

**Supporting Statement – Part A**  
**Notice of Denial of Medical Coverage (or Payment) - NDMCP**  
**CMS-10003/OCN 0938-0829**

**Background**

The Centers for Medicare & Medicaid Services (CMS) requests Office of Management and Budget (OMB) approval of a revision to a previously approved collection, form CMS-10003--the Notice of Denial of Medical Coverage (NDMC) and the Notice of Denial of Payment (NDP). Both notices are due to expire on October 31, 2013. As explained in more detail below, the revised notice that is the subject of this PRA package combines the NDMC and NDP and incorporates text to be inserted if the Medicare health plan enrollee receives full benefits under a State Medical Assistance (Medicaid) program being managed by the plan and the plan denies a service or item that is also subject to Medicaid appeal rights.

Medicare health plans, including Medicare Advantage plans, cost plans, and Health Care Prepayment Plans (HCPPs), are required to issue form CMS-10003 when a request for either a medical service or payment is denied in whole or in part. The notice explains why the plan denied the service or payment and informs Medicare enrollees of their appeal rights. Form CMS-10003 is currently separated into a denial notice for services (a pre-service request), the NDMC, and a denial notice for payment of a service or item the enrollee has received, the NDP.

The revised notice that is the subject of this PRA package seeks to accomplish two key changes to CMS-10003, as explained below.

**1. Merging the NDMC and NDP**

This revised form CMS-10003 combines the content of CMS-10003-NDMC and CMS-10003-NDP. Given the similarity between the two notices, we believe it is feasible and desirable to combine the content of the medical coverage denial notice with the payment denial notice. While accomplishing this requires the addition of bracketed text which a plan must insert, as appropriate, we believe the overwhelming preponderance of the language contained in the notice is applicable to both service and payment denials and can be streamlined. We believe this streamlined approach will be less confusing for beneficiaries and may be less burdensome for plans because there will be a single notice to administer.

**2. Integrating Medicaid Appeal Rights for Individuals Eligible for Medicare and Medicaid**

This revised notice seeks to integrate Medicaid appeal rights into form CMS-10003, where integration of that information is appropriate for an enrollee. It has been a long-standing goal of CMS to develop an integrated denial notice to be used in the managed care setting for beneficiaries who are eligible for Medicare and full Medicaid benefits under a State Medicaid plan. These individuals are often referred to as “full dual eligibles.” Revised form CMS-10003 contains text in square brackets “[ ]” that will be

integrated into the notice for the full dual eligible population if the plan denies a service that is subject to Medicaid appeal rights.

#### Advantages of an Integrated Denial Notice for Full Dual Eligibles

In addition to continuing to use form CMS-10003 to explain appeal rights to Medicare health plan enrollees, this revised notice will be used, as appropriate, to explain Medicaid appeal rights to full dual eligible individuals enrolled in a Medicare health plan that is also managing the individual's Medicaid benefits. To that end, the revised notice contains bracketed text the plan will insert if the denial notice is being delivered to an enrollee who is a full dual eligible. The text in square brackets "[ ]" reflects the Federal protections for Medicaid managed care enrollees. Since a State may offer additional protections, there is also free-text space for inclusion of any State-specific protections that exceed the Federal protections. While use of this form may require some initial customization by plans to reflect additional State protections, if applicable, CMS believes that having a single denial notice for use in the managed care setting will be less confusing for dual eligible enrollees and will be more efficient for managed care plans.

Currently, a full dual eligible enrolled in a plan that is managing the enrollee's benefits under both Medicare and Medicaid would receive two separate denial notices that explain the individual's appeal rights--the form CMS-10003 and a Medicaid notice. Once the use of this revised form CMS-10003 is implemented, full dual eligibles will receive a single notice that integrates information on the individual's Medicare and Medicaid appeal rights.

### **A. Justification**

#### **1. Need and Legal Basis**

Section 1852(g)(1)(B) of the Social Security Act (SSA) requires Medicare health plans to provide enrollees with a written notice in understandable language of the reasons for the denial and a description of the applicable appeals processes. Regulatory authority for this notice is set forth in Subpart M of Part 422 at 42 CFR §422.568, §422.572, §417.600(b), and §417.840.

Section 1932 of the Social Security Act (SSA) sets forth requirements for Medicaid managed care plans, including beneficiary protections related to appealing a denial of coverage or payment. Section 1902(a)(3) of the SSA requires State plans to provide for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon promptly. The Medicaid managed care appeals regulations are set forth in Subpart F of Part 438, Title 42 of the Code of Federal Regulations (CFR). Rules on the content of the written denial notice can be found at 42 CFR §438.404. Related requirements on the information a Medicaid managed care plan must provide to enrollees related to grievances, appeals and fair hearing procedures can be found at 42 CFR §438.10(g)(1). A State may provide for greater appeal protections under its Medicaid State plan.

## **2. Information Users**

CMS will not use these notices to collect and analyze data on Medicare health plan appeals.

## **3. Use of Information Technology**

No data are being collected through these notices for analysis; therefore, CMS does not use automated, electronic, mechanical, or other technological collection techniques or other forms of information technology to collect data related to these notices.

The notice is not available for completion electronically. Medicare health plans are required to provide this notice to Medicare enrollees if a service or payment request is denied to ensure that enrollees are informed of their Medicare appeal rights. In addition, health plans that have enrollees who are full dual eligibles will provide the integrated version of the notice to inform these individuals of their appeal rights under both Medicare and Medicaid. Medicare health plans are required by law to deliver written denial notices to plan enrollees. CMS has no current plans to rely on electronic delivery of this notice. The notice does not require a signature from respondents, so the question of CMS accepting electronic signatures is not applicable.

## **4. Duplication of Efforts**

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. The notices inform enrollees of the right to file an appeal if a request for service or payment is denied in whole or in part.

## **6. Less Frequent Collection**

The statute requires plans to issue written notice to enrollees whenever requests for items/services or payment are denied. Thus, there are no opportunities for less frequent collection.

## **7. Special Circumstances**

The Notice of Denial of Medical Coverage (or Payment) is issued by plans when an enrollee's request for either an item/service or payment is denied in whole or in part. There are no special circumstances to report, and no statistical methods will be employed.

## **8. *Federal Register Notice*/Outside Consultation**

The 60-day Federal Register notice published on September 7, 2012 (77 FR 55216). Comments were received. A summary of those comments and our response has been added to this package.

## **9. Payments/Gifts to Respondents**

Not applicable.

## **10. Confidentiality**

Personally identifiable information contained in the notice is protected by the Privacy Act and HIPAA standards for plans and their providers. CMS will not collect data from the notices. Thus, CMS assurance of confidentiality is not applicable to this collection.

## **11. Sensitive Questions**

No questions of a sensitive nature will be asked.

## **12. Burden Estimate (Total Hours and Wages)**

The number of respondents for this collection is based on 2011 CMS Statistics which indicate that there are 665 Medicare health plans (excluding stand-alone prescription drug plans). Source: 2011 CMS Statistics (Table I.7):  
[http://www.cms.gov/ResearchGenInfo/02\\_CMSStatistics.asp](http://www.cms.gov/ResearchGenInfo/02_CMSStatistics.asp)

Based on data reported to CMS by Medicare health plans, there were 6,960,410 adverse and partially favorable decisions issued in 2011. While the 2011 Medicare Part C Reporting Requirements Technical Specifications instructed plans to omit some types of organization determinations related to certain provider payment requests, we believe the 2011 plan reported data are the most current and reliable data available for the purpose of developing the burden estimates for this PRA package. CMS acknowledges that these burden estimates are significantly higher than the estimates contained in the previous package for CMS-10003. However, at the time the previous package was submitted for approval, CMS did not have plan reported data on organization determinations. CMS now has the advantage of having plan reported data to inform these burden estimates.

In the previous PRA package for CMS-10003, we developed our burden estimates based, in part, on findings from an October 2009 Memorandum Report of the HHS Office of Inspector General which found that plans denied, in whole or in part, about 2.3% of all service-related organization determinations that were part of the OIG's data sample from the last quarter of calendar year 2007 (October 1 – December 31, 2007). For more information on that report, see: OIG Memorandum Report: "Beneficiary Appeals in Medicare Advantage," October 22, 2009, OEI-01-08-00280, pp. 8-9: <http://oig.hhs.gov/oei/reports/oei-01-08-00280.pdf>.

The CMS plan reported data indicate a 2.6% denial rate (6,960,410 denials issued out of a total of 269,979,119 organization determinations), which is essentially the same as the 2.3% denial rate contained in the OIG report. So, while the overall volumes CMS is using for the current estimates are significantly higher due to the use of actual plan reported data, it's noteworthy that there is consistency between the two data sets with respect to the rate at which plans are denying organization determination requests.

The cost burden for this package was calculated using the hourly rate of \$28.88, based on a GS-12/Step 1 salary. We estimate it will take about 6 minutes to complete the notice for Medicare services that have been denied. Since integration of Medicaid appeals information is a new option under this revised notice, it may initially take plans additional time (we estimate up to 13 minutes) to complete the information for the integrated version of the notice. Therefore, we estimate it will take plans an average of 10 minutes to complete the denial notice.

The total annual hourly burden for this collection is 1,159,604 hours (10 minutes/.1666 hour per notice x 6,960,410 notices = 1,159,604 hours), or 1,744 hours per plan. The total estimated annual cost for this collection is \$33,479,572 (.1666 x \$28.88 = \$4.81 per notice x 6,960,410 notices = \$33,479,572), or \$50,345 per plan.

CMS does not have Medicaid data on the rate at which services are denied in the managed care setting. However, since the integrated version of this notice will be provided to individuals who are eligible for Medicare and full Medicaid benefits (full duals), we believe these burden estimates adequately account for this population. According to CMS' Provider Enrollment Entitlement Economic Attribute Reporting (PEAR) database, there are approximately 6,518,237 full dual eligible beneficiaries, of which 919,180 are enrolled in a Medicare health plan. According to the 2011 CMS Statistics there are 10,709,000 Medicare health plan enrollees (excluding those in stand-alone PDPs). Therefore, full dual eligible beneficiaries constitute about 9% of all Medicare health plan enrollees. These individuals are Medicare beneficiaries/health plan enrollees who also receive full Medicaid benefits. Therefore, we do not believe inclusion of Medicaid appeals information materially affects the burden estimate with respect to the total number of denial notices that will be issued by health plans.

### **13. Capital Costs**

There are no capital costs

### **14. Cost to the Federal Government**

No costs to the Federal government are anticipated. The notices will be printed and distributed by individual Medicare health plans.

### **15. Changes to Burden**

The annual hour burden associated with this collection is estimated to be 1,159,604

hours. The annual hour burden in the 2010 submission for this collection was 194,728 hours. As discussed in section 12, the significant increase in the burden estimates is due to the use of Medicare health plan reported data on organization determinations which was not available when the previous PRA package was submitted for this collection. CMS believes the 2011 plan reported data are the most current and reliable data available for the purpose of developing the burden estimates for CMS-10003.

Also, changes have been made since the publication of the 60-day FR notice. Those changes can be found in the NDMCP Crosswalk.

#### **16. Publication / 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 83i is requested.

#### **B. Collection of Information Employing Statistical Methods**

N/A