

Supporting Statement Part A
D-SNP Enrollee Advisory Committee and SNP Standardized Questions
on Health Risk Assessments
(CMS-10799, OMB 0938-TBD)

Background

Our Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs proposed rule (January 12, 2022; 87 FR TBD) (CMS-4192-P, RIN 0938-AU30) proposes revisions to regulation related to dual eligible special needs plans (D-SNPs) and other special needs plans.

This information collection request is for the proposed 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 proposed establishment and maintenance of an enrollee advisory committee would be 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.

Additionally, this information collection request covers the proposed requirement at § 422.101(f)(1)(i) for all SNPs to include standardized questions on housing stability, food security, and access to transportation as part of their health risk assessments (HRAs). This proposal would result in SNPs having a more complete picture of the risk factors that may inhibit enrollees from accessing care and achieving optimal health outcomes and independence. This proposal also would have the benefit of standardizing these data elements collected through HRAs, which would eventually facilitate better data exchange among SNPs (when an individual transitions from one SNP to another) as well as facilitate the care management requirements under section 1859(f)(5) of the Act.

A. Justification

1. Need and Legal Basis

We proposed to establish 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.

Section 1859(f)(5)(A)(ii)(I) of the Act requires each SNP to conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs. We previously codified this requirement at § 422.101(f)(1)(i) as a required component of the D-SNP's model of care. In current practice, we allow each SNP to develop its own HRA, as long as it meets the statutory and regulatory requirements. We propose to amend § 422.101(f)(1)(i) to require that all SNPs (chronic condition special needs plans, D-SNPs, and institutional special

needs plans) include one or more standardized questions on the topics of housing stability, food security, and access to transportation as part of their HRAs.

2. Information Users

MA organizations with D-SNPs and other SNPs would use the information collected from enrollees in the enrollee advisory committee and the standardized questions in the HRA 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) and 422.101(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 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. Regarding the standardized questions in the HRA, the statute requires SNPs to conduct an initial assessment and reassessment annually. Thus, there are no opportunities for less frequent collection.

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 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
- 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 will publish in the Federal Register on January 12, 2022 (87 FR TBD). Comments are due on/by March 7, 2022.

9. Payments/Gifts to Respondents

This collection provides zero payments or gifts to respondents.

10. Confidentiality

CMS will not collect data from the MA organizations from the enrollee advisory committees or HRAs. Personally identifiable information contained in the HRAs is protected by the Privacy Act and Health Insurance Portability and Accountability Act (HIPAA) standards for MA plans and their providers. Thus, CMS assurance of confidentiality is not applicable to this collection.

11. Sensitive Questions

The standardized housing, food insecurity, and transportation in the HRAs could be considered sensitive. However, we do not believe these questions are any more sensitive than unstandardized HRA questions on the enrollee's physical, psychosocial, and functional needs. We believe requiring SNPs to include standardized questions about social risk factors is appropriate in light of the impact these factors may have on health care and outcomes for the enrollees in these plans and that access to this information will better enable SNPs to design and implement effective models of care.

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 2020 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	13-1198	40.53	40.53	81.06
Software and Web Developers	15-1250	52.86	52.86	105.72

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.

Proposed Requirements and Associated Burden Estimates

ICRs Regarding Enrollee Participation in Plan Governance (§ 422.107)

As described in section II.A.4. of the December 2021 proposed rule, we propose 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 propose 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 proposed requirements. We believe that D-SNPs should work with enrollees and their representatives to establish the most effective and efficient process for enrollee engagement, and therefore, we chose not to propose the specific: (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 FIDE and HIDE SNPs); (7) use and adoption of telecommunications technology; and (8) other parameters. Instead, the only requirements proposed in this rule for an MA organization offering one or more D-SNPs in a State would be 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 health equity for underserved populations. The enrollee advisory committee 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 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 proposed 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 LTSS member advisory committee requirement codified at § 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 Financial Alignment Initiative 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 resulting in a cost of \$19,454 annually (240 hr x \$81.06/hr). 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 proposed enrollee advisory committee requirement detailed in the opening paragraph of this ICR, we expect the average time and annual cost for an MA organization to establish and hold an enrollee advisory committee meeting 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 requirement that the committee created by MMPs 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 CMS capitated Financial Alignment Initiative demonstration or this proposed rule. We have used a 40-hour estimate and the services of a business compliance officer to assess burden with the understanding that a wide variety of approaches would probably be used.

Each MA organization offering one or more D-SNPs in a State would 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 this wide variability, we solicit stakeholder comments on our assumptions and burden estimates.

For purposes of this proposed rule for establishing an enrollee advisory committee, we are estimating each MA organization would spend 40 hours at a cost of \$3,242 (40 hr x \$81.06/hr for a business operation specialist).

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. Of the 596 D-SNP PBP for CY 2021, we estimate 478 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 proposed requirement. Therefore, we estimate MA organizations operating D-SNPs will need to establish 260 new enrollee advisory committees.

ICRs Regarding Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessment (§ 422.101)

As described in section II.A.4. of the January 2022 proposed rule, we propose requiring that SNPs include specific questions on housing stability, food security, and access to transportation specified in sub-regulatory guidance as part of their HRAs. This proposal, if finalized, would result in SNPs having a more complete picture of the risk factors that may inhibit beneficiaries from accessing care and achieving optimal health outcomes and independence. We do not believe that collecting this information would require any additional efforts from SNPs outside of customary updates to the HRA tools. Due to the current requirement at § 422.101(f) that the HRA include an assessment of the individual's physical, psychosocial, and functional needs, we believe that many SNPs are already including questions related to housing stability, food security, and access to transportation in their HRA tools. Therefore, if this proposal is adopted, most SNPs would revise their HRA tools to use our standardized questions. If a SNP is not already asking these questions, we do not predict the addition of questions on these three topics would lengthen the time to administer a typical HRA.

We estimate a one-time burden (over the next three years) for the parent organizations offering SNPs to update their HRA tools in their care managements systems and adopt our standardized questions on housing stability, food security, and access to transportation. It is possible that we would change the standardized questions in the future, thereby making the burden of our proposal more than a one-time burden. However, we have no plans at this point to change the standardized questions once we establish them. Therefore, we are unable to reliably estimate the additional burden in subsequent years.

We assume that each parent organization with one or more SNPs would update the care management system where an enrollee's HRA responses are recorded. We believe that it would take a software programmer 3 hours at \$105.72/hr to update the care management system resulting in a cost of \$317 (3hr x \$105.72/hr) per parent organization. For CY 2021, there are 123 parent organizations with a SNP PBP. In aggregate, we estimate a one-time burden for updating the HRA tool of 369 hr (123 parent organizations x 3 hr) at a cost of \$39,011 (369 hr x \$105.72/hr). After the finalization and implementation of our proposed rule, we will reassess the impact of future updates to these HRA questions.

Burden Summary

Section in Title 42 of the CFR	Number of respondents	Total Responses	Time per Response (hours)	Total Time (hours)	Hourly Labor Cost(\$/hr)	Total Cost First Year (\$)	Total Cost Subsequent years (\$)
422.107(f) Solicit committee members	260 (D SNPS)	260	40	10,400	81.06	843,024	843,024
422.101 Update HRA System	123 (SNP Parent Organizations)	123	3	369	105.72	39,011	0
TOTAL	383	383	<i>Varies</i>	10,769	<i>Varies</i>	882,035	843,024

Collection of Information Instruments and Instruction/Guidance Documents

See Appendix A: Standardized Housing, Food Insecurity, and Transportation Questions for the Special Needs Plans Health Risk Assessment (§ 422.101) (New)

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 proposed rule in achieving high-quality, comprehensive, and coordinated care for dually eligible individuals, CMS would 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

This collection is new and is not applicable to any changes in burden.

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

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

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.