



# VCU Medical Center

## Office of Health Innovation

### Final Rule: Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs

**Description:** This final rule implements new medical loss ratio (MLR) requirements for the Medicare Advantage (Part C) Program and the Medicare Prescription Drug Benefit (Part D) Program established under the Patient Protection and Affordable Care Act.

#### **Major Provisions**

Under this final rule, Medicare Advantage and Part D Plan Sponsors must spend at least 85 percent of Medicare contract revenue on clinical services, prescription drugs, quality improvement activities, and direct benefits to beneficiaries in the form of reduced Part B premiums. The higher the MLR, the more the MA organization or Part D sponsor is spending on claims and quality improving activities and the less they are spending on other things.

#### **General Requirements**

For contracts beginning in 2014 or later, an MA organization is required to report an MLR for each contract under this part for each contract year. If CMS determines for a contract year that an MA organization has an MLR for a contract that is less than 0.85, the MA organization has not met the MLR requirement and must remit to CMS an amount equal to the product of the following:

1. The total revenue of the MA contract for the contract year.
2. The difference between 0.85 and the MLR for the contract year.

If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 3 or more consecutive contract years, CMS does not permit the enrollment of new enrollees under the contract for coverage during the second succeeding contract year.

If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS terminates the contract effective as of the second succeeding contract year.

#### **Calculation of Medical Loss Ratio**

The MLR for each contract is the ratio of the numerator to the denominator. An MLR may be increased by a credibility adjustment, or subject to an adjustment determined by CMS to be warranted based on exceptional circumstances for areas outside the 50 states and the District of Columbia.

For a contract year, the **numerator** of the MLR for an MA contract (other than an MSA contract) must equal the sum of:

1. Incurred claims for all enrollees.
2. The amount of the reduction, if any, in the Part B premium for all MA plan enrollees under the contract for the contract year.
3. The expenditures under the contract for activities that improve health care quality.

The numerator of the MLR for an MSA contract must equal the sum of:

1. Incurred claims for all enrollees.
2. The expenditures under the contract for activities that improve health care quality.
3. The amount of the annual deposit into the medical savings account.

For a contract year, the **denominator** of the MLR for an MA contract must equal the total revenue under the contract.

### **Activities that Improve Health Care Quality**

The activity must be designed to achieve one or more of the following:

1. 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, for treatment or services under the plan or coverage.
2. 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.
3. 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.
4. To promote health and wellness.
5. To enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

The activity must be designed for all of the following:

1. To improve health quality.
2. To increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
3. 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.
4. 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.

### **Credibility Adjustment**

An MA organization may add a credibility adjustment to a contract's MLR if the contract's experience is partially credible, as determined by CMS. An MA organization may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as determined by CMS. CMS defines and publishes definitions of partial credibility, full credibility, and non-credibility and the credibility factors through the notice and comment process of publishing the Advance Notice and Final Rate Announcement.

### **Reporting Requirements**

For each contract year, each MA organization must submit a report to CMS, in a timeframe and manner specified by CMS, which includes but is not limited to the data needed by the MA organization to calculate and verify the MLR and remittance amount, if any, for each contract, such as incurred claims, total revenue, expenditures on quality improving activities, non-claims costs, taxes, licensing and regulatory fees, and any remittance owed to CMS.