Supporting Statement A 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)

A. 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). Each MAO must have an effective procedure to develop, compile, evaluate, and report to CMS, its enrollees, and the 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). Part C Reporting Requirements sections are not applicable to national PACE plans and 1833 cost plans.

CMS is requesting an OMB Revision approval type due to the changes for the CY2024 reporting requirements which includes:

- The collection of additional data elements related to supplemental benefits cost and utilization among plan enrollees, with an effective date of January 1, 2024. CMS is adding this section in accordance with recommendations from members of the United States Congress,[1] the Medicare Payment Advisory Commission (MedPAC),[2] Government Accountability Office (GAO),[3] and other industry stakeholders. These

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[1] Representatives Katie Porter, Diana DeGette, Lloyd Doggett, et al., Response to Request for Information: Medicare Program (CMS-4203-NC) (Aug. 31, 2022), retrieved from https://www.regulations.gov/comment/CMS-2022-0123-3360; Representatives Lloyd Doggett, Pramila Jayapal, Jan Schakowsky, et al., Response to Request for Information: Medicare Program (CMS-4203-NC) (Aug. 31, 2022), retrieved from https://www.regulations.gov/comment/CMS-2022-0123-3819.

[2] Michael E. Chernew, *Report to the Congress: Medicare and the Health Care Delivery System,* (MedPAC, June 2021), page 18, retrieved from https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and- the-health-care-delivery-system.

[3] Leslie V. Gordon. *Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight.* (GAO, 2022), page 8, retrieved from https://www.gao.gov/assets/gao-22-106026.pdf.

elements also align with and expand upon the new MLR reporting requirements (87 FR 27704) on supplemental benefits, as well as the more limited information submitted in the Plan Benefit Package (PBP) categories and subcategories. This information will improve CMS's understanding of the accessibility and utilization of supplemental benefits by Medicare Advantage enrollees.

- Part C will formally remove data element K from the enrollment section for Part C Reporting. Plans report enrollment transactions using the Special Election Period (SEP) code "S" using this data element. An SEP is a period outside of the usual Annual Enrollment Period (AEP), the Medicare Advantage Open Enrollment Period (MA-OEP), and the beneficiary's Initial Enrollment Period (IEP) when an individual may elect a Plan, or change the Plan in which they are enrolled. There are various types of SEPs, including, but not limited to, SEPs for dually-eligible individuals, individuals whose current Plan terminates and individuals who change residence.

  An individual's eligibility for an SEP provides an opportunity to make an election, but does not convey eligibility to enroll in the Plan; an individual must also meet all applicable eligibility criteria to enroll in the Plan. It is generally the responsibility of the organization to determine whether the individual is eligible for an SEP. The exception to this determination requirement would be enrollment and disenrollment requests completed or approved by CMS staff. To make this determination, the organization may need to contact the individual directly.

  CMS codified the SEP under CMS-4190 published on June 6, 2020. As a result, CMS operationalized the ability for plans to report the basis for which a beneficiary was eligible for a particular SEP in Medicare Advantage Prescription Drug System (MARx). Previously there was no mechanism in MARx for Plans to indicate the basis for which the SEP was established. Plans previously submitted the enrollments using only Election Type Code 'S' leaving CMS without visibility of how the SEPs were used. After the MARx SEP reason code change, Plans continue to use the 'S' for SEP enrollments, but are now also required to also indicate what type of SEP the beneficiary was eligible for. The MARx system change was announced to the plans through Health Plan Management System (HPMS) memo with the software release of July 24, 2021. This memo at the following link: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance- documents/hpms_announcement_memo_october_2020_813_enroll1.pdf.

- The Part C Reporting Requirements inadvertently excluded language under Section V: Enrollment and Disenrollment.

  CMS updated the section to add back in the missing language and be consistent with the Part C Tech Specifications. The full sentence should read "Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Manual outline the enrollment and disenrollment periods (Section 30) enrollment (Section 40) and disenrollment procedures (Section 50) for all Medicare health and prescription drug plans."

- CMS will also reduce the burden estimates equally by 50 percent for most Part C reporting sections with the exception of SNP and the new Supplemental Benefits sections. This approach is reasonable given these requirements are well established and familiar to the plans.

B. 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:

- The cost of its operations.
- The patterns of utilization of its services.
- The availability, accessibility, and acceptability of its services.
- To the extent practical, developments in the health status of its enrollees.
- Other matters that CMS may require.

These Part C Reporting Requirements will provide key data to CMS on the utilization and cost of these benefits that has not been available since the removal of benefit utilization requirements in 2011. This proposed collection will also build upon the previous collection-by asking for information regarding all unique supplemental benefits categories. These categories match the current Plan Benefit Package (PBP) which is submitted annually by plans. Additionally, the proposed collection will request information to be split out by the authority under which each plan offers the benefits (mandatory, optional, mandatory-SSBCI, mandatory-Uniformity Flexibility). Further information about the need for such changes is included in the Background section, and information regarding previous reporting requirements on supplemental benefit utilization is included in the Appendix.

2. Information Users

There are a number of information users of the Part C reporting requirements. They include CMS staff that use this information to monitor health plans and to hold them accountable for their performance.

CMS users include group managers, division managers, branch managers, account managers, and researchers. Academic researchers and other governmental entities such as GAO and the Office of Inspector General have inquired about this information.

Health plans can use this information to measure and benchmark their performance. CMS receives inquiries from the industry and other interested stakeholders about the beneficiary use of available benefits, including supplemental benefits, grievance and appeals rates, cost, and other factors pertaining to use of government funds, as well 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. MA organizations also use HPMS to submit applications to CMS, and CMS uses the system for announcements. HPMS, therefore, is a familiar tool to MA organizations. Users granted access have their access protected by individual login and password; electronic signatures are unnecessary.

4. Duplication of Efforts

This collection does not duplicate the collection of similar information.

5. Small Businesses

The collection of information will have a minimal impact on small businesses since MA organizations must possess an insurance license to operate and as a condition of that license, generally be able to accept substantial financial risk. State statutory licensure requirements generally preclude small businesses from bearing the risk needed to participate in Medicare Advantage.

6. Less Frequent Collection

With the exception of enrollment and disenrollment (which is semi-annual), there is annual reporting for all Part C reporting sections. 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;
- 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

- 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 was published in the Federal Register on March 14, 2023 (88 FR 15726) and CMS received 15 comments. Responses to the public comments are posted with the 30-day Federal Register notice.

The 30-day Federal Register notice was published in the Federal Register on September 25, 2023 (88 FR 65689).

9. Payments/Gifts to Respondents

There are no payments/gifts to respondents associated with the data reporting 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 protects the confidentiality of the requested proprietary information. Specifically, any information within a submission (or attachments thereto) constituting a trade secret, privileged or confidential information, (as such terms are interpreted under the Freedom of Information Act and applicable case law), is clearly labeled as such by the submitter, and 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)

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2021 National Occupational Employment and Wage Estimates for all salary estimates http://www.bls.gov/oes/current/oes_nat.htm.

Table 1 below 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. Other staff that are involved have a similar wage therefore we use an average hourly rate computer system analyst of $98.28/hour (including the fringe benefits adjustment) to calculate estimated costs.

We adjust the employee hourly wage estimate by a factor of 100 percent. This is a rough estimate because fringe benefits and overhead costs vary significantly from employer to employer, and methods of estimating these costs vary widely. Since there is no practical

alternative, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Table 1 – 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	15-1211	$49.14	$98.28	$98.28

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.

For the 2024 ICR, we used the average hour estimates per contract. The number of reporting sections, formerly eight sections, is now nine with the addition of supplemental benefits collection. We also updated the wage data to that reported in May 2021, which is the most up-to-date information provided by the Bureau of Labor Statistics (BLS). The new wage rate is $49.14 per hour replacing the former number of $46.23 per hour and we believe Computer Systems Analyst continues to be the most appropriate job code for this collection, consistent with the previous approved PRA package. Section 15 of this Supporting Statement provides a more detailed discussion of this package's program changes and burden adjustments.

Table 2 – Annual Record Keeping and Reporting Requirements

Potential no. of respondents (based on the projected number of approved contracts for 2023)	No. of responses per contract based on number of Part C reporting sections	No. of Responses (No. of Respondents*Reporting Frequency)-based on number of 2023 approved contracts	Burden per Response (total annual burden hours /no. of respondents)	Total annual burden hours for all Part C reporting sections	Hourly labor cost of Part C Reporting ($/49.14 hour)	Total Cost for all Part C Reporting
743	9	6,687	29	187,979	$98.28	$18,474,576

The Medicare Part C Plan Reporting Requirements Technical Specifications Document for Contract Year 2024 provides a description of the reporting sections, reporting timeframes and deadlines, and specific data elements for each reporting section.

Note that CMS does not currently have information regarding the number of approved contracts for 2024, and the Office of the Actuary in its Trustee Report does not typically estimate the number of contracts for future years. Furthermore, the number of contracts by year does not have a clear trend. Therefore, we are using the latest available information regarding approved contracts for 2023, which is 743 contracts.

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 CMS Health Plan Management System (HPMS). This amount is the same as previously reported, and is a "standard" estimate used in our ICRs when the HPMS resources support the CMS information processing and reporting role.

15. Program and Burden Changes

CMS added two new elements, and this increases the burden of reporting, but the added burden of our two new elements is negligible. They are both narrative responses that do not require changes to data systems or any similar action like is required of the other sections.

The table below estimates the burden changes in hours and costs for the 2024 ICR accounting for both the decrease in the number of approved contracts for the 2023 reporting year (based on currently available data), updated wage data, and the addition of the supplemental benefit section. The number of contracts reporting in CY 2023 (which for reasons specified in section 12 above are being used to estimate the number of contracts for 2024) is 743 (n=743). The average number of annual responses for the Part C reporting section for 2024 is 743 x 1=743 for sections

reporting annually. In addition, the wage data increased from $46.23 per hour to $49.14 per hour.

Table 3 – Estimated Cost of Information Collection Requirements (ICR)

All Part C Reporting Sections	2021 hours	2021 Cost	2024 hours	2024 Cost	Total Increase/Decrease in Burden for Part C Reporting
Total Burden Increase/Decrease	224,664	$20,772,433	187,979	$18,474,576	$2,297,857

16. Expiration Date

The expiration date for the approved Part C Reporting Requirements document will be located on the front cover of the reporting requirements.

17. Certification Statement

There are no exceptions to the certification statement.

18. Collections of Information Employing Statistical Methods

Reporting organization are not required to do statistical analyses for this information collection.

Appendix: Information on Previous Supplemental Benefit Utilization Data Collection

Data elements collected for each supplemental benefit in Reporting Requirements from 2008-2011:

- Number of enrollees who had access to the benefit during the reporting period;
- Unique number of plan enrollees who used the benefit;
- Appropriate code to identify how you capture utilization data for the benefit;
- Total number of benefit services used by plan enrollees during the period;
- Reimbursement amount from the plan to providers for benefit services used during the period; and
- Total cost sharing paid by members directly to providers for benefit services used during the period.

General data elements collected 2008-2011 for benefit utilization measure:

- Total number of enrollees under the plan during the reporting period;
- Number of member months during the reporting period;
- Dollar figure representing premiums earned over the course of the entire reporting period for this plan;
- Dollar figure representing CMS revenue collected under the plan over the course of the entire reporting period inclusive of rebates applied to A/B services;
- Dollar figure representing CMS rebates for A and B Services under the plan over the course of the entire reporting period; and
- Dollar figure representing reserves for outstanding claims from the reporting period.

Specific supplemental benefits included in 2008-2011 Reporting Requirements

- Transportation;
- Dental services;
- Vision services;
- Hearing Services;
- Health & Education services; and
- Other (Non-covered) services.