Supporting Statement Part A
D-SNP Enrollee Advisory Committee
(CMS-10799, OMB 0938-1422)

Background

The Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Final Rule (May 9, 2022; 87 FR 27704) (CMS-4192-F, RIN 0938-AU30) (hereinafter referred to as the May 2022 final rule) finalizes regulations related to dual eligible special needs plans (D-SNPs) and other special needs plans.

This information collection request is for the requirement at § 422.107(f) that any Medicare Advantage (MA) organization offering a D-SNP must establish one or more enrollee advisory committees in each State to solicit direct input on enrollee experiences. The establishment and maintenance of an enrollee advisory committee is a valuable beneficiary protection to ensure that enrollee feedback is heard by managed care plans and to help identify and address barriers to high-quality, coordinated care for dually eligible individuals. By soliciting and responding to enrollee input, plans can better ensure that policies and procedures are responsive to the needs, preferences, and values of enrollees and their families and caregivers. Federal regulations for other programs, such as the Programs of All-Inclusive Care for the Elderly (PACE) and Medicaid managed care plans that cover LTSS include requirements for stakeholder engagement and committees, including input from beneficiaries.

CMS will not collect information directly from MA organizations offering a D-SNPs regarding the enrollee advisory committee requirement § 422.107(f); however, we believe this requirement meets the definition of a collection of information as defined at 5 CFR 1320.3(c) for the following reasons. First, in order to meet this requirement, MA organizations offering D-SNPs need to solicit applicants for the committee from their D-SNP enrollees. Second, we anticipate that most D-SNPs will voluntarily prepare and distribute committee bylaws and have a recordkeeping system for meetings. The committees are also required solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations. This preceding list of PRA triggers should not be viewed as complete given the flexibilities offered. Instead, the list is intended to demonstrate that the requirements and burden under section 12 of this Supporting Statement are subject to the PRA.

On September 1, 2022, we submitted this non-substantive change request that does not change any of our burden estimates and collection of information requirements. More specifically, the scope of information collection request listed in our January 2022 proposed rule (87 FR 1842, CMS-4192-P, RIN 0938-AU30) included a new regulation at § 422.101(f)(1)(i) requiring all SNPs to include questions on housing stability, food security, and access to transportation as part of their health risk assessments (HRAs). The proposed rule identified this collection of information (CMS-10799; OMB 0938-1422) as the home for the HRA requirements and burden. However, we did not finalize this provision as proposed and inadvertently neglected to revise the package cross reference from CMS-10799 to CMS-10825 in the subsequent May 2022 final rule.

In order to receive public comment on the list of SDOH screening instruments described in the May 2022 final rule, we are using the standard non-rule PRA process that includes the publication of 60- and 30-day Federal Register notices. The list of SDOH screening instruments is provided under a new collection of information (CMS-10825; OMB 0938-TBD).

A. Justification

1. Need and Legal Basis

We established the new paragraph at § 422.107(f) under our authority at section 1856(b)(1) of the Act to establish in regulation other standards not otherwise specified in statute that are both consistent with Part C statutory requirements and necessary to carry out the MA program and our authority at section 1857(e) of the Act to adopt other terms and conditions not inconsistent with Part C as the Secretary may find necessary and appropriate.

2. Information Users

MA organizations with D-SNPs would use the information collected from enrollees in the enrollee advisory committee to help identify and address barriers to high-quality, coordinated care for enrollees. At this time, CMS will not collect or analyze the information gathered from enrollees by MA organizations under this information collection request.

3. Improved Information Technology

MA organizations can use automated, electronic, mechanical, or other technological collection techniques or other forms of information technology to collect data related to this information collection as long as the use of such techniques adheres to the regulations at § 422.107(f).

4. Duplication of Similar Information

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

There is no significant impact on small businesses.

6. Less Frequent Collection

This information collection requires an MA organization with a D-SNP to hold at least one enrollee advisory committee annually. We believe a less frequent collection would not provide MA organizations with enough information from enrollees to meaningfully achieve the objectives of identifying barriers to high-quality, coordinated care for dually eligible individuals.

7. Special Circumstances

There are no special circumstances to report, and no statistical methods will be employed. More specifically this collection:

- Does not require respondents to report information to the agency more often than quarterly;
- Does not require respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Does not require respondents to submit more than an original and two copies of any document;
- Does not require respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Is not connected with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;
- Does not require the use of a statistical data classification that has not been reviewed and approved by OMB;
- Does not include a pledge of confidentiality that is not supported by authority established in statue 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
- Does not 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 Notice/Outside Consultation

Serving as the 60-day notice, our proposed rule (CMS-4192-P, RIN 0938-AU30) filed for public inspection on January 6, 2022, and published in the Federal Register on January 12, 2022 (87 FR 1842). Comments were due on March 7, 2022.

The final rule (CMS-4192-F) was published on May 9, 2022 (87 FR 27704) and is effective on June 28, 2022.

9. Payments/Gifts to Respondents

This collection provides zero payments or gifts to Medicare Advantage Organizations with D-SNPs.

10. Confidentiality

CMS will not collect data from the MA organizations from the enrollee advisory committees. Thus, CMS assurance of confidentiality is not applicable to this collection.

11. Sensitive Questions

These committees will address challenging topics related to plans and their enrollees, including potentially market-sensitive information related to potential changes in future plan benefits. We are not requiring plans to make these enrollee advisory committee agendas or materials publicly

available since it could interfere with committee effectiveness.

12. Collection of Information Requirements and Associated Burden Estimates

Wage Estimates

To derive mean costs, we are using data from the most current U.S. Bureau of Labor Statistics' (BLS's) National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm), which, at the time of drafting of this rule, provides May 2021 wages. In this regard, the following table presents BLS' mean hourly wage along with our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Business Operation Specialists, All Other	13-1199	38.10	38.10	76.20

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent to account for fringe benefits and overhead costs that vary from employer to employer and because methods of estimating these costs vary widely from study to study. We believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Requirements and Associated Burden Estimates

As described in section II.A.3. of the May 2022 final rule, we finalized at § 422.107(f) that any MA organization offering a D-SNP must establish one or more enrollee advisory committees at the State level or other service area level in the State to solicit direct input on enrollee experiences. We also require that the committee include at least a reasonably representative sample of the population enrolled in the dual eligible special needs plan, or plans, or other individuals representing those enrollees and solicit input from these individuals or their representatives on, among other topics, ways to improve health equity for underserved populations.

The burden of establishing and maintaining an enrollee advisory committee is variable due to the flexibilities MA organizations would have to implement the requirements. We believe that D-SNPs should work with enrollees and their representatives to establish the most effective and efficient process for enrollee engagement; therefore, we chose not to establish the: (1) frequency; (2) location; (3) format; (4) participant recruiting and training methods; (5) number of committees (for example, one committee at the State level to serve all of the MA organization's D-SNPs in that State or more than one committee); (6) utilization of existing committees which would meet the requirements of both §§ 438.110 and 422.107(f) (we expect this approach to be used by fully integrated dual eligible special needs plans (FIDE SNPs) and highly integrated dual

eligible special needs plans (HIDE SNPs)); (7) use and adoption of telecommunications technology; and (8) other parameters. Instead, the only requirements in this rule for an MA organization offering one or more D-SNPs in a State is to establish and maintain one or more enrollee advisory committees that serve the D-SNPs offered by the MA organization and for that committee to solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations. The enrollee advisory committee(s) must include at least a reasonably representative sample of the population enrolled in the D-SNP(s), or other individuals representing those enrollees. The enrollee advisory committee(s) may also advise managed care plans under title XIX of the Act offered by the same parent organization as the MA organization offering a D-SNP.

To determine the burden for MA organizations to establish the enrollee advisory committees, we reviewed two estimates from similar committees. First, the May 2016 final rule (81 FR 27778) estimated it will take 6 hours annually for a business operations specialist to establish and maintain the long-term services and supports (LTSS) member advisory committee requirement (§ 438.110) for Medicaid managed care plans.

Second, in 2021 we conducted an informal survey of the three South Carolina Medicare-Medicaid Plans (MMPs) under the capitated FAI demonstration that are required to conduct meetings quarterly and highly value their advisory committees. The MMPs surveyed estimated an annual average of 240 hours (or 60 hours per meeting) to recruit members and establish and maintain the committee. We expect these efforts to include outreach and communication to members, developing meeting agendas, scheduling participation of presenters, preparing meeting materials, identifying meeting location and technology, D-SNP staff attendance at the meeting, and disseminating enrollee feedback to D-SNP and MA organization staff.

Due to the variety of flexibilities in creating the enrollee advisory committee, detailed previously in this section, we expect the average time and annual cost for an MA organization to establish and hold an enrollee advisory committee meeting(s) to be somewhere between 6 hours estimated for the requirement at § 438.110 and 240 hours as reported by MMPs. We believe this large difference in the time spent comes from two sources: (1) the committees created by MMPs must meet quarterly rather than annually and (2) MMPs find value in their committees and have invested more staff and resources to recruit enrollees, and prepare for and hold meetings; for example, MMPs often provide transportation to meetings, refreshments, and nominal incentives for participation, none of which is required by the capitated FAI demonstration or this rule. With this understanding that a wide variety of approaches would be used, we estimate that on average a business compliance officer will spend 40 hours to establish and hold enrollee advisory committee meetings.

In the proposed rule we noted that each MA organization offering one or more D-SNPs in a State will decide how to establish an enrollee advisory committee based on the MA organization's approach to obtaining maximal input from enrollees leading to the highest quality enrollee experience. Because of the wide variability, we solicited stakeholder comments on our assumptions and burden estimates. We received no comments on this issue and therefore we are finalizing our estimates that an MA organization will spend 40 hours at a cost of $3,048 (40 hr x $76.20/hr for a business operation specialist) to establish an enrollee advisory committee.

We believe all FIDE SNPs and HIDE SNPs that provide LTSS currently have an enrollee advisory committee since they have a Medicaid managed care plan that must comply with § 438.110. We are updating these estimates from the estimates used in the proposed rule based on the increase in D-SNP PBPs for contract year 2022. There were 596 D-SNP PBPs in 2021 and 703 D-SNP PBPs in 2022. For 2022, we estimate 578 D-SNPs do not have a corresponding Medicaid managed care plan that provides LTSS. Several of these D-SNP PBPs are in the same State and under the same contract, which means only one enrollee advisory committee is necessary to meet the requirement. Therefore, we estimate MA organizations operating D-SNPs will need to establish 310 (703 D-SNP PBPs minus 125 PBPs in D-SNP contracts that provide LTSS minus 268 PBPs under the same contract in the same State) new enrollee advisory committees.

Thus, the aggregate minimum annual burden for MA organizations operating D-SNPs to meet the requirements of § 422.107(f) is 12,400 hours (310 new committees x 40 hr per committee) at a cost of $944,880 (12,400 hr x $76.20/hr).

Burden Summary

Regulation Section in Part 42 of the CFR	Item	Number of respondents	Responses per respondent	Total Responses	Time per Response (hours)	Total Time (hours)	Hourly Labor Cost ($)	Total Cost First Year ($)	Total Cost Subsequent years ($)
422.107(f)	Solicit committee members	310 D-SNPs	1	310	40	12,400	76.2	944,880	944,880

13. Capital Costs

There are no capital costs.

14. Cost to the Federal Government

To support D-SNPs in establishing enrollee advisory committees that meet the objective of this rule in achieving high-quality, comprehensive, and coordinated care for dually eligible individuals, CMS will provide technical assistance to D-SNPs to share engagement strategies and other best practices. CMS can leverage the body of technical assistance developed for MMPs. For example, the CMS contractor Resources for Integrated Care partnered with Community Catalyst to offer a series of webinars and other written technical assistance to help enhance MMPs' operationalization of these committees.[1] CMS will be able to realize efficiencies by repurposing and building on these resources. Based on the existing technical assistance contracts held by CMS, we estimate an annual cost to the Federal government of $15,000.

15. Program/Burden Changes

1 Resources for Integrated Care and Community Catalyst, "Member Engagement in Plan Governance Webinar Series", 2019. Retrieved from: https:/www.resourcesforintegratedcare.com/article/member-engagement/.

Since this collection is new, changes in burden is not applicable.

16. Publication/Tabulation Dates

CMS does not intend to publish data related this collection of information.

17. Expiration Date

CMS will display the expiration date and OMB approval number on the CMS website.

18. Certification Statement

No exception to any section of OMB Form 83-I is requested.

B. Collections of Information Employing Statistical Methods

This collection does not employ statistical methods.