for the preceding year increased by the national per capita MA growth percentage (defined at § 422.308(a)) for the year, but not taking into account any adjustment under § 422.308(b) for a year before 2004.

(b) *Greater of the minimum percentage increase rate or local area fee-for-service costs.* The annual capitation rate for each MA local area is the greater of—

(1) The minimum percentage increase rate under paragraph (a) of this section; or

(2) The amount determined, no less frequently than every 3 years, to be the adjusted average per capita cost for the MA local area, as determined under section 1876(a)(4) of the Act, based on 100 percent of fee-for-service costs for individuals who are not enrolled in an MA plan for the year, with the following adjustments:

(i) Adjusted as appropriate for the purpose of risk adjustment;

(ii) Adjusted to exclude costs attributable to payments under section 1886(h) of the Act for the costs of direct graduate medical education;

(iii) Adjusted to include CMS' estimate of the amount of additional per capita payments that would have been made in the MA local area if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs; and

(iv) Adjusted to exclude costs attributable to payments under sections 1848(o) and 1886(n) of the Act of Medicare FFS incentive payments for meaningful use of electronic health records.

(c) *Phase-out of the indirect costs of medical education from MA capitation rates.* Beginning with 2010, after the annual capitation rate for each MA local area is determined under paragraph (a) or (b), the amount is adjusted in accordance with section 1853(k)(4) of the Act to exclude from such amount the estimated costs for payments under section 1886(d)(5)(B) of the Act in the area for the year.