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)

A. Background:

CMS is requesting a Revision type of approval from OMB due to several revisions made to the CY2025 Reporting Requirements.

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, to its enrollees, and to 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 provider-patient relationship with respect to the following:

1) The cost of its operations.
2) The procedures related to and utilization of its services and items.
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.

The changes for the CY2025 reporting requirements includes:

- The collection of additional data elements related to supplemental benefits cost and utilization among plan enrollees, with an effective date of January 1, 2025. CMS is amending this section in accordance with updates to the Plan Benefit Package (PBP) submission categories. Further updates to this section will allow for clarity and better data analysis.

  CMS is adding 6 PBP categories, 5 in the Dental Services section and 1 in the Hearing Services section. They are reflected below:

- 16c6: Implant Services o 16c7: Prosthodontics, fixed o 16c8: Oral and Maxillofacial Surgery o 16c9: Orthodontics o 16c10: Adjunctive General Services o 18c: OTC Hearing Aids

In addition, CMS is adding 4 data elements. 2 of these elements clearly identify the contract and plan which is submitting the data. 2 additional elements will allow for greater insight in the submitted data. All new data elements are reflected below:

- A: Contract ID o B: PBP ID
- F: Network type (in-network, outof-network (for PPO), out-ofnetwork (for HMO-POS), Visitor/travel) o O: The median out-of-pocket cost for enrollees

Data element F will allow PPO plans to clearly identify and submit utilization and cost data for in and out of network services for each PBP category. Current submission layouts limit plans to submit all out of network costs and utilization patterns as one single data element. This greatly limits CMS' insight into utilization patterns for out of network services.

Data element O, in combination with the change to data element N (which has been updated to reflect "The total out-of-pocket costs for enrollees" rather than the 2024 data element which asked "The total out-of-pocket costs per utilization for enrollees") allows plans to submit data even when cost-sharing may vary within a single service category. These 2 data elements taken together allows CMS to understand the total cost born by the plan for a PBP service as well as what the average enrollee may expect to pay for that service. CMS is proposing this change to accommodate for different plan offerings.

- The collection of more granular data elements related to payments to providers, with an effective date of January 1, 2025. CMS is amending this section to conform to the Health

Care Payment Learning & Action Network (HCPLAN) Alternative Payment Models (APM) Framework categories. CMS is also including additional data elements related to the number of lives plans have attributed, aligned, assigned, empaneled, or otherwise associated with accountable care arrangements. Updates to this section will allow for clarity and better data analysis.

- The addition of two new reporting sections to capture information related to regulatory requirements for dual eligible special needs plans (D-SNPs). These new reporting sections are titled "D-SNP Enrollee Advisory Committee" and "D-SNP Transmission of Admission Notifications." All D-SNP PBPs will be required to report the D-SNP Enrollee Advisory Committee reporting section, while the D-SNP Transmission of Admission Notifications reporting section is only required for D-SNP PBPs that are not fully integrated D-SNPs or highly integrated D-SNPs, except as specified under 42 CFR 422.107(d)(2).

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 procedures related to and utilization of its services and items.
- 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.

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 (89 FR 56754) published in the Federal Register 07/09/2024.

CMS received 42 comments from external stakeholders for the 60-day Federal Register notice. Many comments requested greater clarity concerning specific data elements required for Part C compliance and reporting periods. Additionally, commenters also had questions about the Payment to Providers and Supplemental Benefits sections. All comments are included in the attached spreadsheet with responses.

The 30-day Federal Register notice (89 FR 85539) published in the Federal Register 10/28/2024.

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 2023 National Occupational Employment and Wage Estimates for all salary estimates https://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 $106.54/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	$53.27	$106.54	$106.24

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 2025 ICR, we used the average hour estimates per contract. We also updated the wage data to that reported in May 2023, which is the most up-to-date information provided by the Bureau of Labor Statistics (BLS). The new wage rate is $53.27 per hour replacing the former number of $49.14 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 number of respondents (based on the number of approved contracts for 2024)	Number of responses per contract based on number of Part C reporting sections	Number of Responses (Number of Respondents* Reporting Frequency)based on number of 2024 approved contracts	Burden per Response (total annual burden hours /number of respondents)	Total annual burden hours for all Part C reporting sections	Hourly labor cost of Part C Reporting ($53.27/hr.)	Total Cost for all Part C Reporting
783	10	7,830	29	225,575	$106.54	$24,032,761

The Medicare Part C Plan Reporting Requirements Technical Specifications Document for Contract Year 2025 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 2025, 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 2024, which is 783 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

The table below estimates the burden changes in hours and costs for the 2025 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. The number of contracts reporting in CY 2024 (which for reasons specified in section 12 above are being used to estimate the number of contracts for 2025) is 783 (n=783). The average number of annual responses for the Part C reporting section for 2025 is 783 x 1=783 for sections reporting annually. In addition, the wage data increased from $49.14 per hour to $53.27 per hour. The increase in burden hours is due to an increase in contracts from 743 to 783 and the addition of 2 new reporting sections in the technical specifications. We estimate a 20% increase in burden hours to account for 2 new reporting sections, from 8 to 10, for contracts to complete (187,979 *.2 = 37,596; 37,596 +

187,979 = 225,575). This results in a net increase of 37,596 burden hours (225,575 – 187,979) and cost increase of $5,558,185 (24,032 – 18,875,576).

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

All Part C Reporting Sections	2024 hours	2024 Cost	2025 hours	2025 Cost	Total Increase/Decrease in Burden for Part C Reporting
Total Burden Increase/Decrease	187,979	$18,474,576	225,575	$24,032,761	$ 5,558,185

16. Expiration Date

There will be an expiration date in the approved Part C Reporting Requirements document.

17. Certification Statement

There are no exceptions to the certification statement.

18. Collections of Information Employing Statistical Methods

Reporting organizations 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 20082011:

- 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.