

Supporting Statement for Paperwork Reduction Act Submission:
Part C Medicare Advantage Reporting Requirements and
Supporting Regulations in 42 CFR 422.516(a)
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 also has oversight authority over cost plans which includes establishment of reporting requirements. If CMS initiates any new Part C reporting requirements, the Office of Management and Budget (OMB) must approve the "Information Collection Request" (ICR) under the Paperwork Reduction Act of 1995 (PRA). National PACE plans and 1833 cost plans are excluded from reporting all the new Part C Reporting Requirements sections.

The changes for the 2017 Reporting Requirements will both require additional reporting where more information is needed to improve CMS oversight of Medicare Part C plans, and eliminate requirements either no longer applicable or needed.

Specifically, Organization Determinations and Reconsiderations will add four new data elements to the reporting section. These data elements are needed to obtain more information about case re-openings. There is a fifth data element but that is an optional field for any additional information the plan may want to provide.

For Payment to Providers, the data elements will increase from 10 to 14. The added elements will help maintain consistency with HHS goals of increasing the proportion of Medicare payments made based on quality and value and to better understand the extent and use of alternate payment models in the MA industry.

The reporting section relevant to Sponsor Oversight of Agents will be suspended in 2017 and will have a significant impact by lowering the resource utilization. CMS found the burden for this reporting requirement to be significant and we're not using the data enough to support the burden.

The enrollment and disenrollment section will decrease its data elements from 22 to 20 as part of CMS efforts to delete data elements no longer needed to monitor the Part C program, are duplicative of the requirements of Part D reporting requirements, and eliminate confusion among MA only plans.

See section 15 of this Supporting Statement for a more detailed discussion of this package's program changes and burden adjustments

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.
- 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 2017 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.
- CMS could potentially require clarification around submitted data, and therefore CMS may need to contact organizations within 60 days of data submission.

Otherwise, there are no special circumstances since this information collection request does not do any of the following:

-Require respondents to report information to the agency more often than quarterly;

-Require respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;

-Require respondents to submit more than an original and two copies of any document;

-Require respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;

-Is connected with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,

-Require the use of a statistical data classification that has not been reviewed and approved by OMB;

-Includes 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

-Require respondents to 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 Federal Register notice published on May 11, 2016 (81 FR 29268). Public comments were received. They are attached to this package along with our response.

The 30-day notice published in the Federal Register on September 12, 2016 (81 FR 62741). Those comments have been addressed and they are also attached to this package.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 in 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)

Wage Estimates

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, 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 \$86.72/hr (including the fringe benefits adjustment) was used to calculate estimated costs.

Table 2: National Occupational Mean Hourly Wage and Adjusted Hourly Wage

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefit (\$/hr)	Adjusted Hourly Wage (\$/hr)
Computer Systems Analyst	15-1121	43.36	43.36	86.72

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.

Burden Estimates

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. Also included is burden that is not strictly “technical.” “Non-technical” aspects of the burden include time to read instructions, answer questions, research solutions to any impediments, to develop estimates of any additional human resources needed, and to use other administrative resources involved in improving the reporting sections.

We used the average hour estimates per contract and reporting section that were applied in the 2016-2017 ICR as the basis for calculating changes in hour burden. Then we adjusted these estimates based on: (1) the percentage increase in the number of data elements for Organization Determinations and Reconsiderations (ODR), (2) the increase in the number of burden hours and costs for adding the reporting section, Payments to Providers, and (3) the burden decreases due to the suspension of the Sponsor Oversight of Agents (SOA) reporting section and the elimination of two data elements from the Enrollment/Disenrollment reporting section. See section 15 of this Supporting Statement for a more detailed discussion of this package’s program changes and burden adjustments.

Annual responses = 3,508
 Total hour burden = 169,077
 Total annual cost = \$14,195,753

The estimates are based on increases in data elements for ODR, and Payments to Providers, decrease in data elements for enrollment/disenrollment, and suspension of SOA (see section

15 of this Supporting Statement).

Burden Summary

Annual Recordkeeping and Reporting Requirements

	Potential Respondents	Responses per Respondent	Total Responses	Burden per Response	Total Annual Burden (hours)	Hourly Labor Cost of Reporting (\$/hr.)	Total Cost (\$)
TOTAL	544	6.5*	3,508	48.2**	169,077	86.72	14,195,753

*6.448529411764706

**48.19754846066135

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.

Information Collection Instruments/Instructions

- Medicare Part C Plan Reporting Requirements Technical Specifications Document Contract Year 2017

This document provides a description of the reporting sections, reporting timeframes and deadlines, and specific data elements for each reporting section.

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. Program and Burden Changes

The following table lists estimated burden changes in hours and costs between 2016 and 2017. Total hour change in burden is estimated at -12,946 and total cost change in burden is estimated at -\$1,086,898. The percentage decrease for hours is 7.1 percent.

Reporting Section	2016 –Estimate	2017 ICR Estimate	Change in Burden
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	Hours	Cost	Hours	Cost	Hours	Cost
Organization Determinations/ Reconsiderations*	74,434	\$6,249,479	84,038	\$7,055,863	9,604	806,384
Payments to Providers	N/A	N/A	11,312	\$949,756	11,312	\$949,756
Enrollment Disenrollment	768	\$64,481	698	\$58,619	-70	-\$5,862
Remaining reporting sections total	106,821	\$8,968,691	73,029	\$6,131,515	-33,792	-\$2,837,176
Total reporting sections total	182,023	\$15,282,651	169,077	\$14,195,753	-12,946*	-\$1,086,898

Note: Figures in above table subject to rounding.

*Overall, the average decrease in hours per contract for the 2017-2018 ICR compared to the 2016-2017 ICR is 24.

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 then 544 x 1=544 since this section is reported annually. The currently approved figure estimates 562 contracts.

Organization Determinations/Reconsiderations

The four new data elements to the reporting section Organization Determinations and Reconsiderations will allow CMS to obtain more information about case re-openings. The new elements are:

- Was the case processed under the expedited timeframe? (Y/N)
- Case Type (Service or Payment)
- Status of treating provider (Contract or Non-Contract)
- Additional Information (An optional category if plans want to provide more information such as a subcategory or notes)

Increasing the number of data elements from 31 to 35 increased the estimated annual reporting burden for ODR by 9,604 hours. Per contract, the hourly burden increase for ODR was from 137 hours to 155 hours.

Justification: For each data element we want to learn the following:

- Was the case processed under the expedited timeframe? (Y/N)
 - CMS wants to determine to what degree expedited requests are being reopened.
- Case Type (Service or Payment)

- Since CMS already collects service/payment data for Organization Determinations (ODs) and Reconsiderations (Recons), thus it is a natural progression to request this data at the reopening level.
- Status of treating provider (Contract or Non-Contract)
 - Even though CMS does not ask the plans to separately report contract or non-contract data, plans are already required to report Organization/Determinations and Reconsiderations for both contract and non-contract providers. We believe it is important to determine to what degree contract or non-provider cases are being reopened.
- Additional Information (optional)
 - Plans generally want to explain in greater detail why a case was reopened. This field can be populated by plans if they wanted to provide more information such as a subcategory or notes. This is not a required field.

The new data elements will also allow for distinction between the various types of organization determination cases, ensuring better accuracy in the future for burden estimates for PRA packages and regulations for any changes made to Medicare enrollment and appeals.

Payments to Providers

Adding four new data elements to the Payments to Providers reporting section increased hours by 11,312. Per contract, this resulted in an average increase of 20.8 hours. The new data elements are:

- Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework)
- Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework)
- Total Medicare Advantage contracted providers paid based risk-based payments not linked to quality (e.g. 3N in the APM definitional framework)
- Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).

Justification: The 2015 MACRA legislation included an emphasis on alternative payment models (APMs). As a result, the increased use of APMs became a priority across HHS. In 2015, CMS added 'Payments to Providers' to the Part C Reporting requirements to better understand the use and scope of APMs in the Medicare Advantage (MA) industry. Such understanding will help us make well-informed policy decisions related to APMs. The addition of the new data elements include a more accurate representation of the categories of APMs currently in use and will therefore give us more accurate reporting data.

Enrollment/Disenrollment

For the Enrollment/Disenrollment reporting section, the decrease in hours was 9.1 percent based on the percentage decrease in data elements from 22 to 20. This translated into a decrease of hour's burden from 768 hours to 698 annual hours (a change of -70 hr).

Justification: Former data elements 1-M and 1-N need to be removed since they no longer apply. This would decrease the reporting burden slightly. The data elements were:

Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP.

Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP.

Sponsor Oversight of Agents

Sponsor Oversight of Agents is being suspended. This 2017 suspension is still planned and would have a significant impact by lowering the resource utilization. The average decrease is 62 hours per contract. *Justification:* CMS found the burden for this reporting requirement to be significant and we were not using the data enough to support the burden.

16. Publication/Tabulation Dates

The data are collected and validated annually. CMS makes data available to the public by posting the Part C and the Part D annual reports on the CMS.gov website. The 2014 reports are currently on the website and we anticipate that 2015 data will be available in the first quarter of the calendar year of 2017.

In addition, CMS makes data from some reporting sections available on an annual basis in the form of public use files (PUFs) in support of its transparency goals. The data is release late in the calendar year once CMS has verified that it is accurate. The public use files are also available on the CMS.gov website.

17. Expiration Date

This collection displays OMB's 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 the reporting organizations.