

**§ 423.2420**

**42 CFR Ch. IV (10–1–24 Edition)**

(ix) Reserves for contingent benefits and the Part D claim portion of lawsuits.

(3) Adjustments that must be deducted from incurred claims include the following:

(i) Overpayment recoveries received from providers.

(4) *Exclusions from incurred claims.* The following amounts must not be included in incurred claims:

(i) Non-claims costs, as defined in § 423.2401, which include the following:

(A) Amounts paid to third party vendors for secondary network savings.

(B) Amounts paid to third party vendors for any of the following:

(1) Network development.

(2) Administrative fees.

(3) Claims processing.

(4) Utilization management.

(C) Amounts paid, including amounts paid to a pharmacy, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, such as the following:

(1) Medical record copying costs.

(2) Attorneys' fees.

(3) Subrogation vendor fees.

(4) Bona fide service fees.

(5) Compensation to any of the following:

(i) Paraprofessionals.

(ii) Janitors.

(iii) Quality assurance analysts.

(iv) Administrative supervisors.

(v) Secretaries to medical personnel.

(vi) Medical record clerks.

(ii) Amounts paid to CMS as a remittance under § 423.2410(b).

(5) Incurred claims under this part for policies issued by one Part D sponsor and later assumed by another entity must be reported by the assuming organization for the entire MLR reporting year during which the policies were assumed and no incurred claims under this part for that contract year must be reported by the ceding Part D sponsor.

(6) Reinsured incurred claims for a block of business that was subject to indemnity reinsurance and administrative agreements effective before 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.

(c) *Determining the MLR denominator.* For a contract year, the denominator of the MLR for a Part D prescription drug contract must equal the total revenue under the contract. Total revenue under the contract is as described in paragraph (c)(1) of this section, net of deductions described in paragraph (c)(2) of this section, taking into account the exclusions described in and paragraph (c)(3) of this section, and be in accordance with paragraphs (c)(4) and (5) of this section.

(1) CMS' payments to the Part D sponsor for all enrollees under a contract, reported on a direct basis, including the following:

(i) Payments under § 423.329(a)(1) and (2).

(ii) Payment adjustments resulting from reconciliation per § 423.329(c)(2)(ii).

(iii) All premiums paid by or on behalf of enrollees to the Part D sponsor as a condition of receiving coverage under a Part D plan, including CMS' payments for low income premium subsidies under § 422.304(b)(2) of this chapter.

(iv) All unpaid premium amounts that a Part D sponsor could have collected from enrollees in the Part D plan(s) under the contract.

(v) All changes in unearned premium reserves.

(vi) Payments under § 423.315(e).

(2) The following amounts must be deducted from total revenue in calculating the MLR:

(i) *Licensing and regulatory fees.* Statutory assessments to defray operating expenses of any State or Federal department, such as the "user fee" described in section 1857(e)(2) of the Act, and examination fees in lieu of premium taxes as specified by State law.

(ii) *Federal taxes and assessments.* All Federal taxes and assessments allocated to health insurance coverage.

(iii) *State taxes and assessments.* State taxes and assessments, such as the following:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly.

(B) Guaranty fund assessments.

(C) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(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 Part D sponsor for community benefit expenditures as defined in paragraph (c)(2)(iii)(A) of this section, limited to the amount defined in paragraph (c)(2)(iii)(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 Part D sponsor can demonstrate to CMS that it made a reasonable effort to collect.

(ii) Coverage Gap Discount Program payments under § 423.2320.

(4) Total revenue (as defined at § 423.2420(c)) of this chapter) for policies issued by one Part D sponsor 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 Part D sponsor.

(5) Total revenue (as defined at § 423.2420(c) of this chapter) that is reinsured for a block of business that was subject to indemnity reinsurance and administrative agreements effective before 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 administra-

tion of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(d) *Allocation of expenses*—(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 entities 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 31310, May 23, 2013; 78 FR 43821, July 22, 2013; 83 FR 16756, Apr. 16, 2018]

#### **§ 423.2430 Activities that improve health care quality.**

(a) *Activity requirements.* (1) Activities conducted by a Part D sponsor 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. 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 current 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) Medication Therapy Management Programs meeting the requirements of § 423.153(d).

(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 pharmacy for care delivery and that are reimbursed as clinical services.

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities (and that are not related to fraud reduction activities under paragraph (a)(4)(ii) of this section) or to meet regulatory requirements for processing claims, including ICD–10 implementation costs in