**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE AND MEDICAID SERVICES**

# COLLECTION OF ENCOUNTER DATA FROM MEDICARE ADVANTAGE ORGANIZATIONS, SECTION 1876 COST HMOs/CMPs, SECTION 1833 HEALTH CARE PREPAYMENT PLANS (HCPPs), and PACE ORGANIZATIONS

## OFFICE OF MANAGEMENT AND BUDGET CLEARANCE PACKAGE SUPPORTING STATEMENT

**Date**

**CONTENTS**

## A. BACKGROUND –

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 30-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In this 30-day notice we are responding to comment on the 60-day notice we published in the Federal Register on December 17, 2010. We received comments requesting that we expand the submission deadlines for encounter data, more accurately address the burden of implementing encounter data, provide sufficient detail on the use of encounter data, and clarify the applicability to non-MA plans. We have made changes throughout the PRA package to address these comments.

In order to fairly evaluate whether an information collection should be approved by OMB, section 3306 (c)(2) of the PRA of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden
- The quality, utility, and clarity of the information to be collected
- Recommendations to minimize the information collection burden on the affected public, including automation collection techniques

CMS intends to collect encounter data, or data on each item or service delivered to enrollees of MA plans offered by Medicare Advantage organizations as defined at 42 CFR 422.4. Medicare Advantage organizations will obtain this data from providers. We will collect this information using standard HIPAA transaction forms and code sets. Typically these data would be collected by MA organizations and other entities for general business activities such as claims payment, coordination of benefits, eligibility and enrollment, quality improvement activities. CMS would use these data for determining the risk adjustment factors for payment, updating the risk adjustment model, calculating Medicare DSH percentages, Medicare coverage purposes, and quality review and improvement activities.

More specifically, CMS would collect the data electronically from Medicare Advantage organizations via the HIPAA compliant standard Health Care Claims transactions for professional data (currently using implementation guide ASC X12N 837/005010X222 *with* Errata for ASC X12N 837/05010X222A1) and institutional data (currently using implementation guide ASC X12N 837/005010X223 *with* Errata for ASC X12N 837/05010X223A2). A comparison of the prior ASC X12 4010A1 format to the 5010 version, including the data elements collected, can be found at the CMS website through the following link: https://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp. In addition, CMS has provided specific training and communications to the industry regarding encounter data submission under these standards. These communications can be found at www.csscoperations.com. CMS'

instructions to the industry include companion guides for institutional and professional claims to be used in conjunction with the associated 837 Implementation Guides.

CMS also intends to collect encounter data using similar formats for each item or service delivered to enrollees of §1876 Cost HMOs/CMPs, §1833 HCPPs and PACE organizations. Public commenters on our December 2010 publication of the PRA asked us to clarify the applicability of encounter data collection to non-MA plans. In the case of §1876 Cost HMOs/CMPs and §1833 Health Care Prepayment Plans (HCPPs), CMS would only require submission of encounter data for items/services for which such plans claim costs on their CMS Cost Reports. Additional uses for the data would include verifying the accuracy and validity of the costs claimed on Cost Reports. For PACE organizations, encounter data would serve the same purposes it does related to the MA program and would be submitted in a similar manner. We have updated our language throughout this document to include cost plans and PACE organizations.

## B. Justification

1. Need and Legal Basis

Section 1853 of the Act requires CMS to make advance monthly payments to a Medicare Advantage (MA) organization for each beneficiary enrolled in an MA plan offered by the organization for coverage of Medicare Part A and Part B benefits. Section 1853(a)(1)(C) of the Act requires CMS to adjust the monthly payment amount for each enrollee to take into account the health status of MA plan enrollees. Under the CMS-Hierarchical Condition Category (HCC) risk adjustment payment methodology, CMS determines risk scores for MA enrollees for a year and adjusts the monthly payment amount using the appropriate enrollee risk score.

Under section 1853(a)(3)(B) of the Act, MA organizations and other entities are required to ''submit data regarding inpatient hospital services . . . and data regarding other services and other information as the Secretary deems necessary'' in order to implement a methodology for ''risk adjusting'' payments made to MA organizations. Risk adjustments to payments are made in order to take into account ''variations in per capita costs based on [the] health status'' of the Medicare beneficiaries enrolled in an MA plan offered by the organization. Submission of data on inpatient hospital services has been required with respect to services beginning on or after July 1, 1997. Submission of data on other services has been required since July 1, 1998.

While we initially required the submission of comprehensive data regarding services provided by MA organizations, including comprehensive inpatient hospital encounter data, we subsequently permitted MA organizations to submit an ''abbreviated'' set of data. We currently collect limited risk adjustment data from MA organizations, primarily diagnosis data under OMB No. 0938-0878.

From calendar years 2000 through 2006, the application of risk adjustment to MA payments was ''phased in'' with an increasing percentage of the monthly capitation payment subjected to risk adjustment. Prior to calendar year 2000, and in diminishing proportion from 2000-2006, CMS

also adjusted monthly capitation payments based on "demographic" factors such as age, disability status, gender, and institutional status. Beginning with calendar year 2007, 100 percent of payments to MA organizations have been risk-adjusted. Given the increased importance of the accuracy of our risk adjustment methodology, we amended § 422.310 in August of 2008 to authorize the collection of data from MA organizations regarding each item and service provided to an MA plan enrollee. Collection of such data would allow CMS to incorporate the Medicare Advantage utilization in the development of the risk adjustment models for the Medicare Advantage program.

Once encounter data for MA enrollees are available, CMS would have beneficiary-specific information on the utilization of services by MA plan enrollees. These data could be used to develop and calibrate the CMS–HCC risk adjustment models using MA patterns of diagnoses and expenditures. These new models could be used to risk adjust payment to beneficiaries enrolled in Medicare Advantage plans. As stated in the amendment to § 422.310 we would also use the data for such things as calculating Medicare DSH percentages, Medicare coverage purposes, and quality review and improvement activities.

A similar rationale applies to PACE organizations which are also paid under section 1853 of the Social Security Act – see section 1894(d) of the Act.

Section 1876 Cost HMOs/CMPs are paid reasonable costs actually incurred under the authority in section 1876(h)(3) of the Act. Section 1833 HCPPs are paid reasonable costs under the authority in section 1833(a)(1)(A) of the Act. Reasonable costs are further defined in section 1861(v) of the Act. CMS has the authority to require Cost HMOs/CMPs to submit encounter data under 42 C.F.R. §417.568(b)(1) which requires submission of "adequate cost and statistical data. . .that can be verified by qualified auditors," and 42 C.F.R. §427.576(b)(2)(iii) which requires "[a]ny other information required by CMS" for purposes of final cost-settlement of payment amounts due. CMS also has the authority to require HCPPs to submit encounter data under 42 C.F.R. §417.806(c) to access "records of the HCPP.. .that pertain to the determination of amounts payable for covered Part B services furnished its Medicare enrollees" and 42 C.F.R. §417.871(b)(2)(iii) to require "other data as specified by CMS" for purposes of final cost-settlement of payment amounts due. In short, in addition to the other stated purposes for collection of encounter data, with respect to §1876 Cost HMOs/CMPs and§1833 HCPPs, additional data submission requirements included in this encounter collection data will assist us in verifying the accuracy and validity of the costs claimed on Cost Reports.

CMS' fundamental goal is to have the least burdensome data submission requirements necessary to ensure accurate payment and appropriate program oversight. Since the industry has an effective electronic encounter submission standard, which is electronically automated, we would use the electronic, HIPAA compliant professional data (currently using implementation guide ASC X12N 837/005010X222 *with* Errata for ASC X12N 837/05010X222A1) and institutional data (currently using implementation guide ASC X12N 837/005010X223 *with* Errata for ASC X12N 837/05010X223A2)(we will call both of them together the 5010 format) as the format for

encounter submissions. Under HIPAA (Public Law 104-191) Administrative Simplification, health plans, health care clearinghouses, and health care providers who choose to conduct transactions electronically use the 5010 format for the electronic exchange of medical, billing, and other information within the health care system. All of the HIPAA Administrative Simplification Rules are located at 45 CFR Parts 160, 162, and 164. The information is used to submit health care claims or equivalent health encounter information, carry out health plan enrollments and disenrollments, determine health plan eligibility, send and receive health care payment and remittance advices, transmit health plan premium payments, determine health care claim status, provide referral certifications and authorizations, and coordinate the benefits for individuals who have more than one health plan. The 5010's use was mandated in order to reduce handling and processing time, eliminate the inefficiencies associated with the handling of paper documents, reduce administrative burden, lower operating costs, and improve data quality and standardization.

The standard ANSI ASC X12N formats have been published and are available at Washington Publishing Company at http://www.wpc-edi.com/. The organizations responsible for adopting the standards have developed implementation guides to assist covered entities and their business associates. The guides provide comprehensive technical details for HIPAA implementation. They define the specific activities related to each transaction, list non-medical standardized code sets and directions for how data should be moved electronically. Further, the final rule associated with the establishment of the 5010 format can be found at 74 FR 3296 published on January 16, 2009.

The following table summarizes the key functions for data collection for risk adjustment and the authorizing legislation under the Social Security Act as amended by the BBA (Public Law 105-33), BBRA (Public Law 106-113), BIPA (Public Law 106-554), and most recently the MMA (Public Law 108-173) and the current regulations.

**Table 1. The Roles of Risk Adjustment/Encounters and Authorizing Legislation/Regulations**

| **Function** | **Authorizing legislation (The Social Security Act)** |
|---|---|
| Risk adjusted Part C payment | §1853(a)(1)(C), 1853(a)(3) |
| Data Collection | §1853(a)(3)(B) |
| Establishment of risk methodology and factors | §1853(a)(3)(C)(iii) |
| Publishing Part C risk factors | §1853(b)(1)(B) |
| Risk adjustment in Part C bidding (used in determination of benchmarks and premiums) | §1854(a)(6)(A)(i)<br>1854(b)(3) |
| Calculating Medicare DSH percentages, Medicare coverage purposes | 1886(d)(5)(F)(vi) |
| Quality review and improvement activities | 1852(e) |
| Payment to §1876 Cost HMOs/CMPs | 1876(h)(3) and 1861(v) |
| Payment to §1833 HCPPs | 1833(a)(1)(A) and 1861(v) |
| Payment to PACE organizations | 1894(d) |

2. Information Users

Table 1 above also summarizes the purposes for which the encounter data would be used. CMS would use the data to develop individual risk scores for risk adjusted payment under Part C. As required by law, CMS also establishes the risk adjustment methodology and annually publishes the risk adjustment factors for MA organizations and other interested entities in the Advance Notice of Methodological Changes for MA Payment Rates (every February) and the Announcement of Medicare Advantage Payment Rates (every April). Encounter data in particular could be used to calibrate the CMS-HCC risk adjustment models using MA patterns of diagnoses, utilization, and expenditures.

While establishing a risk adjustment model appropriate for the MA program is the paramount reason for collecting MA encounter data, there are other important uses of the data that will improve other key functions undertaken by CMS. Data may be used for the calculation of Medicare Disproportionate Share Hospital (DSH) payments. CMS would collect inpatient stay information for the Medicare managed care enrollees. In particular, we would collect the admission date, discharge date, HICN, Medicare hospital number/CCN. Further, we will also use the data for quality review and improvement activities. For example, MA encounter data may be used in the development and calculation of quality measures for MA organizations. Finally, as stated in the regulation, we will use the data for Medicare coverage purposes. For example, we can use encounter data for the determination of whether day limits have been exhausted and, if not, how many such days are left.

The commenters on the December 2010 PRA package asked us to address other uses of the data. Other uses for the data would include geographical acuity studies, utilization trends and detection of abuse as defined in the False Claim Act. Additional uses for the data include verifying the accuracy and validity of the reasonable costs claimed on Cost Reports submitted by §1876 Cost HMOs/CMPs and §1833 HCPPs.

3. Use of Information Technology

The encounter data would be collected 100% electronically. Encounter data would be processed through the Encounter Data Systems (EDS). A summary of the data collection/submission process is as follows.

**Encounter Data Collection/Submission Overview**

CMS is in the process of building a new suite of systems, the Encounter Data Systems (EDS), to collect and price encounter data for items and services provided to beneficiaries enrolled in MA organizations, PACE organizations, Cost HMOs/CMPs and HCPPs. The EDS would consist of the following new functionalities:

- capability to receive, edit and process encounter data,
- transaction reporting
- an operational data store,
- encounter data pricing,
- encounter data analysis and reporting system.

MA organizations and other entities would use an electronic connection between the organization and CMS to submit encounter data and to receive information in return. Submitters must sign an Electronic Data Interchange (EDI) agreement annually in advance of submission. MA organizations and other entities would have a choice between three connectivity options: CONNECT:DIRECT, File Transfer Protocol (FTP) and Gentran.

**Data Collection**

All Medicare Advantage (MA) organizations, PACE organizations, demonstration plans and cost plans (including both §1876 Cost HMOs/CMPs and §1833 HCPPs) would be required to submit encounter data. The types of Medicare Advantage organizations are: coordinated care plans (including Special Needs Plans), private fee for service plans, and Medical Savings Accounts. This would include Medicare Advantage-Prescription Drug plans, PACE organizations, , Employer Group Health Plans (both "direct contract" with an employer group and those that are offered by MA organizations), and cost plans (both §1833 HCPPs and §1876 Cost HMOs/CMPs).

MA organizations, PACE organizations, and cost plans will collect this information from providers. MA organizations, PACE organization and cost plans may choose to collect data from providers in a variety of formats which include:

- Uniform Billing Form (UB-04)
- HCFA 1500
- HIPAA compliant standard (5010 format)

**Data Submission**

As stated, we would use the electronic, HIPAA compliant standard professional and institutional version (the 5010 format) as the format for encounter submissions. The International Classification of Diseases, 9th Revision (ICD-9) and the new International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes have been approved for use in the 5010 format. Other significant data elements in the 5010 include claim pricing information, condition information, contact information, service provider information, revenue center codes, modifiers, HCPCs, diagnosis codes, and CPT codes. We will collect encounters for all services covered by affected entities. In the case of cost plans, only encounter data for services covered by the plans will be collected.

4. Duplication of Efforts

The information collection requirements contained in the regulations are not duplicated through any other effort and the information cannot be obtained from any other source. In the case of cost plans, we will obtain data from the FFS claims processing system and add it to encounter data submitted by cost plans for their cost plan enrollees to ensure correct computation of risk scores for these enrollees. Correct risk scores for these individuals are important because they will assist us in calibrating the Part C and Part D risk adjustment models. Additionally, in the absence of

encounter data for cost plan enrollees, risk scores for them under Part D would be inaccurate. (Many cost plan enrollees, both §1876 Cost HMO/CMP and §1833 HCPP enrollees, are enrolled in Part D – either through their §1876 Cost HMO/CMP, or another Part D sponsor.) Finally, should cost plan enrollees later join a Part C plan, risk adjusted payments to that new Part C plan would be inaccurate in the absence of cost plan encounter data.

For §1876 Cost HMOs/CMPs and §1833 HCPPs, CMS will only require submission of encounter data for items/services for which such plans claim costs on their CMS Cost Reports or for items/services not reimbursed by FFS Medicare.

5. Small Businesses

The collection of information would have a minimal impact on small businesses or other small organizational entities since the applicants must possess an insurance license and be able to accept risk. Generally, state statutory licensure requirements effectively prevent small organizations from accepting the level of risk needed to provide the medical benefits required in the Medicare Advantage program.

For cost plans (both §1876 Cost HMOs/CMPs and §1833 HCPPs), the average enrollment is over 10,000 Medicare enrollees per cost plan and cost plan sponsors have substantial enrollment in the form of commercial membership (§1876 Cost HMOs/CMPs) or other employer group members (§1833 HCPPs). While the issue of accepting risk is not germane to cost plans, CMS will mitigate impacts on small businesses by reimbursing 100% of the reasonable costs these plans incur in establishing and maintaining encounter data processes needed to compile and transmit information to CMS. CMS will provide payment for the full reasonable cost for gathering and transmitting such data to CMS, consistent with 42 CFR 417.550 et seq. Such full payment for the reasonable costs incurred for gathering and transmitting such data can include reasonable start-up costs incurred in 2011. Consistent with our long-standing policy, we will not reimburse full cost for the creation or enhancement of data systems that can be used for other purposes. Reasonable costs for system's development or enhancement may, however, be claimed (where appropriate) under normal administrative and general cost reimbursement rules found in §417.564.

6. Collection Frequency

We have clarified the submission timeframes here based on the public comments we received on the PRA package published in December 2010, which asked for clarification, and our experience with Prescription Drug Event and Risk Adjustment Data. All claim types, including hospital inpatient, hospital outpatient, and physician encounter data would be required to be submitted according to a specific schedule that is based on the size of the MA (or other entity) contract. The schedule is shown in the table below.

| Number of Medicare Enrollees | Minimum Submission Frequency |
|---|---|

| | |
|---|---|
| Greater than 100,000 | Weekly |
| 50,000 – 100,000 | Bi-weekly |
| Less than 50,000 | Monthly |

This more frequent submission process would mitigate the volume constraints. PACE organizations and §1876 Cost HMOs/CMPs and §1833 HCPPs would have similar options and requirements. Data collection will commence, subject to OMB approval, January 3, 2012. Because of their unique characteristics, data collection for PACE organizations will begin January 2013. CMS would publish the final submission deadlines as we do for risk adjustment data in the Call Letter each year. MA organizations and other entities are encouraged to submit data more frequently. Medicare Advantage organizations and other entities must submit encounter data within 13 months of the claim's date of service.

7. Special Circumstances

There are no special circumstances for this information collection request.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice was published on December 17, 2010. As stated, we received comments requesting that we expand the submission deadlines for encounter data, more accurately address the burden of implementing encounter data, provide sufficient detail on the use of encounter data, and clarify the applicability to non-MA plans. We have made changes throughout the PRA package to address these comments.

CMS has consulted with industry through regular user group conference calls, plan interviews, work groups and meetings with trade associations. CMS conducted a national meeting in October 2010 and conducted regional IT Technical Assistance sessions.

We received several comments on the burden the new encounter data system will place on plans in response to our December 2010 posting of this PRA package. CMS appreciates that the system implementation timeline for encounter data and ICD-10 may place additional burden on some of the Medicare Advantage Organizations (MAO) and Third Party Administrators (TPA). The Plans were informed of the implementation of Encounter Data through the Advanced Notice published February 2010, technical requirements were provided in the April 2010 Rate Announcement, and additional information regarding the implementation schedule and requirements were discussed during the National Encounter Data meeting held on October 29, 2010 and the 2012 Advance Notice and Rate Announcement. In December 2010, CMS began hosting multiple Encounter Data Work Groups and Industry Update meetings to further define requirements and address solutions to known concerns. CMS also hosted Regional IT Technical Assistance Sessions throughout the summer of 2011. This forum for communication between CMS, Medicare Advantage Organizations (MAOs), Third Party Administrators and others have been invaluable in finalizing requirements to support a successful implementation of the collection of encounter data.

The following table provides a detailed schedule of all events hosted by CMS providing information and updates on the implementation of the Encounter Data System.

| Date | Event |
|---|---|
| 10/29/2010 | Encounter Data National Meeting |
| 12/8/2010 | Third Party Submitter Workgroup |
| 12/15/2010 | Chart Review Workgroup |
| 1/12/2011 | Editing & Reporting Workgroup |
| 1/19/2011 | Industry Wide Update |
| 1/26/2011 | PACE Organization Workgroup |
| 2/9/2011 | Collection Strategies Workgroup |
| 2/16/2011 | Chart Review Workgroup |
| 2/23/2011 | Third Party Submitter Workgroup |
| 3/2/2011 | Editing & Reporting Workgroup |
| 3/16/2011 | Industry Wide Update |
| 4/20/2011 | Encounter Data Call |
| 5/25/2011 | Industry Wide Update |

In these forums, CMS discusses the need for encounter data submission, provides technical assistance, listens to concerns, invites feedback, gathers information, and provides operational guidance for stakeholders.

As noted above, CMS held a national meeting to discuss encounter data in October 2010. The goal of this meeting was to discuss the approach to encounter data collection, provide the implementation schedule, and provide system requirement information. Additionally, this meeting provided an opportunity for managed care organizations to ask questions regarding the collection of encounter data.

We have provided and continue to provide technical assistance sessions that would provide detailed information and instruction on the latest data collection requirements. These sessions were designed for MA organizations, PACE, and cost plan staff involved in data submission in various capacities from executive management to operations and IT systems.

The table below provides the dates and locations for the Regional IT Technical Assistance sessions held in the summer of 2011.

| Regional IT Technical Assistance Sessions | |
|---|---|
| **Date** | **Event** |
| June 20 - Jun 24, 2011 | Orlando, FL |
| July 11 - 15, 2011 | San Diego, CA |

| | |
|---|---|
| August 1 - 5, 2011 | Chicago, IL |

9. Payments/Gifts to Respondents

Many conditions must be met for payment. This is just one requirement for participation in MA, PACE and cost plans. There are no gifts to respondents.

10. Confidentiality

The data are protected and kept confidential under System of Record (SOR) #09-70-0005.

We also note that any electronic claims or encounter data sent from providers (hospitals and physicians) to MA and PACE organizations and cost plans are HIPAA-covered transactions. The HIPAA Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164) provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. The Security Rule (45 CFR Part 160 and Subparts A and C of Part 164) specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information.

11. Sensitive Questions

There are no sensitive questions included in this collection effort.

12. Burden Estimates (Hours & Wages)

The burden placed on MA and MA-PD plans (contracts), PACE organizations and cost plans (§1876 Cost HMOs/CMPs and §1833 HCPPs) associated with submitted encounter data is predicated upon the following factors: a) the amount of data that must be submitted; b) the number of plans submitting data; and c) the time required to complete the data processing and transmission transactions. We have updated the cost information below based on the public comments we received on the December 17, 2010 PRA package. We have also updated the information to include PACE organizations and cost plans.

a) Encounter Data Submission: The amount of data that must be submitted is a function of the number of encounters per beneficiary and the number of data elements per encounter. Plans should have most of the encounter data, as this transaction format is required by HIPAA. In order to estimate the number of encounters we must use FFS claims data as plans have not begun encounter data submission. FFS claims are similar to encounters, in that they are also based on a beneficiary's interaction with a health care provider. Based on 2008 enrollment data, CMS estimates that 35,554,955 Medicare beneficiaries enrolled in FFS. In 2008, the number of FFS claims was

1,162,310,929. The minimum beneficiary claim count was 0. The maximum claims per beneficiary were 1,501. To compute the average number of encounters per FFS beneficiary, we divide the number of FFS claims per year by the number of FFS beneficiaries enrolled in that year. This computation leads to an average of 32.7 FFS claims per beneficiary per year. We have increased the frequency of response by 30% to include the chart reviews that plans complete. To compute the number of projected MA encounters per year, we multiply the average FFS claims per beneficiary per year by the number of Medicare beneficiaries enrolled in MA and MA-PD plans per year. The number of projected Medicare managed care encounters per year is 398,396,363.

**TABLE 1**

| | | | NOTES |
|---|---|---|---|
| A | NUMBER OF FFS CLAIMS PER YEAR | 1,162,310,929 | The number is based on FFS claims in 2008 |
| B | NUMBER OF FFS ENROLLEES PER YEAR | 35,554,955 | Based on 2008 enrollment data |
| C | FREQUENCY OF RESPONSE | 42.5 | Average encounters per beneficiary per year = (A) divided by (B), Add 30% for chart review |
| D | NUMBER OF MEDICARE BENEFICIARIES ENROLLED IN MA AND MA-PD PLANS PER YEAR | 11,744,375 | Number of Medicare beneficiaries enrolled in Part C |
| E | NUMBER OF MEDICARE BENEFICIARIES IN PACE ORGANIZATION PER YEAR | 20,000 | Number of Medicare beneficiaries enrolled in PACE |
| F | NUMBER OF MEDICARE BENEFICIARIES IN COST HMOs/CMPs | 358,000 | Number of Medicare beneficiaries enrolled in Cost HMOs/CMPs |
| G | NUMBER OF MEDICARE BENEFICIARIES IN HCPPs | 61,000 | Number of Medicare beneficiaries enrolled in HCPPs |
| H | NUMBER OF PROJECTED MA ENCOUNTERS PER YEAR | 517,793,438 | C multiplied by (D+E+F+G)* |

*We made no adjustment to account for lower volume of encounters expected from "billing option (1)" Cost HMOs/CMPs and HCPPs - which will not submit Part A claims. Impact estimated at less than .3% .

b) Number of MA/MA-PD, PACE, and Cost Plan Contracts (Respondents): The number of MA/MA-PD, PACE and Cost Plan contracts per year is 827 (based on 2011 data).

| TABLE 2 | | | |
|---|---|---|---|
| | | | NOTES |
| A | NUMBER OF RESPONDENTS | 827 | 827 is the number of Part C, PACE contracts, and cost plans from 2011 |

c) Time Required to Process Data: The third factor that contributes to the burden estimate for submitting encounter data depends upon the time and effort necessary to complete data transaction activities. Since our regulations require plans/sponsors to submit encounter data to CMS that can be linked at the individual level to Part A and Part B data in a form and manner similar to the current processes for risk adjustment and prescription drug event data, the data transaction timeframes will be based on risk adjustment (Part C) and prescription drug industry experiences. Moreover, our encounter data submission format will only support electronic formats. The industry's estimated average processing time for electronic data submission is 15,000 records or transactions per hour. Since we project 517,793,438 transactions, we expect 34,520 transaction hours for the industry. The risk adjustment estimated average annual electronic processing time cost per hour is $15.00. We have doubled this cost for encounters, because of the increased amount of data that must be processed. This brings the estimated annual electronic processing time cost per hour to $30.00. Thus, the estimated cost of transaction hours is $1,035,600. We divided this by the number of managed care beneficiaries to get the cost of encounter transactions per beneficiary and multiply this by the average number of beneficiaries in the plan to get the cost per plan. The estimated cost for that effort is $ 1,325.88 per plan per year. These calculations are illustrated in Table 3 below.

| TABLE 3 | | | |
|---|---|---|---|
| | | | NOTES |
| A | NUMBER OF RESPONDENTS | 827 | 827 is the number of managed care contracts from 2011 |
| B | NUMBER OF MEDICARE BENEFICIARIES ENROLLED IN MEDICARE MANAGED CARE PLANS PER YEAR | 12,183,375 | Number of Medicare managed care enrollees in Part C, PACE, Cost HMOs/CMPs and HCPPs |
| C | AVERAGE NUMBER OF MA AND MA-PD BENEFICIARIES PER PLAN | 14,732 | (B) divided by (A) |
| D | FREQUENCY OF RESPONSE | 42.5 | Average encounters per beneficiary per year from Table 1 |
| E | NUMBER OF PROJECTED | 517,793,438 | D multiplied by B |

| | | | |
|---|---|---|---|
| | MA ENCOUNTERS PER YEAR FOR INDUSTRY | | |
| F | NUMBER OF TRANSACTIONS PER HOUR | 15,000 | Industry's estimated average processing volume per hour |
| G | TOTAL ANNUAL TRANSACTION HOURS | 34,520 | (E) divided by (F) |
| H | AVERAGE ELECTRONIC COST PER HOUR | $30.00 | Based on $30.00 per hour, the current risk adjustment estimated average annual electronic processing cost per hour doubled because of increased data |
| I | COST OF ANNUAL TRANSACTION HOURS | $1,035,600 | (G) multiplied by ( H) |
| J | AVERAGE COST PER PART C BENEFICIARY | $.09 | (I) divided by (B) |
| K | ANNUAL COST TO RESPONDENTS | $1,325.88 | (J) multiplied by ( C) |

13. Capital Costs

We do not anticipate significant start-up costs for any new MA plans, PACE organizations, and other entities submitting data. The capital and operational costs for this data collection that may be incurred by MA organizations should be part of their customary and reasonable business practices. Health plans will be required use the 5010 format for electronic transactions with the submission of ICD-10 data, so it is likely they already collect these data in this format and have communication protocols in place with CMS. Also, these entities have sufficient capital assets in place to address reporting encounter data.

MA organizations and other entities will need to rework the 5010 to an appropriate outbound file format and certain fields may need to be reformatted according to the MA Encounter Data specifications. MA organizations and other entities may choose to participate in our encounter data technical assistance program for which they are only responsible for the cost of travel. MA organizations and other entities will need to interface with our new front end, have the capability to send CMS more data and resolve more errors. MA organizations and other entities will need to participate in testing to ensure a clean transmission to CMS and internal testing to ensure inbound data maps to the outbound data correctly prior to the time they begin to send data to CMS. They will need to test and certify claims of each type. We expect the cost of these activities to be less than $10,000. The cost to purchase each standard ANSI ASC X12N format from the Washington Publishing Company at http://www.wpc-edi.com/ is currently $525. We also expect that plans will need to add about .5 FTE for responding to reports received from the Encounter Data Processing System and other manual interventions. This is based on the average plan size. The number of FTEs that a plan will need to add vary depending on the size of the plan and the number of claims

received. We expect that the addition of .5 FTE will cost approximately $25,000. This is based on a salary of $50,000.

For cost plans – both §1876 Cost HMOs/CMPs and §1833 HCPPs – although there may be start-up costs, as we have said, we will reimburse the full reasonable cost under our authority in 42 C.F.R. §417.550, including those reasonable start-up costs incurred in 2011. We believe for cost plans this will represent less than $10,000/plan. As there are currently 11 HCPPs and 20 Cost HMOs/CMPs, this would amount to, at most, $310,000 – which costs are all also captured below, under Costs to the Federal Government.

For MA and PACE organizations, note that any administrative and/or capital costs incurred will be recouped through the bidding process.

14. Cost to Federal Government

The costs to the Federal Government for data collection can best be described as the total costs of acquiring and preparing the required data for MA organization payment calculation. Calculation of the precise costs for all processes involved in the data collection is not feasible for the purposes of the Paperwork Reduction Act without conducting a costly study. It is also difficult to disaggregate efforts and resources used for encounter data collection and preparation from other MA payment processes and data collection efforts. Therefore, aggregate costs have been estimated taking into consideration programming, software, technical assistance, tapes, overhead costs, etc. CMS's total cost for implementing encounter data collection is expected to be approximately $24.7 million. Costs to the Federal Government also include reasonable costs CMS will reimburse to Cost plans under our authority in 42 C.F.R. 417.550.

| | Cost |
|---|---|
| Software Development | $20 million |
| Technical Support | $4 million |
| FTE | $700,000 |
| Cost plan start-up costs | $310,000 |
| Totals | 25.01 million |

15. Changes to Burden

The 60-day Federal Register notice was published on December 17, 2010. We received comments on that package, asking that we more accurately address the burden of implementing encounter data. We have made changes to B.12, B.13, and B.14 in order to address these comments.

16. Publication/Tabulation Dates

The purpose of this data submission request is to support the payment of Medicare Advantage for beneficiaries who are members of Part C plans and to verify the accuracy and validity of the reasonable costs claimed on Cost Reports submitted by §1876 Cost HMOs/CMPs and §1833

HCPPs. There are no publication and tabulation dates.

17. Expiration Date

This information collection effort does not involve a data collection instrument (i.e. Survey or form). The display of an expiration date is not applicable.

18. Certification Statement

CMS has no exceptions to Item 19, “Certification for Paperwork Reduction Act Submissions” of OMB Form 83-1.