Supporting Statement, Part A
Medicare Advantage Appeals and Grievance
Data Form
(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 § 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 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 "MA plans" in this Supporting Statement. Data collection/disclosure categories are based on the MA plan's grievance and appeals processes as prescribed under 42 CFR part 422, subpart M.

An organization determination, defined in 42 CFR § 422.566, is a MA plan's coverage decision – i.e., the decision whether to pay for or provide an item or service. When a MA plan denies coverage, an enrollee may dispute the adverse organization determination (denial). When an MA plan reconsiders its adverse organization determination, the reconsideration marks the beginning of the appeals process.

42 CFR § 422.561 defines a grievance as any complaint or dispute other than one involving an organization determination as defined in 42 CFR § 422.566(b).

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 MA plan choices, MA plans must report appeals and grievance data requested by any individual eligible to elect a MA plan. The individual may use this data to evaluate and compare plan performance.

We are requesting a revision approval from OMB for currently approved collection CMS-R282. In an effort to identify opportunities to reduce burden for this collection, we compared data provided by plans to CMS in Part C reporting requirements (OMB 0938-1054) with the requirements to provide aggregate grievance and appeals data to MA eligible beneficiaries. We found that data reported to CMS in the Part C reporting requirements was data that would meet the disclosure requirements at § 1852(c)(2)(C) of the Social Security Act and 42 CFR § 422.111(c).

We are proposing to revise this form by allowing plans to use data collected for Part C reporting requirements (OMB 0938-1054) that also meet requirements for this collection. This change merges and aligns the collection and reporting periods, so MA plans do not need to keep two separate sets of data and reports each year. For example, with this collection, plans had to collect 6 months of data, wait a 3 month reconciliation period, then add the previous two six month collections to create one annual report (which was not always based on a calendar year). Plans were only permitted to send the 12-month report for a six month period, resulting in two reports per year, in addition to the reporting requirements data collected. For CMS Part C reporting requirements, data is collected quarterly, but only reported annually. To match this and reduce plan burden, CMS is revising this form to use the data reported annually to CMS, and that data be valid for one year versus creating a new report every six months. Further, data provided to enrollees would be consistent with data provided to CMS.

To further decrease burden, reduce enrollee confusion, and ensure a simplified, easy to read report, we have removed the following data elements:

- Expedited appeals
- Disposition of expedited appeals
- IRE (level 2) appeals
- Disposition of IRE (level 2) appeals
- Withdrawals

Removing these items reduces the number of data elements plans have to add to the report from nineteen to six. We do not believe that removing these data items will negatively impact enrollees because they are not necessarily based on plan performance. The decision to expedite an appeal request is based on medical necessity and the enrollee's health condition, which is specific to the enrollee making the request. Further, expedited appeals are already included in number of total appeals received. For independent review, IRE (level 2) appeals data was removed because overturn data is not indicative of plan performance (i.e., the decision was overturned because the IRE received different information, not because the plan's decision was incorrect). Lastly, withdrawals are at the request of the party who originally filed the appeal and do not reflect any action by the plan, therefore, it provides no value to the individual seeking plan specific information. Also, the data element "grievances" was added so individuals have data for all grievances. Quality of care grievances have been included in the total number of grievances.

A. Justification

1. Need and Legal Basis

MA plans disclose grievances and appeals information pertaining to the number of disputes and their disposition, in the aggregate, to any MA plan eligible individual

who requests this information. This disclosure is pursuant to § 1852(c)(2)(C) of the Social Security Act and 42 CFR § 422.111(c)(3).

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

2. Information Users

MA 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 those individuals. 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

CMS has not created or mandated the use of a specific system to collect or report out this information. MA organizations may use their own systems to collect the data and produce the reports.
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. While the purpose and format of this collection is unique from other collection efforts, and guarantees beneficiaries' access to grievance and appeals data, the collection of the specific data used in this form is duplicative of data in collection (OMB 0938-1054).

5. Small Businesses

We do not anticipate small businesses 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

Previously, MA plans were required to collect data in six-month intervals. At the time, CMS determined six-month intervals would allow for the collection of meaningful data without overburdening organizations. We have now determined that tracking two intervals of data in addition to annual CMS reporting requirements is burdensome. In order to reduce burden, CMS has revised R282 collection requirements to align with the quarterly reporting requirements of collection (OMB 0938-1054).

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 08/15/2019 (84 FR 41723). CMS did not receive comments during this 60-day period. There will be no changes to the collection.

The 30-day notice published in the Federal Register (84 FR 63657) 11/18/2019.

9. Payments/Gifts to Respondents

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

10. Confidentiality

The data MA 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 2018 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	18.75	18.75	37.50

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 June 2019, CMS contracted with 733 MA plans.[1]

1 June 2019 Monthly Contract Summary Report: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2019/June/Monthly-Summary-Report2019-06.zip .

We determined that it would take 1 hour per collection period for each organization to collect the appeals data. Previously, CMS required that the information be collected every 6 months, so the hours needed per organization would be 2 hours per year. With this revision, because the data is already being collected internally by each of the MA plans and reported to CMS via Part C reporting requirements, it would therefore only have to be downloaded or compiled into a single report once a year instead of twice a year, reducing burden by 50%. In aggregate, we estimate 733 annual hours (1 hours x 733 Medicare health plans).

12.3 Burden Estimates for Disclosing Appeals and Grievance Data

There are 58.4 million Medicare beneficiaries according to 2017 CMS statistics (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/Downloads/MDCR_ENROLL_AB/2017_CPS_MDCR_ENROLL_AB_1.pdf)

We estimated that 0.1%, or 58,400 beneficiaries would request an appeal and/or grievance disclosure report from a MA 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 4,672 hours (58,400 responses per year x .08 hours/response).

We determined the average hourly rate for the individual responsible for gathering 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 $ 18.75. The adjusted hourly rate for this position is $37.50. We then multiplied this adjusted hourly rate ($37.50) by the .08 hours per response estimated for reporting appeals and grievance data to arrive at $3.00 cost per response. Last, we multiplied $3.00 by the annual number of responses (58,400) to determine the total annual wage burden of $ 175,200 per year, or $ 239.02 per organization (175,200 divided by 733 MA 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	1 x year	733	733	1 hr	733	37.50	27,488
Disclosing Information	On occasion	733	58,400	0.08 hr	4,672	37.50	175,200

TOTAL	**varies**	**733**	**59,133**	**1.08 hr**	**5,405**	**37.50**	**202,688**

12.5 Collection Instruments and Associated Guidance/Instructions

The appeals and grievance data form is an OMB approved 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 form, MA organizations will meet the disclosure requirements set forth in regulations at 42 C.F.R. 422.111(c)(3). There are revisions to the form in this iteration.

First, we removed language that may be confusing to MA eligible enrollees and used plain language, where applicable. We have provided a blank table plans may use to enter data and also deleted language where plans were required to enter data within the text portion of the form. Lastly, we removed the data related to expedited appeals, IRE (level 2 appeals), and withdrawals. This reduces the total number of pages of the form by 50% (previously six pages and is now three pages).

Included in this PRA Package are instructions for completing the appeals and grievance data form. The form instructions serve as a reference for MA organizations on the collection and disclosure requirements of grievance and appeal data. The instructions are revised in this iteration to remove sections related to the data collection, reconciliation and reporting periods as well as information related to types of data no longer used (expedited appeals, IRE/level 2 appeals and withdrawals). The instructions now include where to find data in the reporting requirements and the places to insert that data on the simplified R282 form. The changes also reduce the total number of pages in the instructions from seven to four.

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:

- A change in the collection and reporting periods to align with the Part C Reporting Requirements (OMB 0938-1054).
- The change in the number of items reported (reduced from nineteen to six).

- An increase in the number of MA eligible beneficiaries that may request this report (due to an increase number of Medicare beneficiaries)
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- Consequent revisions to our estimates to reflect the increases and costs associated with producing appeals and grievance data reports for the increased number of Medicare beneficiaries; and

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 and OMB control number will be 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