Issue Brief

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CMS Proposes Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs

The Centers for Medicare and Medicaid Services (CMS) are proposing a rule with respect to Contract Year 2024 Policy and Technical Changes to the Medicare Advantage (MA) and Medicare Drug Benefit Programs.

The proposed rule would revise the Medicare Advantage (Part C), Medicare Prescription Drug Benefit (Part D), Medicare cost plan, and Programs of All-Inclusive Care for the Elderly (PACE) regulations to implement changes related to Star Ratings, medication therapy management, marketing and communications, health equity, provider directories, coverage criteria, prior authorization, passive enrollment, network adequacy, identification of overpayments, formulary changes, and other programmatic areas.

The proposal would also amend the existing regulations for Medicare Parts A, B, C, and D regarding the standard for an identified overpayment.

Additionally, the rule would implement certain sections of the following Federal laws related to the Parts C and D programs:

- The Inflation Reduction Act (IRA) of 2022.
- The Consolidated Appropriations Act (CAA), 2021.
- The Bipartisan Budget Act (BBA) of 2018.
- The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018.

A copy of the 957-page document is available at: https://public-inspection.federalregister.gov/2022-26956.pdf. The rule is scheduled for publication on December 27. A comment period ending on February 13.

COMMENT

To say the least, this is a long and detailed rule. The actual regulatory changes are more than 100 pages.

Below is CMS' estimate and summary of costs and benefits. The material is quoted.

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MISSOURI HOSPITAL ASSOCIATION

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Provision	Description	Impact
a. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (§§ 422.162, 422.164, 422.166, 422.260, 423.182, 423.184, and 423.186)	We propose several measure changes and methodological clarifications and enhancements to the Part C and Part D Star Ratings as described in section V. In addition to proposing to establish an HEI reward as a replacement for the current reward factor and to reduce the weight of patient experience/complaints and access measures, we are proposing to: modify the improvement measure highest rating hold harmless provision so it applies only to contracts with 5 stars for their highest rating, remove the cut point guardrails, add a rule for the sub- regulatory removal of Star Ratings measures when a measure steward other than CMS retires the measure, remove the 60 percent rule for extreme and uncontrollable circumstances, clarify existing rules around administrative review process for QBP determinations, and clarify additional aspects of the existing Star Ratings calculations.	The HEI reward provision, which would replace the current reward factor, is expected to result in net savings of between $680 million in 2028 and $1.05 billion in 2033, resulting in a ten-year savings estimate of $5.13 billion. The patient experience/ complaints and access measure weight provisions are expected to result in net savings of between $330 million in 2027 and $580 million in 2033, which results in a ten year savings estimate of $3.28 billion. For the improvement measure hold harmless provision, net savings are estimated to be between $2.08 billion in 2027 and $3.52 billion in 2033, resulting in a ten-year savings estimate of $19.3 billion. The net impact of all of the Star Ratings proposed provisions is $24.97 billion in savings over ten years accounting for 0.37% of the private health baseline.
b. Medication Therapy Management (MTM) Program (§ 423.153)	We propose changes to the MTM targeting criteria to: Require Part D sponsors to include all core chronic diseases in their targeting criteria, codify the current 9 core chronic diseases in regulation, and add HIV/AIDS for a total of 10 core chronic diseases. Lower the maximum number of covered Part D drugs a sponsor may require from 8 to 5 drugs and require sponsors to include all Part D maintenance drugs. Revise the cost threshold methodology based on the average annual cost of 5 generic Part D drugs ($1,004 in 2020).	We estimate that these proposed changes would increase the number and percentage of Part D enrollees eligible for MTM services from 4.5 million (9 percent) to 11 million (23 percent). The increase in MTM program enrollment is estimated to cost approximately $336 million annually for required MTM services. We cannot definitively score this proposal because there may be other administrative costs attributable to MTM, which is not a specific line item that can be easily extracted from plan bids. Also, there is evidence that MTM services may generate overall medical savings, but we cannot quantify those savings at this time.
c. Strengthening Translation Requirements for Medicare Advantage, Cost plans, Part D, and D-SNP Enrollee Marketing and Communication Materials (§§ 422.2267 and 423.2267)	We propose to require that: (1) MA organizations, cost plans, and Part D sponsors provide materials to enrollees on a standing basis in any non-English languages that is the primary language of at least 5 percent of the individuals in that service area and/or accessible formats using auxiliary aids and services; and (2) fully integrated D- SNPs (FIDE SNPs), highly integrated D- SNPs (HIDE SNPs) and applicable integrated plans (AIPs) translate both Medicare and Medicaid materials into any languages required by the Medicare translation standard plus any additional languages required by the Medicaid translation standard as specified through their Medicaid capitated contracts.	We estimate the proposal to require MA organizations, cost plans, and Part D sponsors to establish a process to provide materials to enrollees on a standing basis would cost $10.4 million. We expect that implementing a standing request process would reduce future costs to MA organizations, cost plans, and Part D sponsors by decreasing rework of sending two sets of information, one in the incorrect language or format and the other in the correct format. We estimate it would cost $2.1 million for FIDE SNPs, HIDE SNPs, and AIPs to translate one set of materials into one additional language. Any additional documents needing translation would be a one- time cost with a smaller cost to update the documents in future contract years.

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d. Health Equity in Medicare Advantage (MA) (§§ 422.111and 422.112)	We propose to: (1) clarify the broadapplication of our policy that MA services be provided in a culturally competent manner, (2) require each provider's cultural and linguistic capabilities and notations for certain MOUD-waivered providers be included in all MA provider directories, (3) require MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits, and (4) require MA organizations to incorporate one or more activities into their overall QI program that reduce disparities in health and health care among their enrollees.	Expanding the list of populations is proposed for purposes of clarity, and is not expected to have any economic impact on the Medicare Trust Fund. Codifying providers' cultural and linguistic capabilities and notations for certain MOUD-waiveredproviders as required provider directory data elements is not expected to have any economic impact on the Medicare Trust Fund. Our proposal requiring MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy is expected to have an unknown economic impact on the Medicare Trust Fund. Aligning MA QI programs with health equityefforts across CMS policiesand programs is not expected to have any economic impact on the Medicare Trust Fund.
e. Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Mandate Annual Review of Utilization Management Tools (§§ 422.101, 422.112, 422.137 and 422.138422.4)	We propose to: 1) require MA plans to follow Traditional Medicare coverage NCDs, LCDs, statutes and regulations when making medical necessity determinations, 2) require plans to provide a public summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations, 3) require that an approval granted through PA processes must be valid for the duration of a prescribed course of treatment and that plans are required to provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan, switches from Traditional Medicare to an MA plan, or is new to Medicare, and 4) require MA organizations to establish a committee, led by the Medical Director, that reviews utilization management, including PA, policies annually and keeps current of LCDs, NCDs, and other Traditional Medicare coverage policies.	Require MA plans to follow Traditional Medicare coverage guidelines when making medical necessity determinations. The impact is difficult to quantify. Requires plans to post a public summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations. Requires PA approval to be valid for the duration of the approved course of treatment and is not expected to have economic impact on the Medicare Trust fund. Require MA organizations to establish a committee (similar to a P&T committee), led by the Medical Director, that reviews utilization management, including PA, policies annually and keeps current of LCDs, NCDs, and other Traditional Medicare coverage policies. This is qualitatively beneficial for enrollees and is not expected to have economic impact on the Medicare Trust fund.
f. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)	We propose several changes to strengthen beneficiary protections and improve MA and Part D marketing. Examples include notifying enrollees annually, in writing, of the ability to opt out of plan business; requiring agents to explain the effect of an enrollee's enrollment choice on their current coverage; clarifying that the prohibition on door-to-door contact still applies solely based on collection of a business reply card (BRC) or scope of appointment (SOA); prohibiting marketing of benefits in a service area where those benefits are not available, prohibiting the marketing of savings available based on a comparison of typical expenses borne by uninsured individuals; requiring TPMOs to list or mention all of the MA organization or Part D sponsors that they sell; requiring plans and sponsors to have an oversight plan that monitors agent/broker activities and reports non-compliance to CMS; adding SHIPs to the TPMO disclaimer as an option for beneficiaries to obtain additional help; placing discrete limits around the use of the Medicare name, logo, and Medicare card; prohibit the use of superlatives unless the material provides documentation to support the statement; and, clarifying the requirement to record calls between TPMOs and beneficiaries includes virtual connections such as Zoom and Facetime.	We recognize the impact of these provisions to be primarily one of changes to Plans' policy and procedure documents. We have tallied the one-time costs of these changes to be $172,593 ($76.20/hr * 2265 hr). We believe there would be an impact of time and cost to Plans for the requirement to report non-compliant agents and brokers to CMS. We are unable to estimate that cost at this time, however, and have solicited comment on how we could accurately do so.

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g. Behavioral Health in Medicare Advantage (MA) (§§ 422.112 and 422.116)	We propose to add Clinical Psychology Licensed Clinical Social Worker, and Prescribers of Medication for Opioid Use Disorder, as specialty types that will be evaluated using the time, distance and minimum provider standards in our network adequacy reviews; amend our access to services standards to include behavioral health services; codify minimum access wait time standards (from current example wait times for primary care) to apply to both primary care and for behavioral health services; clarify that behavioral health services may qualify as emergency services and therefore not be subject to prior authorization when furnished as emergency services; and require plans to establish behavioral health care coordination programs to ensure enrollees are offered the behavioral health services to which they are entitled to close gaps in behavioral health treatment.	We estimate negligible costs for this proposal.
h. Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations (§§ 422.111 and 422.2267)	CMS requires notification to enrollees when a provider network participation contract terminates. CMS is proposing to revise § 422.111(e) by establishing specific enrollee notification requirements for no-cause and for-cause provider contract terminations and adding specific and more stringent enrollee notification requirements when primary care and behavioral health provider contract terminations occur. CMS is also proposing to revise § 422.2267(e)(12) to specify the requirements for the content of the notification to enrollees about a provider contract termination.	This proposal is not expected to have any economic impact on the Medicare Trust Fund.

Provision	Description	Impact
i. Limited Income Newly Eligible Transition (LI NET) Program	We propose to make the longstanding demonstration program a permanent part of Medicare Part D, as directed by the CAA.	The projected costs, estimated by OACT, are the same as what the government would have incurred if the demonstration continued. Further, the costs of the payments provided for under this program will continue, as under the demonstration, to be covered through the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance (SMI) Trust Fund. The provision is estimated to cost the Medicare Trust Fund $95 million over 10 years. There is an additional 10 year paperwork burden of $2.6 million.
j. Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act (§§ 422.326(c), 423.360(c), (§ 401.305(a)(2))	We propose to remove the "reasonable diligence" standard and adopt by reference the "knowledge" standard set forth in the False Claims Act at 31 U.S.C. 3729(b)(1).	We do not have a basis for estimating the impact on new Parts A, B, C and D overpayment recoveries.
k. Changes to an Approved Part D Formulary - Immediate Substitutions	We propose to permit Part D sponsors to immediately substitute: (i) a new interchangeable biological product for its corresponding reference product; (ii) a new unbranded biological product for its corresponding brand name biological product; and (iii) a new authorized generic for its corresponding brand name equivalent.	We estimate no significant impact to the Medicare Trust Fund or other paperwork burden as a result of this specific proposal.
l. Expanding Eligibility for Low-Income Subsidies Under Part D of the Medicare Program (§§ 423.773 and 423.780)	We propose to implement section 11404 of the IRA to expand eligibility for the full LIS subsidy group to individuals currently eligible for the partial LIS subsidy beginning on or after January 1, 2024	We estimate that this change will increase Medicare spending by $2.3 billion over 10 years.

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Summary of Major Provisions

CMS is proposing a health equity index (HEI) reward for the 2027 Star Ratings to further incentivize Parts C and D plans to focus on improving care for enrollees with social risk factors (SRFs); as part of this change, CMS is also proposing to remove the current reward factor.

The following items are short excerpts from the proposed rule.

1. 45 CFR Part 153

In accordance with the OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2023, the permanent risk adjustment program is subject to the fiscal year 2023 sequestration. Therefore, the risk adjustment program will be sequestered at a rate of 5.7 percent for payments made from fiscal year 2023 resources (that is, funds collected during the 2023 fiscal year). The funds that are sequestered in fiscal year 2023 from the risk adjustment program will become available for payment to issuers in fiscal year 2024 without further Congressional action.

CMS also proposes a risk adjustment user fee for the 2024 benefit year of $0.21 per member per month (PMPM).

CMS proposes to shorten the window to confirm the findings of the second validation audit (SVA) (if applicable), or file a discrepancy report to dispute the SVA findings, to within 15 calendar days of the notification by HHS, beginning with the 2022 benefit year HHS-Operated Risk Adjustment Program (HHS-RADV).

2. 45 CFR Part 155

CMS proposes to revise the Exchange Blueprint approval timelines for States transitioning from either a FFE to a SBE-FP or to a State-based Exchange (SBE), or from a SBE-FP to a SBE. CMS proposes to remove the deadlines for when HHS provides approval, or conditional approval, on an Exchange Blueprint, and instead proposes to require that such approval is provided at some point prior to the date on which the Exchange proposes to begin open enrollment either as an SBE or SBE-FP.

CMS proposes to remove the prohibition on Navigators from going door-to-door or using other unsolicited means of direct contact to help provide consumers with enrollment assistance.

CMS proposes to allow up to an additional 15 calendar days to review evidence submitted by agents, brokers, or web-brokers to rebut allegations that led to suspension of their Exchange agreement(s).

CMS proposes to revise the failure to file and reconcile (FTR) process at § 155.305(f)(4). First, CMS is proposing to codify CMS's guidance that, for plan year 2023 coverage, the Exchanges on the Federal platform would not act on data from the IRS for consumers who have failed to file tax returns and reconcile a previous year's advance payments of the premium tax credit (APTC) with the premium tax credits (PTC) allowed for the year. Second, CMS proposes to provide that, beginning on January 1, 2024, Exchanges must once again determine enrollees ineligible for APTC when HHS notifies the Exchange that a taxpayer (or a taxpayer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC. However, CMS proposes that an Exchange may only determine enrollees ineligible for APTC after a taxpayer (or a taxpayer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC for two consecutive years. CMS also proposes a technical correction to § 155.305(f)(4) to clarify that HHS receives data from the IRS for consumers who have failed to file tax returns and reconcile a previous year's APTC.

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3. 45 CFR Part 156

In part 156, proposes user fee rates for the 2024 benefit year for all issuers participating on the Exchanges using the Federal platform. For the 2024 benefit year, CMS proposes an FFE user fee rate of 2.5 percent of total monthly premiums and an SBE-FP user fee rate of 2.0 percent of total monthly premiums. HHS will issue the 2024 benefit year premium adjustment percentage index and related payment parameters in guidance, consistent with the policy finalized in part 2 of the 2022 Payment Notice.

Fact Sheet Excerpts

It is truly amazing that CMS can provide a good summary of the rule in its fact sheet accompanying the proposal. Below are excerpts from the fact sheet.

Increasing Access to Health Care Services

CMS proposes to revise the network adequacy and essential community provider (ECP) standards to provide that all individual market qualified health plans (QHPs), including stand-alone dental plans (SADPs) and all Small Business Health Option Program (SHOP) plans across all Marketplace-types must use a network of providers that complies with the network adequacy and ECP standards in those sections, and to remove the exception that these sections do not apply to plans that do not use a provider network.

CMS also proposes to expand access to care for low-income and medically underserved consumers by establishing two additional major ECP categories for Plan Year (PY) 2024 and beyond: 1) Mental Health Facilities; and, 2) Substance Use Disorder (SUD) Treatment Centers.

Additionally, for PY 2024 and beyond, CMS proposes to retain the overall 35 percent provider participation threshold, and also extend the 35 percent threshold to two major ECP categories: Federally Qualified Health Centers (FQHCs) and Family Planning Providers. These changes would increase provider choice and access to care for low-income and medically underserved consumers.

Simplifying Choice and Improving the Plan Selection Process

Standard Plan Options

CMS proposes that for PY 2024 and subsequent PYs, issuers offering QHPs through the Federally-facilitated Marketplace (FFM) and State-based Marketplaces on the Federal platform (SBM-FP) must offer standardized QHP options designed by CMS at every product network type, at every metal level except the non-expanded bronze level, and throughout every service area that they offer non-standardized QHP options.

In addition, CMS proposes that issuers of standardized plan options must: (1) place all covered generic drugs in the standardized plan options' generic drug cost-sharing tier, or the specialty drug tier if there is an appropriate and non-discriminatory basis; and, (2) place brand name drugs in either the standardized plan options' preferred brand or non-preferred brand tiers, or specialty drug tier if there is an appropriate and non-discriminatory basis.

CMS also proposes to limit the number of non-standardized plan options that issuers of QHPs can offer through Marketplaces on the Federal platform (including SBM-FPs) to two non-standardized plan options per product network type and metal level (excluding catastrophic plans), in any service area, for PY 2024 and beyond, as a condition of QHP certification. The average number of plans available to consumers on the Marketplace has increased from 25.9 in PY 2019 to 113.6 in PY 2023.

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Under this proposed requirement, an issuer would, for example, be limited to offering through a Marketplace two gold health maintenance organization (HMO) and two gold preferred provider organization (PPO) non-standardized plan options in any service area in PY 2024 or any subsequent PY.

Similar to the approach taken with respect to standardized plan options in the 2023 Payment Notice and in this proposed rule, CMS proposes to not apply this requirement to issuers in State Marketplaces. Further, consistent with the approach taken with respect to standardized plan options in the 2023 Payment Notice and in this proposed rule, since SBM-FPs use the same platform as the FFMs, CMS proposes to apply this requirement equally on FFMs and SBM-FPs. Finally, also in alignment with the approach taken with standardized plan options in the 2023 Payment Notice as well as the approach taken in this proposed rule, CMS proposes that this proposed requirement would not apply to plans offered through the SHOPs or to SADPs.

As an alternative to limiting the number of non-standardized plan options that issuers in FFMs and SBM-FPs can offer through the Marketplaces in order to reduce the risk of plan choice overload, CMS could also apply a meaningful difference standard in PY 2024 and subsequent PYs. Under this proposed
standard, CMS proposes grouping plans by issuer ID, county, metal level, product network type, and deductible integration type, and then evaluating whether plans within each group are "meaningfully different" based on differences in deductible amounts. With this proposed approach, two plans would need to have deductibles that differ by more than $1,000 to satisfy the new proposed meaningful difference standard. CMS seeks comment on this alternative proposal.

In conjunction with the requirement for issuers to offer standardized plan options, having a more manageable number of plan choices for consumers to select from would further streamline the plan selection process and facilitate more meaningful evaluation of available plan choices, which would also allow consumers to more easily select a health plan that best fits their unique health needs.

Stand-Alone Dental Plans (SADPs)

CMS proposes to require issuers of SADPs, as a condition of Marketplace certification, to use age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes beginning with Marketplace certification for PY 2024. CMS proposes that this requirement apply to Marketplace-certified SADPs, whether they are sold on- or off-Marketplace. Requiring SADPs to use the age on effective date methodology to calculate an enrollee's age as a condition of QHP certification, and consequently removing the less commonly used and more complex age calculation methods, would reduce consumer confusion and promote operational efficiency.

CMS also proposes to require issuers of SADPs, as a condition of Marketplace certification, to submit guaranteed rates beginning with Marketplace certification for PY 2024. CMS proposes that this requirement apply to Marketplace-certified SADPs, whether they are sold on- or off-Marketplace. This policy change would help reduce the risk of incorrect advance payments of the premium tax credit (APTC) calculation for the pediatric dental essential health benefit (EHB) portion of premiums, thereby reducing the risk of consumer harm.

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Re-enrollment Hierarchy

CMS proposes to allow Marketplaces, beginning for PY 2024, to modify their automatic re-enrollment hierarchies such that enrollees who are eligible for cost-sharing reductions (CSRs) and who would otherwise be automatically re-enrolled in a bronze-level QHP without CSRs, to instead be automatically re-enrolled in a silver-level QHP (with CSRs) in the same product with a lower or equivalent premium, provided that certain conditions are met. Furthermore, CMS proposes to amend the Marketplace re-enrollment hierarchy to allow all Marketplaces (Marketplaces on the Federal platform and SBMs) to ensure enrollees whose QHPs are no longer available to them and enrollees who would be re-enrolled into a silver-level QHP in order to receive income-based CSRs are re-enrolled into plans with the most similar network to the plan they had in the previous year, provided that certain conditions are met. CMS proposes that Marketplaces (including Marketplaces on the Federal platform and SBMs) would implement this option beginning with the open enrollment period for plan year 2024 coverage, if operationally feasible, and if not then beginning with the open enrollment period for PY 2025 coverage.

Establish Requirements for Qualified Health Plan and Plan Variant Marketing Names

CMS proposes to require that QHP plan and plan variant marketing names include correct information, without omission of material fact, and do not include content that is misleading. If finalized as proposed, CMS would review plan and plan variant marketing names during the annual QHP certification process in close collaboration with State regulators in States with Marketplaces on the Federal platform.

Making It Easier to Enroll in Coverage

Special Enrollment Periods

CMS proposes that beginning January 1, 2024, that Marketplaces have the option to implement a new special rule for consumers losing Medicaid or Children's Health Insurance Program (CHIP) coverage that is also considered minimum essential coverage (MEC). This special rule would mean that consumers would have 60 days before, or 90 days after, their loss of Medicaid or CHIP coverage to select a plan for Marketplace coverage via a special enrollment period (SEP). Marketplaces would have additional flexibilities to decide whether to offer this special rule or not, depending on eligibility and/or enrollment trends for their respective populations.

CMS also proposes to change the current coverage effective date requirements so that Marketplaces have the option to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC and who would otherwise experience gaps in coverage effective as of the date of the final rule.

CMS also proposes removing consumer burden by aligning the regulations with the policy and operations of the Marketplaces on the Federal platform for granting special enrollment periods (SEPs) to qualified consumers who are affected by a material plan display error with current plan display error SEP operations. Currently, the regulation requires the qualified individual or enrollee, or their dependent, to adequately demonstrate to the Marketplace that a material error related to plan benefits, service area, or premium influenced their decision to purchase a QHP through the Marketplace. However, CMS has found that consumers may benefit when other interested parties

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can demonstrate to the Marketplace that a material plan error influenced the enrollment decision to purchase a QHP through the Marketplace.

Income Data Matching Issues

CMS proposes to accept the household's income attestation when HHS requests tax return data from the Internal Revenue Service (IRS) but such data is not available. Such cases often occur when household composition changes across tax years (marriage, divorce, birth of a child) or if individuals were previously below the filing threshold and did not receive advance payments of the premium tax credits. All individuals receiving advance payments of the premium tax credits are required to file taxes and to reconcile those payments with final annual income.

Allow Door to Door Enrollment by Navigators and other Assisters

CMS proposes to permit assisters to conduct door-to-door enrollment to increase consumer engagement and advance health equity. Assisters currently conduct door-to-door outreach, education, and schedule follow-up appointments, but are prohibited from providing enrollment assistance upon an initial interaction at the consumers' residence.

Strengthening Markets

FFM and SBM-FP User Fees

For the 2024 benefit year, CMS proposes to lower the user fee rate from 2.75% to 2.5% of premium for QHPs sold on the FFM, and to lower the user fee rate from 2.25% to 2.0% of premium for QHPs sold on the SBM-FP. CMS anticipates these user fee rate decreases may exert downward pressure on insurance premiums, resulting in lower costs for consumers.

HHS-Operated Risk Adjustment Program

For the 2024 benefit year risk adjustment models, CMS proposes to use the 2018, 2019, and 2020 enrollee-level EDGE data for model recalibration, with one exception. For the adult models' age-sex coefficients, CMS proposes to blend only the 2018 and 2019 enrollee-level EDGE data and to exclude the 2020 enrollee-level EDGE data given CMS' analysis of the 2020 enrollee-level EDGE data and observed anomalous decreases in the unconstrainted coefficients for the 2020 benefit year enrollee-level EDGE recalibration data for older adult enrollees, especially female enrollees.

Additionally, CMS proposes to continue to apply a market pricing adjustment to the plan liability associated with Hepatitis C drugs in the risk adjustment models for the 2024 benefit year. CMS also requests comment on whether to add a new payment HCC for gender dysphoria to the risk adjustment models for future benefit years.

CMS also proposes, beginning with the 2023 benefit year, to collect and extract from issuers' EDGE servers a new data element, a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator, and to extract plan ID and rating area data elements issuers have submitted to their EDGE servers from certain benefit years prior to the 2021 benefit year.

Finally, CMS proposes to repeal the ability of all states, including those prior participant states that had previously submitted a state flexibility request, to request a reduction in risk adjustment state transfers starting with the 2025 benefit year. CMS also solicits comments on the requests submitted by Alabama to reduce risk adjustment state transfers by 50 percent in its individual (including

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catastrophic and non-catastrophic risk pools) and small group markets for the 2024 benefit year.

HHS Risk Adjustment Data Validation

CMS proposes further refinements to HHS Risk Adjustment Data Validation (HHS-RADV) to promote the goals of HHS-RADV and support the timely release of HHS-RADV results. Beginning with the 2021 benefit year, CMS proposes to no longer exempt exiting issuers from adjustments to risk scores and risk adjustment transfers when they are negative error rate outliers in the applicable benefit year's HHS-RADV results. Additionally, CMS proposes to change the materiality threshold for random and targeted sampling from $15 million in total annual premiums Statewide to 30,000 total billable member months Statewide. CMS proposes to shorten the window to confirm or dispute the findings of the Second Validation Audit to within 15 calendar days of the notification by HHS beginning with the 2022 benefit year. Finally, CMS solicits comments on discontinuing the use of the lifelong permanent condition list and the use of Non-EDGE Claims in HHS-RADV.

Bolstering Program Integrity

Establish Improper Payment Pre-Testing and Assessment for State Marketplaces

To comply with the Payment Integrity Information Act of 2019 (PIIA), CMS proposes to establish and implement a required Improper Payment Pre-Testing and Assessment (IPPTA) program in calendar years 2024 - 2025. The proposed IPPTA would prepare State Marketplaces for the planned measurement of improper payments of APTC by testing processes and procedures that support HHS's review of determinations of APTC. IPPTA would also provide a mechanism for HHS and State Marketplaces to share information that would aid in developing a measurement process in future years.

New Requirements Related to Agents, Brokers, or Web-brokers

CMS proposes to allow HHS additional time to review evidence submitted by agents, brokers, or web-brokers to rebut allegations that led to suspension of their Marketplace agreements or to request reconsideration of termination of their Marketplace agreements. For suspensions, HHS would receive an additional 15 calendar days, or a total of up to 45 calendar days, to review evidence and notify the submitting agents, brokers, or web-brokers of HHS' determination regarding the suspension of their Marketplace agreements. For terminations, HHS would receive an additional 30 calendar days, or a total of up to 60 calendar days to review reconsideration requests and notify the submitting agents, brokers, or web-brokers of HHS' reconsideration decision related to the termination of their Marketplace agreements.

CMS also proposes to require agents, brokers, and web-brokers to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer prior to application submission. This proposal would help with enforcement activities related to agents, brokers, and web-brokers and help expedite the adjudication of consumer complaints related to the provision of incorrect information of their eligibility applications. CMS is proposing that this documentation be retained by the agent, broker, or web-broker for a minimum 10 years and be produced upon request in response to monitoring, audit, and enforcement activities.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting