

(D) State income, excise, and business taxes other than premium taxes.

(iv) *Community benefit expenditures.* Community benefit expenditures are payments made by a Federal income tax-exempt MA organization for community benefit expenditures as defined in paragraph (c)(2)(iv)(A) of this section, limited to the amount defined in paragraph (c)(2)(iv)(B) of this section, and allocated to a contract as required under paragraph (d)(1) of this section.

(A) Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden.

(B) Such payment may be deducted up to the limit of either 3 percent of total revenue under this part or the highest premium tax rate in the State for which the Part D sponsor is licensed, multiplied by the Part D sponsor's earned premium for the contract.

(3) The following amounts must not be included in total revenue:

(i) The amount of unpaid premiums for which the MA organization can demonstrate to CMS that it made a reasonable effort to collect.

(ii) The following EHR payments and adjustments:

(A) EHR incentive payments for meaningful use of certified electronic health records by qualifying MAOs, MA EPs and MA-affiliated eligible hospitals that are administered under 42 CFR part 495 subpart C.

(B) EHR payment adjustments for a failure to meet meaningful use requirements that are administered under 42 CFR part 495 subpart C.

(iii) Coverage Gap Discount Program payments under § 423.2320 of this chapter.

(4) Total revenue (as defined at § 422.2420(c)) for policies issued by one MA organization and later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year during which the policies were assumed and no revenue under this part for that contract year must be reported by the ceding MA organization.

(5) Total revenue (as defined at § 422.2420(c)) that is reinsured for a block of business that was subject to

indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(d) *Allocation of expense*—(1) *General requirements.* (i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses.

(ii) Expenditures that benefit multiple contracts, or contracts other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.

(2) *Description of the methods used to allocate expenses.* (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories in paragraph (b) or (c) of this section will generally be the most accurate method.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contracts incurring the expense.

(iii)(A) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

(B) Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

[78 FR 31307, May 23, 2013; 78 FR 43821, July 22, 2013; 83 FR 16736, Apr. 16, 2018; 85 FR 33908, June 2, 2020]

§ 422.2430 Activities that improve health care quality.

(a) *Activity requirements.* (1) Activities conducted by an MA organization to improve quality must either—

(i) Fall into one of the categories in paragraph (a)(2) of this section and meet all of the requirements in paragraph (a)(3) of this section; or

(ii) Be listed in paragraph (a)(4) of this section.

(2) *Categories of quality improving activities.* The activity must be designed to achieve one or more of the following:

(i) To improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage.

(ii) To prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.

(iii) To improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage.

(iv) To promote health and wellness.

(v) To enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Such activities, such as Health Information Technology (HIT) expenses, are required to accomplish the activities that improve health care quality and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, and are consistent with meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance cur-

rent quality improving activities or make new quality improvement initiatives possible.

(3) The activity must be designed for all of the following:

(i) To improve health quality.

(ii) To increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) To be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) To be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(4)(i) For an MA contract that includes MA-PD plans (described in § 422.2420(a)(2)), Medication Therapy Management Programs meeting the requirements of § 423.153(d) of this chapter.

(ii) Fraud reduction activities, including fraud prevention, fraud detection, and fraud recovery.

(b) *Exclusions.* Expenditures and activities that must not be included in quality improving activities include, but are not limited to, the following:

(1) Those that are designed primarily to control or contain costs other than those that are related to fraud reduction.

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.

(3) Those which otherwise meet the definitions for quality improving activities but which were paid for with grant money or other funding separate from premium revenue.

(4) Those activities that can be billed or allocated by a provider for care delivery and that are reimbursed as clinical services.

(5) Establishing or maintaining a claims adjudication system, including