Supporting Statement, Part A
Medicare Advantage Appeals and Grievance
Data Disclosure Requirements (42 CFR 422.111)
CMS-R-282, OMB 0938-0778

Background

Part 422 of Title 42 of the Code of Federal Regulations (CFR) distinguishes between certain information a Medicare Advantage (MA) organization must provide to each enrollee (on an annual basis) and information that the MA organization must disclose to any MA eligible individual (upon request). This requirement can be found in section 1852(c)(2)(C) of the Social Security Act and in 42 CFR 422.111(c)(3) which states that MA organizations must disclose information pertaining to the number of disputes, and their disposition in the aggregate, with the categories of grievances and appeals, to any individual eligible to elect an MA organization who requests this information. Medicare demonstrations, such as Dual Eligible Special Need Plans (D-SNP), also are required to conform to MA appeals regulations and thus are included in the count of organizations. Such demonstrations, as well as MA organizations, are collectively referred to as "Medicare health plans" in this Supporting Statement. Data collection/disclosure categories are based on the Medicare health plan's grievance and appeals processes as prescribed under 42 CFR part 422, subpart M.

An organization determination, defined in § 422.566, is a Medicare health plan's coverage decision – i.e., the decision whether to pay for or provide an item or service. When a Medicare health plan denies coverage, an enrollee may dispute the adverse organization determination, or denial. When a Medicare health plan reconsiders its adverse organization determination, the reconsideration marks the beginning of the appeals process.

If, upon reconsideration, a Medicare health plan continues to deny an enrollee health coverage, then the plan must automatically forward the enrollee's case file to an independent review entity for it to render a final decision. For this effort, CMS requires Medicare health plans to report aggregate appeals data at both the plan's and the independent review entity's reconsideration levels.

Medicare health plans also are required by the statute and the MA regulation to provide aggregate grievance data to MA eligible beneficiaries, upon request. Regulations at § 422.564 require that Medicare health plans provide meaningful procedures for timely hearing and resolving enrollees' grievances. Section 422.561 defines a grievance as any complaint or dispute other than one involving an organization determination as defined in § 422.566(b). For this effort, CMS is only requiring that Medicare health plans report grievances that involve quality of care complaints. Since most states already regulate quality of care issues, CMS continues to expect that reporting in this area will not pose a problem for Medicare health plans.

The Balanced Budget Act (BBA) of 1997 required that MA organizations provide appeals and grievance data to beneficiaries beginning January 1, 1999.

As part of CMS's continued effort to provide information to beneficiaries concerning their Medicare health plan choices, Medicare health plans must report appeals and grievance data requested by any individual eligible to elect a Medicare health plan. The individual may use this data to evaluate and compare plan performance.

A. Justification

1. Need and Legal Basis

Medicare health plans disclose grievances and appeals information pertaining to the number of disputes and their disposition, in the aggregate, to any Medicare health plan eligible individual who requests this information. This disclosure is pursuant to section 1852(c)(2)(C) of the Social Security Act and 42 CFR 422.111(c)(3).

Medicare health plans remain under a requirement to collect and provide this information to individuals eligible to elect a Medicare health plan. We continue to use the same format and form for reporting.

2. Information Users

The information collected by plan on Medicare health plan's appeals and grievance information will be provided to individuals eligible to elect a plan, or persons or entities making the request on behalf of the individuals requesting this information. MA eligible individuals will use this information to help make informed decisions about their organization's performance in the area of appeals and grievances.

3. Use of Information Technology

There is currently no automated, electronic, mechanical, or other technological collection techniques, or other forms of information technology required for electronic submission of the responses under this effort. However, there are no barriers or obstacles that prohibit organizations from using improved technology for this information collection activity.

Government Paperwork Elimination Act (GPEA) questions concerning electronic completion are not applicable to this collection activity. For this effort, appeal and grievance data generally is being collected for enrollee informational purposes. While this collection currently is available for electronic completion by plans, we believe it is most cost beneficial to permit plans to collect this information in the format each plan finds most efficient, based on each plan's systems configurations. Since this collection does not require a signature from the respondent, CMS acceptance of electronic signatures is not applicable.

4. Duplication of Efforts

This effort involves the collection and reporting of grievance and appeals data upon request by an MA eligible individual. The purpose, content, and format of this collection is unique from other collection efforts, and guarantees beneficiaries'

access to grievance and appeals data.

5. Small Businesses

We do not anticipate small Medicare health plans will be significantly affected by these information collection requirements, since the amount of data collected will be proportionate to the number of members enrolled in the plan. In other words, the number of appeals and/or grievances to be reported should be proportionate to the member population.

6. Less Frequent Collection

Medicare health plans are required to collect data in six-month intervals. In its initial consultations with Medicare health plans, CMS determined six-month intervals would allow for the collection of meaningful data without overburdening organizations. For consistency and ease of continued implementation, CMS plans to maintain this six-month collection interval.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

The 60-day notice published in the Federal Register on December 14, 2015 (80 FR 77352). No comments were received.

9. Payments/Gifts to Respondents

Medicare health plans are under contract with CMS. The collection and subsequent disclosure of this information is required to be completed by Medicare health plans. There are no payments or gifts associated with the collection of this data.

10. Confidentiality

The data Medicare health plans are collecting is aggregate. There is no beneficiary specific information reported in the data collection. Therefore, there is no requirement needed to maintain the confidentiality of the information collected.

11. Sensitive Questions

We are not collecting any information of a sensitive nature.

12. Burden Estimate (Hours & Wages)

12.1 Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2015 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 (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Office and Administrative Support Occupations	43-0000	17.47	17.47	34.94

As indicated, we are adjusting 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.

12.2 Burden Estimates for Collecting Appeals and Grievance Data

We determined that, as of 2015, CMS contracted with 741 Medicare health plans.[1]

We determined that it would take 1 hour per collection period for each organization to collect the appeals data. CMS requires that the information be collected every 6 months,

[1] Source: CMS Statistics (Table I.7): https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2015CMSStatistics.pdf.

so the hours needed per organization would be 2 hours per year. We arrived at this figure through the presumption that the data requested by CMS is already being collected internally by each of the Medicare health plans and would therefore only have to be downloaded or compiled into a single report. In aggregate, we estimate 1,482 annual hours (2 hours x 741 Medicare health plans).

We determined the average hourly rate for the individual responsible for collecting the appeals information. The professional and analytical skills required to perform this function are similar to those of office and administrative support occupations with an hourly wage of $17.47. To account for fringe benefits and overhead costs, the adjusted hourly rate for this position is $34.94. We then multiplied this adjusted hourly rate ($34.94) by the number of hours for data collection (1,482 hours) to arrive at the annual wage burden of $51,781.08 per year.

12.3 Burden Estimates for Disclosing Appeals and Grievance Data

There are 55.3 million Medicare beneficiaries according to 2015 CMS statistics (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2015CMSStatistics.pdf -- Table I.2.)

We estimated that 0.1%, or 55,300 beneficiaries would request an appeal and/or grievance disclosure report from a Medicare health plan. We then estimated it would take approximately 5 minutes (.08 hours) for a staff person to send the appeals report to these beneficiaries. In aggregate we estimate 4,424 hours (55,300 responses per year x .08 hours/response).

We determined the average hourly rate for the individual responsible for collecting and formatting the appeals information. The professional and analytical skills required to perform this function are similar to those of office and administrative support occupations with an hourly salary of $17.47. The adjusted hourly rate for this position is $34.94. We then multiplied this adjusted hourly rate ($34.94) by the .08 hours per response estimated for reporting appeals and grievance data to arrive at $2.80 cost per response. Last, we multiplied $2.80 by the annual number of responses (55,300) to determine the total annual wage burden of $154,840 per year, or $208.96 per organization (154,840 divided by 741 Medicare health plans).

12.4 Summary of Burden Estimates

Collection Type	Frequency	No. Respondents	Total Responses	Burden per Response (time)	Total Annual Burden (hours)	Labor Cost ($/hour)	Total Cost ($)
Collecting Information	2 x year	741	1,482	1 hr	1,482	34.94	51,781

Disclosing Information	On occasion	741	55,300	0.08 hr	4,424	34.94	154,840
TOTAL	**varies**	**741**	**56,782**	**1.08 hr**	**5,906**	**34.94**	**206,621**

12.5 Collection Instruments and Associated Guidance/Instructions

The Sample Report (Appendix 2) is an appendix in Chapter 13 of the Medicare Managed Care Manual. The Sample Report is an OMB approved data form for use by Medicare Advantage organizations to disclose grievance and appeal data, upon request, to individuals eligible to elect an MA organization. By utilizing the Sample Report, MA organizations will meet the disclosure requirements set forth in regulations at 42 C.F.R. 422.111(c)(3). There are no revisions to the Sample Report (Appendix 2) in this 2016 iteration.

Included in this PRA Package are instructions for the Sample Report (Appendix 2). The form instructions serve as a reference for MA organizations on the collection and disclosure requirements of grievance and appeal data. The instructions are not revised in this 2016 iteration.

13. Capital Costs

There are no capitals costs associated with these information collection requirements.

14. Cost to the Federal Government

We do not expect a cost to the government.

15. Changes to Burden

The change in burden is due to:

- An increase in the number of Medicare health plans reporting this data (from 670 to 741 Medicare health plans);
- Consequent revisions to our estimates to reflect the increases and costs associated with producing appeals and grievance data reports for all 741 Medicare health plans; and
- The 2013 PRA package's respondent cost calculations used OPM's GS 07 Step 1 salary of $16.28/hr. In this 2016 iteration, we are using BLS data and adjusting the mean hourly wage to include fringe benefits. The cost in this iteration is using a revised wage of $34.94/hr.

16. Publication and Tabulation Dates

CMS does not plan to publish this data. The data is for CMS internal use.

17. Expiration Date

The expiration date is displayed on the sample form and the form instructions.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

N/A