Supporting Statement for the
Expedited Appeals Notices and Supporting Regulations
Contained in 42 CFR §§ 422.624(b), and 422.626(e) (1) – (5)

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) requests an extension of OMB approval of two (2) previously certified Medicare Advantage (MA) notices; the Notice of Medicare Non-Coverage (NOMNC) and the Detailed Explanation of Non-Coverage (DENC). This information collection results from a final rule to improve the managed care appeals process. See 68 Fed. Reg. 16,652 (April 4, 2003). The rule provides for an expedited appeals process when a beneficiary enrolled in a managed care organization receives notice from a plan or provider of services that the services will be terminated. The rule allows enrollees to request an expedited appeal, also termed a "fast track" appeal, to an independent review entity regarding whether such services should continue. Providers affected by the rule include skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs).

A. Background

The OMB previously approved the NOMNC and DENC under 0938-0910 A and 0938-0910 B respectively, which expire on March 31, 2007. Consistent with sections 422.624, SNFs, HHAs, and CORFs must provide notices to all enrollees whose services will end, no later than two days in advance of the termination of service. This information is provided to the enrollee using the NOMNC. If the enrollee appeals the termination decision, the plan or provider must send a detailed explanation of why services should end to both a Quality Improvement Organization (QIO) and the enrollee. This detailed explanation is provided to the enrollee using the DENC, the second notice included in this extension package. Thus, the purpose of the NOMNC and DENC is to help the enrollee decide whether to pursue an appeal and, if so, when and where to file a request.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L., 108-173) allowed CMS to promulgate regulations that corrected an inadvertent omission. Thus, the regulation promulgated at 42 CFR 417.600 (b)(1) makes clear the enrollees in section 1876 cost plans also have access to the fast track review provisions beginning January 2006.

For this reason, we are also making minor, non-substantive revisions to the notices and form instructions to take into account the variation among plan types delivering the notices under MMA. One edit replaces the term "Medicare Advantage plan" with "Medicare Health plan" to

ensure consistency with the language used in the 2006 *Medicare & You* handbook when referring to the Medicare Advantage and 1876 cost plans collectively. Another edit replaces the term “authorized representative with the term “representative,” to be consistent with the definition at 42 CFR 422.561.

We are also improving the usefulness of the form instructions by incorporating responses to frequently asked questions (FAQs) that were previously only available on the CMS.gov website. For example, we inform plans that ink colors used to print the NOMNC and DENC must be in high contrast for ease of readability. We also instruct them to ensure that the font size of the notice is at least 12-point font.

B. JUSTIFICATION

1. NEED AND LEGAL BASIS

Pursuant to 42 CFR.624 (b)(1), providers in SNFs, HHAs, and CORFs must deliver to Medicare Health plan enrollees a 2-day advance notice of termination of services. Per requirements at 42 CFR 422.626(e)(1), plans must deliver detailed notices to the QIO and enrollees upon request for appeal of the termination of services. The NOMNC and the DENC fulfill these regulatory requirements. Additionally, 42 CFR 417.600(b) provides that cost plans must follow these same fast track appeal notification procedures for their enrollees in SNFs, HHAs and CORFs.

- §422.624(b) – Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the MA organization’s decision to terminate services.

- §422.626(e)(1) – When an IRE notifies an MA organization that an enrollee has requested a fast-track appeal, the MA organization must send a detailed notice to the enrollee by close of business of the day of the IRE’s notification.

- §417.600(b)(1) – The rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

2. INFORMATION USERS

Providers will deliver a NOMNC to enrollees at least two days prior to the end of covered services in SNFs, HHAs, and CORFs. Enrollees will

use this information to determine whether they wish to appeal the service termination to the QIO in their State. If the enrollee decides to appeal, the Medicare Health organization will send the QIO and the enrollee a DENC detailing the rationale for the termination decision.

3. IMPROVED INFORMATION TECHNOLOGY

Providers in SNFs, CORFs, or HHAs generally deliver advance written notices to enrollees, in person or by mail on behalf of Medicare Health plans. Plans must deliver detailed written notices whenever those enrollees request appeals. There is no provision for alternative uses of information technology for the advance or detailed notices

4. DUPLICATION OF SIMILAR INFORMATION

The requirement for providers to supply plan enrollees in these provider settings with advance notice of service terminations is not duplicated elsewhere in the law.

5. SMALL BUSINESS

This requirement will not adversely affect small businesses.

6. LESS FREQUENT COLLECTION

Consumer research continues to support providing information close to when an individual needs to make a decision. In the case of an individual receiving provider services, he or she needs to decide whether the services continue to be medically necessary. (Providing the information other than during the receipt of services would significantly reduce its effectiveness). In addition, providing the notice two days in advance of coverage ending decreases an enrollee's potential financial liability in the event the enrollee wants to appeal. Providing advance notices to less than 100% of all individuals who receive the services would not afford all enrollees equal protection of their rights.

Additionally, there is no reliable method of discerning whether an enrollee is dissatisfied with the impending termination of services other than to provide notice and appeal procedures. The distribution of the NOMNC is similar to the Important Message from Medicare, which is delivered to all Medicare beneficiaries receiving in-patient hospital services upon admission, or shortly thereafter. The DENC is similar to the Notice of Discharge and Medicare Appeal Rights (NODMAR), which is a notice given to managed care enrollees who object to being discharged from an in-patient hospital setting.

7. SPECIAL CIRCUMSTANCES

The regulation at §422.624(c) requires that the notices be validly delivered to either enrollees or their representatives. Given the short timeline for notice delivery in plan and provider settings, valid delivery means that providers must ensure that the enrollee can understand the notice or else arrange to have the notice delivered to the enrollee's representative. Although Providers are required to deliver the NOMNC on behalf of the plan, CMS holds the Medicare Health plan responsible for delivery of all notices, and compliance with the regulations governing this activity.

8. FEDERAL REGISTER NOTICE/OUTSIDE CONSULTATION

A 60-day Federal Register notice was published on January 12, 2007. No comments were received.

9. PAYMENT/GIFT TO RESPONDENT

We do not plan to provide any payment or gifts to respondents.

10. CONFIDENTIALITY

CMS does not collect information. The provider and plan will maintain records of the notices, but those records do not become part of a federal system of records. Therefore, this item is not applicable.

11. SENSITIVE QUESTIONS

We do not ask any question of the enrollee. Therefore, this item is not applicable.

12. BURDEN ESTIMATE

The total hourly burden for notice delivery (NOMNC and DENC) is: 23,780.52.
The total wage burden for notice delivery (NOMNC and DENC) is: $630,896.56.

In 2005, 6,127,678 enrollees in 376 plans requested 8000 fast-track appeals. This data provided the basis for determining that only 0.13 percent of eligible enrollees use the fast-track appeal process. In August 2006, we note that there were 7,316,562 enrollees in 454 Medicare Health plans.

- We therefore used the same projection (0.13%) to determine that an enrollment of 7,316,562 members would yield 9,511.53 appeals.

- We know that the majority of NOMNCs are not disputed, and therefore estimate that the notices resulting in appeals represent only 25% of the notices issued, result in an appeal therefore,

- we estimate that the 9,511.53 appeals represent a universe of 38,046.12 NOMNCs and 9,511.53 DENCS, for a combined total of 47,557.65 notices.

To arrive at the combined burden and cost we made the following calculations for the individual notices.

The DENC requires 60 to 90 minutes to prepare.

- Preparation and delivery of the 9,511.53 DENCs that result in appeals would take between 60 to 90 minutes at an annualized hour burden of 14,267.29 hours or 31.43 hours per plan.

The NOMNC is completed in 15 minutes.

- Providers require 15 minutes to deliver the 38, 046.12 NOMNCs that are required each year, at an annualized burden of 9511.53 hours, or 20.95 hours per plan.

The total notices required for both notices is 47,557.65 notices or approx 104.75 notices per plan at 23,780.52 hours or 52.38 hours per plan.

We estimate also that these notices would most likely be prepared by a staff person with professional skills at the GS-12 Step 1 with an hourly salary of $26.53, for a total wage burden of $630,896.56 or $1389.64 per plan or provider.

13. CAPITAL COSTS

There are no capital costs associated with this collection.

14. COSTS TO FEDERAL GOVERNMENT

There is no cost to the Federal Government for this collection.

15. PROGRAM OR BURDEN CHANGES

This extension request uses the hour burden taken from data gathered from the QIOs performing these reviews, thus, we have adjusted our hour request from 68,000 hours down to 23,780.52. Note that until January 2006, cost plans were not included in the fast track process. However, they are factored into current calculations.

We adjusted the wage burden to account for the increase in salary of the typical nurse or social worker notice preparer from 2003 to 2006. Moreover, unlike the initial OMB submission, we do not separate out burden hours for provider organizations.

16. PUBLICATION AND TABULATION DATES

No publication of data is intended.

17. EXPIRATION DATE

Display of the expiration date is acceptable

18. CERTIFICATION STATEMENT

This information complies with 5 C.F.R. 1320.9.

C. COLLECTION OF INFORMATION EMPLOYING STATISTICAL METHODS

There are no statistical methods associated with this collection.