

CMS Final Rule for Medicare Part D and Medicare Advantage Programs Allows Certain Medication Therapy Management (MTM) and Fraud Prevention Activities to Count toward Medical Loss Ratio (MLR)

In a [final rule](#) that will officially publish in the *Federal Register* on May 23, 2013 and will be effective in late July 2013, the Centers for Medicare and Medicaid Services (CMS), will allow for certain MTM activities and fraud reduction activities to count toward Medicare Part D and Medicare Advantage medical loss ratio (MLR). Under the final rule, Medicare Part D and Medicare Advantage programs must spend at least 85% of its revenues on MLR activities defined as, clinical services, prescription drugs, quality improvement activities (QIA), and direct benefits to beneficiaries to reduce Part B premiums.

In a February 2013 proposed rule, CMS sought comments on whether MTM activities should be incorporated under MLR. AMCP supported incorporation of MTM and certain fraud reduction activities as a component of MLR calculations and therefore, is pleased that some of the administrative costs currently associated with MTM could be recognized as a QIA.

Overview of Activities that Meet Definition of QIA and Exclusions from QIA

CMS' final rule finds that certain MTM and fraud prevention activities may be included under MLR so long as they meet the definition of QIA requirements (§422.2430 and §422.2430 of MLR final rule). QIAs must be designed to improve quality in one or more of the areas:

- Outcomes improvement through implementation of quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including use of medical home models;
- Prevention of hospital readmissions through a comprehensive program for hospital discharge, including patient-centered education and counseling and post-discharge reinforcement by an appropriate health care professional;
- Patient safety improvement and medical error reduction through appropriate use of best clinical practices, evidence-based medicine, and health information technology (HIT);
- Promotion of health and wellness; and,
- Enhanced use of health care data to improve quality, transparency, and outcomes and support meaningful use of HIT. These activities must be consistent with meaningful use requirements and may in whole or in part improve quality of care.

The activity must be designed to meet all of the following:

- Improve health care quality;
- Increase the likelihood of desired outcomes in ways capable of being objectively measured with verifiable results and achievements;
- Be directed to enrollees and non-enrollees to ensure health improvements (enrollees may not incur additional costs because of activities provided to enrollees);
- Be grounded in evidence-based medicine, widely accepted clinical practice, or criteria issued by recognized accreditation bodies, professional associations, government agencies, or nationally recognized health care quality organizations.

Activities that may not be incorporated into MLR include:

- Those designed primarily to control or contain costs;
- Activities allocated or billed by a pharmacy for care delivery and reimbursed as clinical services;
- Establishing a claims adjudication system including retrospective and concurrent utilization review;
- Fraud prevention activities;
- Cost of developing and executing pharmacy contracts and fees associated with managed a pharmacy network;
- Pharmacy network credentialing; and,
- Marketing expenses.

CMS' final rule contained the following background information in response to comments from AMCP and others on incorporation of MTM and fraud activities into MLR.

CMS Analysis on MTM and MLR

Comment: A number of commenters responded to the solicitation for comments regarding Medication Therapy Management (MTM) programs in a Part D context, with the recommendation that programs be considered for inclusion in the MLR as quality improving activities. Generally, commenters remarked that MTM programs required by CMS improve quality and care coordination and therefore, should be included in the MLR. In addition, commenters noted the importance of MTM programs in individualized disease management and some commenters believe the inclusion of MTM programs would further encourage and incentivize providers to strengthen their MTM programs.

Response: We appreciate the comments on this topic and will use them to inform our MTM requirements. We also agree that so long as the MTM activities meet the requirements set forth in § 422.2430 and § 423.2430, they would qualify as a QIA.

Fraud Reduction Initiatives

Comment: Many commenters requested that CMS consider as QIA all activities to prevent and reduce fraud, waste, and abuse, noting that CMS requires such activities as a condition of participation in the Part C and D programs. Commenters stated their concerns that by not allowing plans to count all expenses incurred in reducing fraud, waste, and abuse, it will result in a disincentive to engage in these beneficial activities.

Response: Fraud reduction efforts include both fraud prevention and fraud recovery. We are allowing the amount of claim payments recovered through fraud reduction efforts, not to exceed the amount of fraud

reduction expenses, to be included in incurred claims per § 422.240(b)(2)(ix) and § 423.240(b)(2)(xiii). Thus, even though fraud prevention is not a QIA, we believe this provides an incentive for MA organizations and Part D sponsors to engage in fraud reduction activities. To the extent that MA organizations and Part D sponsors are engaging in other activities that meet the requirements in § 422.2430 and § 423.2430, they may be considered as quality improving activities.

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To review AMCP's comments and summary of the proposed MLR rule, visit <http://www/WorkArea/DownloadAsset.aspx?id=16528>.