Supporting Statement for Paperwork Reduction Act Submissions:
Part C Medicare Advantage Reporting Requirements and
Supporting Regulations in 42 CFR §422.516 (a)

A. Background

The Centers for Medicare and Medicaid Services (CMS) has established reporting requirements for Medicare Advantage Organizations (MAOs) under the authority described in 42CFR §422.516 (a). It is noted that each MAO must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information with respect to the cost of its operations, patterns of service utilization, availability, accessibility, and acceptability of its services, developments in the health status of its enrollees, and other matters that CMS may require.

CMS also has oversight authority over cost plans which includes establishment of reporting requirements. The data requirements in this supporting statement are specifically relevant to the cost plan requirements in section 1876(c)(1)(C) of the social security act which establishes beneficiary enrollment and appeal rights.

CMS initiated new Part C reporting requirements with the Office of Management and Budget (OMB) approval of the "Information Collection Request" (ICR) under the Paperwork Reduction Act of 1995 (PRA) in December, 2008 (OMB # 0938-New; CMS-10261). National PACE plans and 1833 cost plans are excluded from reporting all Part C Reporting Requirements measures. The initial ICR involved thirteen measures. Two of these thirteen measures have been suspended from reporting because the information is available elsewhere: Measurement #10 *Agent Compensation Structure* and; Measurement #11 *Agent Training and* Testing. One new measure has been added: Enrollment and Disenrollment.

New Measure: Enrollment/Disenrollment

CMS provides guidance for Part C plans' processing of enrollment and disenrollment requests. CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate the plan's processing of enrollment requests in accordance with CMS requirements.
Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the Health Plan Management System (HPMS) at the Contract level:

CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate the sponsor's processing of enrollment and disenrollment requests in accordance with CMS requirements. For example, while there are a number of factors that result in an individual's eligibility for a Special Enrollment Period (SEP), sponsors are currently unable to specify each of these factors when submitting enrollment transactions. Sponsor's reporting of data regarding SEP reasons for which a code is not currently available will further assist CMS in ensuring sponsors are providing support to beneficiaries, while complying with CMS policies.

Data elements 1.A-1.K must include all enrollments (code 61 transactions). Disenrollments must not be included in Section 1 Enrollment.

Section 2 Disenrollment must include all voluntary disenrollment transactions.

1. Enrollment:

A. The total number of enrollment requests received in the specified time period.
B. Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).
C. Of the total reported in A, the number of enrollment requests that required requests for additional information.
D. Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect the plan (e.g. individual not having a valid enrollment period).
E. Of the total reported in C, the number of incomplete enrollment requests received that are completed within established timeframes.
F. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.
G. Of the total reported in A, the number of paper enrollment requests received.
H. Of the total reported in A, the number of telephonic enrollment requests received (if offered).
I. Of the total reported in A, the number of internet enrollment requests received via plan website (if offered).
J. Of the total reported in A, the number of Online Enrollment Center (OEC) enrollment requests received.

K. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage.
L. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" for individuals affected by a contract nonrenewal, plan termination or service area reduction.

2. **DISENROLLMENT**:

A. The total number of voluntary disenrollment requests received in the specified time period.

B. Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).

C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.

Revised Measure: Part C Grievances

The current (2009-2011) categories for Part C grievances are: fraud, enrollment/disenrollment/benefit package/access, marketing, privacy, quality of care, expedited, other. This categorization resulted in most grievances reported as “other,” and was not especially informative. The grievances below are more consistent with Part D reporting. In addition, we will now be obtaining data on the timeliness of handling grievances.

Grievance Category	**Total number of Grievances**	**Number of grievances which the Sponsor provided timely notification of its decision**
No. Fraud Grievances		Does not apply to this category
Enrollment/Disenrollment		
Benefit Package Grievances		
Access Grievances		
Marketing Grievances		
Customer Service Grievances		
Privacy Issues Grievances		Does not apply to this category
Quality Of Care Grievances		
Appeals Grievances		
Other Grievances		

Revised Measure: Procedure Frequency

Plans are now required to report all Procedure Frequency data for 2012-2014, regardless of whether they are reporting similar data through HEDIS.

Data collection for the Part C reporting requirements was effective on January 1, 2009. Contract year 2010 data are currently being collected and complied. Contract year 2011 is the last year for the current ICR. This ICR is requesting approval for three additional years of data collection for these Part C reporting requirements (2012-2014).

Reporting Requirement Measures List

The following summary table provides an overview of the parameters around each of the current Part C reporting requirements measures.

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
1. Benefit Utilization	CCP, PFFS, Demo, MSA (includes all 800 series plans), Employer/Union Direct Contract	1/year Plan Benefit Package (PBP)	1/1-12/31	8/31 of the following year
2. Procedure Frequency	CCP, PFFS, Demo, MSA (includes all 800 series plans), Employer/Union Direct Contract	1/year Contract	1/1-12/31	5/31 of following year
3. Serious Reportable Adverse Events	CCP, PFFS, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	1/year Contract	1/1-12/31	5/31 of following year
4. Provider Network Adequacy	CCP, 1876 Cost, Demo (includes all 800 series plans)	1/year Contract	1/1 - 12/31	2/28 of following year
5. Grievances	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	4/Year PBP	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year
6. Organization Determinations/ Reconsiderations	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

7. Employer Group Plan Sponsors	CCP, PFFS, 1876 Cost, Demo, MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contract	1/year PBP	1/1 - 12/31	2/28 of following year
8. PFFS Plan Enrollment Verification Calls	PFFS (800-series plans should NOT report)	1/year PBP	1/1-12/31	2/28 of following year Validation unnecessary—using for monitoring only
9. PFFS Provider Payment Dispute Resolution Process	PFFS (includes all 800 series plans), Employer/Union Direct Contract	1/year PBP	1/1-12/31	2/28 of following year Validation unnecessary—using for monitoring only
10. Agent Compensation Structure		Suspended Indefinitely		
11. Agent Training and Testing		Suspended indefinitely		
12. Plan Oversight of Agents	CCP, PFFS, 1876, Cost, Demo, MSA (includes all 800 series plans)	1/Year Contract	1/1 – 12/31	2/28 of the following year
13. Special Need Plans (SNP) Care Management	Local, CCP, Demo, Regional CCP,RFB Local CCP with SNPs	1/Year PBP	1/1-12/31	5/31 of following year
14. Enrollment/ Disenrollment	CCP, PFFS, Demo, MSA	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

B. Justification

1. Need and Legal Basis

In accordance with 42 CFR § 422.516 (a), each MA organization under Part C Medicare is required to have an effective procedure to provide statistics indicating:

1) The cost of its operations.
2) The patterns of utilization of its services.
3) The availability, accessibility, and acceptability of its services.
4) To the extent practical, developments in the health status of its enrollees.
5) Other matters that CMS may require.

2. Information Users

Before Part C reporting CMS had mainly clinical performance measures on Part C plans such as HEDIS, CAHPS, and the Health Outcomes Survey (HOS). However, CMS also needs other performance data on Medicare Advantage Organizations (MAOs) under Part C Medicare. CMS has received and continues to receive many inquiries about the operations, costs, availability of services, beneficiary use of available services, patient safety, grievance rates, and other factors pertaining to the performance of MA plans. Prior to the collection and reporting of these data, CMS was unable to respond to these requests for information. Now, with the availability of Part C reporting, CMS can respond to most of these requests.

There are a number of information users of Part C reporting. CMS information users include central and regional office staff, who use this information to monitor health plans and to hold them accountable for their performance. Among CMS users are top-level CMS administrators, program administrators, group managers, division chiefs, branch managers, account managers, and researchers. Health plans use this information to measure and benchmark their performance. Other government agencies such as GAO and IOG have inquired about this information. In 2008, Congress asked for information about health plan benefits utilization which we did not have at the time. CMS hopes to make some of these data available for public reporting.

3. Use of Information Technology

MA organizations utilize the Health Plan Management System (HPMS) to submit or enter data for 100% of the data elements listed within these reporting requirements. The reporting time periods vary for each section of the reporting requirements, on a quarterly, semi-annual or yearly basis. HPMS is the current conduit by which MA organizations submit data to CMS; for example, application materials, bids, and formularies if offering Medicare Part D. CMS and its subcontractors, in turn, communicate to MA organizations regarding this information, including approval and denial notices and other related announcements through HPMS. HPMS, therefore, is already a familiar tool to MA organizations. If organizations are already reporting data elements through HEDIS®, they are exempt from reporting identical

information under this PRA package. Additionally, as access to HPMS must be granted to each user, and is protected by individual login and password, electronic signatures are unnecessary.

4. Duplication of Efforts

This collection does not contain duplication of similar information.

5. Small Businesses

There are no small businesses involved.

6. Less Frequent Collection

In an effort to reduce the burden for MA organizations, measures vary in terms of reporting frequency in order to capture data as frequently as necessary without increasing undue burden for MA organizations. Less frequent collection of the reporting requirement data from MA organizations would severely limit CMS' ability to perform accurate and timely oversight, monitoring, compliance and auditing activities around the Part C MA benefits.

7. Special Circumstances

- As mandated by 42CFR §422.504 (d), MA organizations must agree to maintain for 10 years books, records, documents and other evidence of accounting procedures and practices.
- CMS could potentially require clarification around submitted data, and therefore CMS may need to contact MA organizations within 60 days of data submission.

8. Federal Register/Outside Consultation

The 2012 Part C reporting requirement document was posted in the Federal Registry for a 60-day comment period on December 17, 2010. Another Federal Register notice will be published for a30-day comment period. CMS staff will review all received comments and questions, revise the document as appropriate, and forward revisions to the Office of the DHHS Secretary for submission to OMB.

9. Payments/Gifts to Respondents

There are no payments/gifts to respondents associated with this information collection request.

10. Confidentiality

CMS will adhere to all statutes, regulations, and agency policies. CMS will not be requesting any beneficiary identification information. Social security numbers will not be collected.

11. Sensitive Questions

CMS will adhere to all statutes, regulations, and agency policies. There are no sensitive questions being asked in this reporting initiative. This is a data collection and reporting effort that concentrates on collecting and reporting of data related to access to benefits, quality of care, plan monitoring, and oversight. All of these areas are focuses of concern and need to be supported by accurate, complete, and comparable reporting.

12. Burden Estimates (Hours & Wages)

The burden associated with this ICR is the time and resources it takes to develop computer code to compile the data, gather the ‘raw” data, “clean” the data in order to eliminate errors, enter data, review technical specifications, and perform tests on the data.

Virtually all of the data elements required to support the Part C Reporting Requirements are already available to MA organizations. Anticipated staff performing these data collection would be computer systems analysts. An average competitive hourly rate (including wages, benefits and overhead) of $63.09 was used to calculate estimated costs (data from http://bls.gov/oes/2009/may/oes151051.htm).

As an outgrowth of discussions with OMB on August 4, 2011, CMS became aware that it was about to request “double-reporting” for the new enrollment/disenrollment measure. The reason is that MA-only and MA-PD organizations were included in both the Part C enrollment/disenrollment “measure” and the Part D enrollment/disenrollment “section.” We have now eliminated the “double-reporting” issue: Part C will only request that MA-only organization report for Part C. There are only 16 of them. This reduces the annual burden estimate substantially for the new Part C enrollment/disenrollment measure. Previously we had an annual hourly burden estimate of this measure at 37,632 because we had included 588 organizations as respondents. The new annual hourly burden estimate is 1,024 with only 16 respondents.

The burden estimates by measure are contained in the following table. The measures are shown in the leftmost column. The second column from the left is the measure-specific estimated number of burden hours for each respondent (health contract, sometimes also referred to as heath plan). The third column from the left is the number of contracts reporting the measure. The number varies by measure, because the number of health contracts reporting depends on the organization type. The next column shows the measure-specific frequency of reporting (most measures are reported once annually but three are reported 4 times annually--reported each quarter). The next column shows the number of respondents multiplied by the reporting frequency for each measure. This is a calculation needed to compute the total hourly burden. The measure-specific total annual hourly burden is shown in the next column. It is equal to the number in the previous column—the no. of respondents times the frequency of reporting on an annual basis—times the measure-specific estimated annual hours per respondent. The last column, the rightmost column, is the average annual burden per respondent. It equals the measure-specific annual hourly burden divided by the number of respondents.

To get an estimate of the annual total burden hours across all measures, we summed the numbers in the column labeled “Total Part C Hour Burden.” This equaled 208,920 hours. To calculate the estimate of the total annual cost burden, we multiplied the hours, 208,920 times the estimated average cost per hour for computer systems analysts, including fringe, benefits, and overhead ($63.09). The total annual estimated cost burden was, therefore, $13,180,763 (208,920 times $63.09).

CY2012 Estimated Hours and Costs						
Measure	**# hrs/respond**	**# of Respond.**	**Freq. Of Reporting**	**No Respond. x Freq. Of Reporting**	**Total Part C Hour Burden**	**Avg. Annual Burden/respond.**
Utilization of Benefits	80	588	1	588	47,040	80
Procedures	56	588	1	588	32,928	56
Serious Reportable Adverse Events	40	588	1	588	23,520	40
Provider Network Adequacy & Stability	16	554	1	554	8,864	16
Grievances	20	588	4	2352	47,040	80
Organization Determinations/Reconsiderations	16	588	4	2352	37,632	64
Employer Group Plan Sponsors	8	432	1	432	3,456	8
PFFS Enrollment Verification Calls	8	34	1	34	272	8
PFFS Plan Provider Payment Dispute Resolution Process	8	44	1	44	352	8
Plan Oversight of Agents	8	588	1	588	4,704	8
SNP Care Mgt.	8	261	1	261	2,088	8
Enrollment	16	16	4	64	1,024	64
Total				8,445	208,920	440
Annual responses=# respondents x reporting frequency	8,445					
Total Hour Burden	208,920					
Avg. Cost/Hr*	$63.09					
Total Annual Cost	$13,180,763					

13. Capital Costs

    There is no capital cost associated with this collection.

14. Cost to Federal Government

    $300,000 to support reporting through the Health Plan Management System (HPMS).

15. Changes to Burden

    There is a decrease in cost and hour burden. One measure was added and another was enhanced, but these costs are more than offset by the suspension of two measures and the decrease in reporting frequency of some measures. The change in burden was:

    Annual Responses = - 4,264
    Annual Hour Burden =-78,024

16. Publication/Tabulation Dates

    Collection of these data will commence in January 1, 2012. The collection of these data from MA organizations will continue indefinitely.

17. Expiration Date

    This collection does not lend itself to displaying an expiration date.

18. Certification Statement

    There are no exceptions.

C. Collections of Information Employing Statistical Methods

This information collection does not employ any statistical analyses to be conducted by the reporting organizations.