Supporting Statement for Paperwork Reduction Act Submission
Part C Medicare Advantage Reporting Requirements and
Supporting Regulations in 42 CFR 422.516(a)
CY 2016 and CY 2017
CMS-10261, OMB 0938-1054

Background

The Centers for Medicare and Medicaid Services (CMS) established reporting requirements for Medicare Advantage Organizations (MAOs) under the authority described in 42 CFR 422.516(a). It is noted that each MAO must have an effective procedure to develop, compile, evaluate, and report to CMS, its enrollees, and the general public at the times and in the manner that CMS requires. At the same time, each MAO must, in accordance with 42 CFR 422.516(a), safeguard the confidentiality of the doctor-patient relationship, statistics and other information with respect to the following:

(1) The cost of its operations.
(2) The patterns of service utilization.
(3) The availability, accessibility, and acceptability of its services.
(4) To the extent practical, developments in the health status of its enrollees.
(5) Information demonstrating that the MAO has a fiscally sound operation.
(6) Other matters that CMS may require.

CMS initiated new Part C reporting requirements that were approved by the Office of Management and Budget (OMB) on December 24, 2008. The initial ICR involved 13 "measures" now termed "reporting sections." Four of these 13 reporting sections have been suspended from reporting: Reporting Section # 1 *Benefit Utilization*; Reporting Section #3 *Provider Network Adequacy*; Reporting Section #10 *Agent Compensation Structure* and; Reporting Section #11 *Agent Training and Testing*. One new reporting section was added beginning 2012: # 13 *Enrollment and Disenrollment*.

The changes proposed in this 2016 iteration include three new reporting sections: Rewards and Incentives Program, Mid-Year Network Changes and Payments to Providers.

Rewards and Incentives CMS has added a new regulation at 42 CFR §422.134 that permits MA organizations to offer one or more Rewards and Incentives Programs to currently enrolled members. Plans have a choice as to whether or not they offer a Rewards and Incentives Program(s), but if they do, they must comply with the regulatory requirements set forth at §422.134. CMS needs to collect Rewards and Incentives Program data in order to track which MA organizations are offering such programs and how those programs are structured. This will inform future policy development and allow CMS to determine whether programs being offered adhere to CMS standards and have

proper beneficiary protections in place.

Mid-Year Network Changes This section is similar to a reporting section, "Provider Network Adequacy," that was suspended in 2013. Because CMS is increasing its oversight and management of MAOs' network changes in order to ensure that changes made during the plan year do not result in inadequate access to care for enrolled beneficiaries and that MAOs are provided timely and appropriate notification to providers and enrollees. The data collected in this new measure will provide CMS with a better understanding of how often Medicare Advantage Organizations (MAOs) undergo mid-year network changes and how many enrollees are affected. The new section has 52 data elements, an increase from 13 data elements that were set out in the 60-day PRA package. The increased number of elements is to add specificity in response to comments received on the 60 day notice. Collecting these data also will help to inform CMS in determining how broadly to use the new Network Management Module (NMM) in the Health Plan Management System (HPMS) to verify that plans' networks meet CMS network adequacy standards. In addition, responses from MAOs will enhance CMS' ability to improve network change protocols.

Payments to Providers This section is new in the 30-day PRA package and seeks to capture data related to MA organizations' value-based payments. CMS is adding this new requirement based on internal review. In order to maintain consistency with HHS goals of increasing the proportion of payment made based on quality and value, HHS developed four categories of value based payment: fee-for-service with no link to quality; fee-for-service with a link to quality; alternative payment models built on fee-for-service architecture; and population-based payment. CMS is seeking to collect data from MA organizations about the proportion of their payments to providers made based on these four categories in order to help us understand the extent and use of alternate payment models in the MA industry.

Three reporting sections were enhanced by adding additional data elements: Organization Determinations/Reconsiderations (ODR), Special Needs Plans Care Management (SNPs), and Enrollments/Disenrollments.

Organization Determinations/Reconsiderations For ODR, two new data elements would be added: Number of Requests for Organization Determinations—Dismissals, and Number of Requests for Reconsiderations—Dismissals. These additions will fill user needs for data on dismissals and make this reporting section more consistent with a similar reporting section in Part D, Coverage Determinations and Redeterminations.

Special Needs Plans Care Management In addition to reporting on the number of health risk assessments (HRAs) provided within the required timeframe, SNPs also will report the HRAs completed within an expanded required timeframe and will be able to show enrollee refusals to complete HRAs and the SNPs' unsuccessful efforts to reach enrollees in order to perform HRAs. The SNP must document in its internal records that the enrollee did not respond to at least 3 phone calls and a follow up letter, all soliciting participation in the HRA.

Enrollments/Disenrollments For the reporting section Enrollments/Disenrollments, four new

data elements would be added. These data elements would report the number of involuntary disenrollments for failure to pay plan premium in the specified time period, of these, the number of disenrolled individuals who submitted a timely request for reinstatement for Good Cause, of these, the number of favorable Good Cause determinations, and, of these, the number of individuals reinstated.

Other minor changes that do not affect the burden are also proposed in this 2016 iteration. For Part C Grievances, Sponsor Oversight of Agents, and Employer Group Plan Sponsors, the data due dates were changed to the first Monday in February. The data due date for Enrollment/Disenrollment was changed to the last Monday of August and February. This "staggering" of data due dates was proposed so that the reporting load would be more manageable in 2016 than it was in 2015 for CMS and its data system (HPMS). Also, having the data due date fall on February 28, as it was in the past, introduced problems when February 28 was on a weekend or when it occurred in a leap year. By listing weekdays, this problem is eliminated. The changes in data due dates is not be expected to change any burden estimates.

A. **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; and
5) Other matters that CMS may require.

These Part C Reporting Requirements fill the need for the data that had not been available prior to the inception of the requirements in 2008. Further information about the need for such changes is included in the Background section.

2. Information Users

There are a number of information users of Part C reporting. They include CMS central and regional office staff that use this information to monitor health plans and to hold them accountable for their performance. Among CMS users are group managers, division managers, branch managers, account managers, and researchers. Other government agencies such as GAO and OIG have inquired about this information.

Health plans can use this information to measure and benchmark their performance. CMS receives inquiries from the industry about the beneficiary use of available services, patient safety, grievance rates, and other factors pertaining to the performance of MA plans.

3. Use of Information Technology

MA organizations and other health plan organizations (e.g., cost plans) utilize the Health Plan Management System (HPMS) to submit or enter data for 100% of the data elements listed within these reporting requirements. This system is also used by MA organizations to submit applications to CMS and CMS uses the system for announcements. HPMS, therefore, is a familiar tool to MA organizations. 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

The collection of information will have a minimal impact on small businesses since applicants must possess an insurance license and be able to accept substantial financial risk. Generally, state statutory licensure requirements effectively preclude small business from being licensed to bear risk needed to serve Medicare enrollees.

6. Less Frequent Collection

Most of the Part C reporting requirements data for reporting year 2016 will be reported on an annual basis. While not a statutory or regulatory requirement, less frequent collection of these 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 42 CFR 422.504(d), MA organizations must agree to maintain for 10 years books, records, documents and other evidence of accounting procedures and practices.

8. Federal Register/Outside Consultation

8.1 Federal Register: 60-day Notice

The 60-day Federal Register notice published on May 1, 2015 (80 FR 24934). Comments were received. A summary of the comments and our response has been added to this package as Appendix A.

We added four data elements to improve monitoring capability under the SNPs Care Management reporting section. This change increased our currently approved burden estimate by 1,416 hr. We also increased the data elements from 13 to 52 under the new Mid-Year Network Changes reporting section. This change increased our burden estimate by 6,014 hr.

While the 60-day notice set out a burden of 201,503 hours, we are adjusting that estimate by -19,480 hours to a total of **182,023** hours. Based on internal review, the 60-day estimate contained a computational or transcription error of 27,560 which has been eliminated in the 30-day iteration. We also added a new requirement, Payments to Providers, which accounted for an additional 8,080 hours in this 30-day iteration.

Please see section 15 for a discussion of the changes to the currently approved requirements/burden.

8.2 Federal Register: 30-day Notice

A 30-day notice was published on August 24, 2015 (80 FR 51275) but was subsequently withdrawn based on internal review. A revised notice published on September 18, 2015 (80 FR 56468). Comments on the second 30-day notice were received and CMS responses are contained in Appendix B.

The comments involved identifying a missing data element, a clarification of the definition of an "affected enrollee," questions about definitions of data elements, a question about when data were due for the new reporting section, and a discussion by one commenter about increased reporting. The burden increase was contained in the ICR, and CMS believes the reporting requirements are feasible and appropriate. Appendix C contains the crosswalk which summarizes changes in this Information Collection Request compared to the 2015 iteration.

The revised notice published on September 2015 Information Collection Request added a new requirement for MA organizations to report the extent to which their MA payments are tied to alternative payment arrangements. In January 2015, Secretary Burwell announced the goal of tying 30 percent of all traditional Medicare payments to quality or value through Alternative Payment Models (APMs) by 2016 and 50 percent of all traditional Medicare payments to quality or value by 2018. In April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act, which included many APM provisions. The Secretary's announcement coupled with this legislation solidified APMs as a major priority for CMS. Given the added Congressional interest in APMs, CMS believes it is urgent to collect information about APMs from MA organizations. In order to maintain consistency with HHS goals of increasing the proportion of payment made based on quality and value, HHS developed four categories of value based payment: fee-for-service with no link to quality; fee-for-service with a link to quality; alternative payment models built on fee-for-service architecture; and population-based payment. CMS is seeking to collect data from MA organizations about the proportion of their payments to providers made based on these four categories in order to help it understand the extent and use of alternate payment models in the MA industry.

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 regarding confidentiality.

11. Sensitive Questions

Consistent with federal government and CMS policies, CMS will protect the confidentiality of the requested proprietary information. Specifically, only information within a submitted application (or attachments thereto) that constitutes a trade secret, privileged or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), and is clearly labeled as such by the Applicant, and which includes an explanation of how it meets one of the expectations specified n 45 CFR Part 5, will be protected from release by CMS under 5 U.S.C. §552(b)(4). Information not labeled as trade secret, privileged, or confidential or not including an explanation of why it meets one or more of the FOIA exceptions in 45 CFR Part 5 will not be withheld from release under 5 U.S. C. § 552(b)(4).

12. Burden Estimates (Hours & Wages)

The burden associated with this ICR is the time and resources it takes to develop computer code, to "de-bug" computer code, gather the "raw" data, "clean" the data in order to eliminate errors, enter data, to compile the data, review technical specifications, and perform tests on the data. This burden also included aspects of burden that were not strictly "technical." These "non-technical" aspects of the burden include time to read instructions, answer the questions, research solutions to any impediments, developing estimates of any additional human resources needed, and other administrative time and resources involved in developing the reporting sections.

12.1 Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2014 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits, and the adjusted hourly wage. Anticipated staff performing the activities required of this data collection and reporting vary, but we believe computer systems analysts would be the primary staff person responsible for this work. We believe that other staff that are involved have a similar wage therefore we use an average hourly rate of $83.96 (including the fringe benefits adjustment) was used to calculate estimated costs.

We adjusted our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary

significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method

National Occupational Mean Hourly Wage and Adjusted Hourly Wage:
Computer Systems Analysts

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr.)	Fringe Benefit ($/hr.)	Adjusted Hourly Wage ($/hr.)
Computer Systems Analyst	15-1121	41.98	41.98	83.96

12.2 Burden Estimates

Anticipated staff performing the activities required of this data collection and reporting would be computer systems analysts. An average competitive hourly rate (including wages, benefits and overhead) of $83.96/hr. was used to calculate estimated costs (see above for details).

2016-2017 Burden Estimates for Part C Reporting Requirements by Reporting Section

Reporting Section	Estimate	
	Hours	Cost ($)
Organization Determinations / Reconsiderations	74,528	6,257,371
SNPs Care Management	3,728	313,003
Enrollment/Disenrollment	319	26,783
Rewards and Incentives Program(s)	1,960	164,562
Mid-Year Network Changes	7,968	668,993
Payments to Providers	8,080	678,397
Remaining 5 reporting sections total (no changes)	85,440	7,173,542
Total for 10 reporting sections	**182,023**	**15,282,651**

Note: Figures in above table are subject to rounding.

These hours and costs pertained to all respondents. However, based on organization type, which varies among the plans, not all respondents (plans) complete all reporting sections. The reporting sections that are not new—Organization Determinations and Reconsiderations, SNPs Care Management, Enrollment/Disenrollment, and the remaining 5 reporting sections that are unchanged—are based on previous estimates supplied in an ICR and applying a factor proportionate to the percent increase in data elements made necessary by the need for additional data. The hours for the reporting sections that are new – Rewards and Incentives Program(s), Mid-Year Network Changes, and Payments to Providers – are based on estimates that factor in the amount of contracts presently active with hours and wages based on May 2014 BLS data BLS data + 100 % adjustment for fringe.

12.3 Burden Summary

The proposed annual burden estimates for 2016-2017 are as follows:

Respondents = 562
Responses per respondent = 5.47
Total annual responses = 3,072
Hours per response = 59.25
Total annual hours = 182,023
Total annual cost=$**15,282,651**

Please note that respondents usually have more than one response per respondent. This is because each reporting section is counted as one response and respondents (plans) generally report on multiple reporting sections. If a plan reports on five sections annually, that would be five responses for that plan.

13. Capital Costs

There is no capital cost associated with this collection because as indicated above, MAOs are familiar with the electronic system used to fill out this data, HPMS.

14. Cost to Federal Government

The estimated annual cost is $300,000 to support reporting through the Health Plan Management System (HPMS). This is the same as previously reported. This is a “standard” estimate that we have used in our ICRs when the Health Plan Management System resources support the CMS information processing and reporting role.

15. Changes to Burden

While we estimated an hourly wage of $64.57/hour in our currently approved package, in this 2016 iteration we are adjusting our employee hourly wage estimate by a factor of 100 percent to a wage of $83.96/hr.

The total increase in hours is estimated at **12,465** hours while the total cost increase is estimated at $**4,334,290**. This increase is from the last approved collection in May 2014.

15.1 Organization Determinations and Reconsiderations

We estimated the number of contracts reporting in 2016 based on the number of contracts reporting in CY 2014 (n=544). The number of annual responses for this reporting section was 544 x 1=544 since this section is reported annually.

Adjustment

Based on more recent data we are adjusting our 2014 estimate from 75,264 hour to 69,632 hour for a decrease of -5,632 hr. Our 2014 estimate of the number of contracts involved was too high and we lowered that estimate based on data that were more recent at the time of this ICR. That is, we lowered the estimated number of contracts (respondents) from 588 to 544 based on more recent data.

Program Change

Separately, for Organization Determinations and Reconsiderations, we propose to increase the number of data elements from 29 to 31, and therefore, increase the reporting burden by 6.9 percent.

Per contract, this increase was from 128 hr to 137 hr for a total increase of 4,896 hr (74,528 hr – 69,632 hr).

2014	69,632 hr = 544 x 128 hr/contract
2016	74,528 hr = 544 x 137 hr/contract

Total Change

The net change is –736 hr (4,896 hr – 5,632 hr) or (74,528 hr - 75,264 hr).

15.2 Special Needs Plans (SNPs) Care Management

Adjustment

The number of SNPs decreased from 261 in CY 2014 to an estimated 233 in CY 2016.

Program Change

We propose to double the number of data elements (from 4 to 8) in this reporting section so that SNPs can accurately report enrollee refusal to complete a Health Risk Assessment and report attempts to reach enrollees who have not completed an Health Risk Assessment within

the required time-frame. Consequently, we estimate that the average number of hours per contract would double (from 8 to 16).

Total Change

2014 2,088 hr = 261 x 8 hr/contract
2016 3,728 hr = 233 x 16 hr/contract

The proposed increase in burden from 2014 to 2016 is 1,640 hours (3,728 hr – 2,088 hr) and $137,694.

15.3 Enrollment/Disenrollment

Under Part C reporting, these are contracts with no Part D Medicare enrollment, necessarily a small group of contracts. Using 2014 data, the latest data available at the time this ICR was developed, 10 contracts, all of them 1876 cost contracts with no Part D Medicare, reported enrollment/disenrollment under Part C. We estimate that 10 contracts would report in 2016. All of these contracts reported in 2014.

Adjustment

Based on more recent data we are adjusting our 2014 estimate from 1,166 hour to 240 hour for a decrease of -926 hour. We should have used 10 contracts in 2014 instead of 16 which we used in that ICR. This was because we included 6 contracts that also offered Part D. Those contracts are supposed to be reported under Part D RR. Also, we now believe that a lower estimate for hours per contract for reporting this section twice per year is 24 hours—12 hours for each reporting cycle instead of our 2014 estimate of 36 hours per reporting cycle. That is why we now believe that a better estimate of the 2014 total hours is 240 hours (24 hours/contract x 10 contracts.) We increased the data elements by 33.3 percent for 2016, accounting for our estimate of 319 hours.

Program Change

We used an estimated 24 hours for each contract for 2014. We are still proposing an increase in the hourly burden of 33.3 percent for 2016 due to the addition of a 33.3 percent increase in data elements—from 12 to 16.

The total increase in estimated hourly burden across the 10 contracts was from 240 in 2014 to 319 in 2016, an increase of 79 hours. The proposed increase in cost is still: (319 x $83.96/hr.) – (240 x $83.96/hr.) = 79 x $83.96/hr. = $6,633.

The change in due date is not expected to affect any burden estimates.

Total Change

The net change is –847 hr (79 hr – 926 hr) or (319 hr – 1,166 hr).

15.4: Rewards and Incentives (RI) Program

We arrived at the numbers for the RI Program by estimating that 30% of contracts will have RI Programs. This estimation is based on discussions and inquiries from the industry and considering the number of contracts held by the organizations that have contacted us to discuss such programs. We estimated that it would take 8 hours to fully and accurately complete the survey questions in this first year. HPMS indicated that we had 814 active contracts for CY 2015. We estimated that 30% of those contracts (or 245) would report. Thus, we estimated 1,960 hour (245 contracts x 8 hour/contract) for this reporting requirement.

15.5 New Reporting Section: Mid-Year Network Changes

For Mid-Year Network Changes, we estimate 498 contracts (Regional CCPs, Local CCPs, and 1876 Cost Plans are the organization types that report on this section). We propose to collect 53 data elements and estimate 16 hours per contract to collect and report the data for the first year of reporting. In aggregate, we estimate 7,968 hour (498 contracts x 16 hour/contract).

15.6 New Reporting Section: Payments to Providers

For Payments to Providers, we estimate 505 contracts (Regional CCPs, Local CCPs, PFFS and 1876 Cost Plans are the organization types that report on this section). We estimate that the average hours per contract to collect and report these data in the first reporting year is 16 hours. In aggregate, we estimate 8,080 hr (505 contracts x 16 hr/contract).

Summary of Key Estimates for New Reporting Sections

Name of Reporting Section	# Contracts	Average # Hours Per Contract	Total Hours	Cost Per Hour ($/hr)	Total Costs ($)
Rewards and Incentives Programs	245	8	1,960	83.96	164,562
Mid-Year Network Changes	498	16	7,968		7,968
Payments to Providers	505	16	8,080		8,080
TOTAL	1,248	14.43 (ave)	18,008	83.96	180,610

*Note: Cost estimates are subject to rounding errors.

15.7 Remaining 5 Reporting Sections

There are no changes to the five remaining reporting sections. We have no basis to predict an increase in hours for 2016 for these five sections; therefore, for these five reporting sections, we used the 2014 time estimate for the 2016 time estimate.

Our cost estimate, however, has increased by $1,656,681 in response to the increase of our adjusted hourly wage which was based on more recent BLS wage data.

15.8 Hospital Acquired Conditions

Subsequent to the issuance of the April 7, 2014, Notice of Action, the "Hospital Acquired Conditions" reporting section was suspended and was not part of CY 2014 Part C reporting requirements. This reduced our 169,558 estimate by -5,600 hr.

15.9 Changes to ICR Attachments

The currently approved package includes a number of attachments which are no longer applicable or are duplicative. Specifically, Attachment III (Medicare Advantage Medical Utilization and Expenditure Experience) has been removed since CMS collects similar information elsewhere. Attachments IV (Mapping of MA PBP to Medical Utilization and Expenditure Experience) and V (Codes to Identify Procedures/ Serious Adverse Reportable Events Codes/ Hospital Acquired Conditions) are obsolete. The information in Attachments I (Part C Reporting Overview) is now included in the Technical Specifications document.

15.10 Summary of Changes in Burden Between 2014 and 2016/2017

Reporting Section	2014 Burden Estimate		2016/2017 Burden Estimate		Change	
	Hours	Cost (in dollars at $64.57/hr)	Hours	Cost (in dollars at $83.96/hr)	Hours	Cost
Organization Determinations/Reconsiderations *	75,264	4,859,797	74,528	6,257,371	-736	1,397,574
SNPs Care Management	2,088	134,822	3,728	313,003	1,640	178,181
Enrollment/Disenrollment	1,166	75,289	319	26,783	-847	-48,506
Rewards and Incentives Program(s)	0	0	1,960	164,562	1,960	164,562
Mid-Year Network Changes	0	0	7,968	668,993	7,968	668,993
Payments to Providers	0	0	8,080	678, 397	8,080	678,397
Remaining 5 reporting sections total (no program changes, only adjust cost)	85,440	5,516,861	85,440	7,173,542	0	1,656,681

Hospital Acquired Conditions (suspended, see below)	5,600	361,592	0	0	-5,600	-361,592
TOTAL	**169,558**	**10,948,361**	**182,023**	**14,604,254**	**12,465**	**4,334,290**

Note: Figures in above table are subject to rounding.

16. Publication/Tabulation Dates

N/A.

17. Expiration Date

We will display the expiration date although the form may be revised before the expiration date.

18. Certification Statement

There are no exceptions.

B. Collections of Information Employing Statistical Methods

This information collection does not require statistical analyses to be conducted by CMS.