Supporting Statement – Part A
Fast Track Appeals Notices: NOMNC / DENC
CMS-10095 / OMB approval #0938-0910

Introduction

The Centers for Medicare & Medicaid Services (CMS) requests a revision of two Office of Management and Budget (OMB) -approved Medicare health plan notices: the Notice of Medicare Non-Coverage (NOMNC) and the Detailed Explanation of Non-Coverage (DENC). This information collection results from the fast track appeals process available to Medicare beneficiaries enrolled in Medicare health plans who receive notice that their Medicare-covered services are being terminated. Medicare health plan enrollees are permitted by law to request that an independent review entity decide whether Medicare-covered services should continue. For purposes of these provisions, the term "Medicare providers" includes skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs), and the term "Medicare health plans" includes Medicare Advantage plans and cost plans.

A. Background

The Office of Management and Budget (OMB) previously approved the NOMNC and DENC under 0938-0910. 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. Consistent with 42 CFR 422.624, SNFs, HHAs, and CORFs must provide notices to all enrollees whose Medicare-covered services will end, no later than two days in advance of the proposed termination of service. This information is provided to the enrollee through the NOMNC.

If the enrollee appeals the termination decision, the Quality Improvement Organization (QIO) and the enrollee, consistent with 42 CFR 422.624(b) and 422.626(e)(1)-(5) will receive a detailed explanation of the reasons services should end. This detailed explanation is provided to the enrollee using the DENC, the second notice included in this revision package.

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

B. Justification

1. Need and Legal Basis

Pursuant to 42 CFR 422.624 (b)(1), 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 whenever an enrollee appeals a 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 Medicare health plan's decision to terminate services.
- §422.626(e)(1) – When an IRE notifies an Medicare health plan that an enrollee has requested a fast track appeal, the Medicare health plan must send a detailed notice to the enrollee by close of business on 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 no later than two days prior to the end of Medicare-covered services in SNFs, HHAs, and CORFs. Enrollees will use this information to determine whether they want to appeal the service termination to the QIO in their State. If the enrollee decides to appeal, the Medicare health plan will send the QIO and the enrollee a DENC detailing the rationale for the termination decision.

3. Use of Information Technology

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 these notices.

4. Duplication of Efforts

The requirement that providers supply plan enrollees in HH, SNF and CORF settings with advance notice of service terminations does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

This requirement will not adversely affect small businesses.

6. Less Frequent Collection

Consumer research supports providing information close to the time 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 the 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 are facing service terminations would not afford all enrollees equal protection of their rights.

7. Special Circumstances

There are no special circumstances to report. No statistical methods will be employed. 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 understands the notice or arranges to have the notice delivered to the enrollee's representative. Providers are required to deliver the NOMNC on behalf of the plan. Note: 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 April 30, 2010. Two comments were received.

9. Payments/Gifts to Respondent

Not applicable.

10. Confidentiality

Not applicable; 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.

11. Sensitive Questions

Not applicable. We do not ask any question of the enrollee.

12. Burden Estimates

The total hourly burden for the NOMNC is: **20,157 hours**
The total hourly burden for the DENC is: **25,196.25 hours**

The total wage burden for the NOMNC is: **$582,134.16**
The total wage burden for the DENC is: **$727,667.70**

In 2009, 10,894,000 Medicare health plan enrollees, in 740 plans, requested 20,157 fast track appeals. Thus, 0.19 percent of Medicare health plan enrollees used the fast track appeal process in 2009.

- We know the majority of NOMNCs are not disputed. Therefore, we estimate that the NOMNCs resulting in fast track appeals represent only 25% of the notices issued.

- To this end, we estimate the 20,157 fast track appeals represent a universe of 80,628 NOMNCs and 20,157 DENCS, for a combined total of 100,785 notices.

To arrive at the combined burden and cost we made the following assumptions for the individual notices:

Plan administrative staff spend 75 minutes per DENC.

- Issuing the 20,157 DENCs that result in appeals would take an estimated 75 minutes at an annualized hour burden of **25,196.25 hours** (1.25 hours multiplied by 20,157) or 34.05 hours per plan (25,196.25 divided by 740).

Provider staff spend 15 minutes per NOMNC.

- Issuing the 80,628 NOMNCs results in a total annualized burden of **20,157 hours** (.25 hours multiplied by 80,628), or 0.81 hours per provider (20,157 hours divided by 24,915 HH/SNF/CORF providers).

The total number of DENC and NOMNC notices issued is 100,785. These figures breakdown as follows:

- The total number of DENCs issued per year is 20,157, or approximately 27.24 notices per plan (20,157divided by 740 plans).

- The total number of NOMNCs issued per year is 80,628, or approximately 3.24 notices per provider (80,628 divided by 24,915 providers).

We estimate 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 $28.88.

- Thus, for the DENC, we estimate a total wage burden of **$727,667.70** (25,196.25 total annual hours x $28.88) or $36.10 per response ($727,667.70 divided by 20,157 annual responses).
- For the NOMNC, we estimate a total wage burden of **$582,134.16** (20,157 total annual hours multiplied by $28.88) or $7.22 per response ($582,134.16 divided by 80,628 annual responses).

13. Capital Costs

There are no capital costs associated with this collection.

14. Cost to Federal Government

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

15. Changes to Burden

Our revised methodology for calculating the total burden, in part, is responsible for the increase in burden. We now include the total number of affected providers as well as the total number of Medicare health plans in our calculations (see explanation below).

Additionally, the number of Medicare health plans has grown from 376 to 740 plans, the number of Medicare enrollees has increased from 6.1 million to 10.9 million, and the hourly wage for a GS-12, Step 1 employees has increased from $26.53 to $28.88.

In the current package, we have broken down our estimates according to the entity responsible for delivering the notices. That is:

- We calculated the total burden for the NOMNC based on the total number of covered providers in the Medicare program (i.e., SNFs, HHAs, CORFs): 20,157 hours divided by $582,134.16.
- We calculated the total burden for the DENC based on the total number of Medicare health plans: 25,196.25 hours divided by $727,667.70.

Previously, we estimated the total burden for notice delivery (NOMNC and DENC) based solely on the total number of Medicare health plans: 23,780.52 divided by $630,896.56.

16. Publication and Tabulation Dates

CMS does not intend to publish data related to the notices.

17. Expiration Date

CMS would like to display the expiration date.

18. Certification Statement

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