

Supporting Statement – Part A
Fast Track Appeals Notices: NOMNC / DENC
CMS-10123/-10124 (OMB 0938-0953)

Introduction

The Centers for Medicare & Medicaid Services (CMS) requests a revision of two Office of Management and Budget (OMB)-approved Medicare notices: the Notice of Medicare (Provider) Non-Coverage (NOMNC) and the Detailed Explanation of Non-Coverage (DENC). This information collection results from the fast appeal process available to Medicare beneficiaries in Original Medicare and enrollees in Medicare health plans who receive notice that their Medicare-covered services are being terminated. Medicare beneficiaries and 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),
- The term “Medicare providers” also includes hospices when referring to beneficiaries in Original Medicare,
- The term “Medicare health plans” includes Medicare Advantage plans and cost plans, and
- “Beneficiaries” refers to Medicare beneficiaries in Original Medicare and “enrollees” refers to Medicare beneficiaries enrolled in Medicare health plans.

Background

The purpose of the NOMNC is to help the beneficiary/enrollee decide whether to pursue an appeal and, if so, when and where to file a request. Consistent with 42 CFR 405.1200 and 42 CFR 422.624, SNFs, HHAs, CORFs, and Hospices must provide notices to all beneficiaries/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 beneficiary/enrollee through the NOMNC.

If the beneficiary/enrollee appeals the decision to terminate covered services to the Quality Improvement Organization (QIO), the QIO and the beneficiary/enrollee, consistent with 42 CFR 405.1200(b) and 405.1202(f) for Original Medicare, and 42 CFR 422.624(b) and 422.626(e)(1)-(5) for Medicare health plans, will receive a detailed explanation of the reasons services should end. This detailed explanation is provided to the beneficiary/enrollee and QIO using the DENC, the second notice included in this revision package.

A. Justification

1. Need and Legal Basis

Section 521 of BIPA, Pub.L.106--554, amended section 1869 of the Social Security Act (the Act) to require significant changes to the Medicare appeals procedures. Among these changes is a requirement under section 1869(b)(1)(F) of the Act that the Secretary establish a process by which an individual may obtain an expedited determination and reconsideration with respect to the termination of provider services. The NOMNC and the DENC fulfill these regulatory requirements.

- §405.1200(b) – Prior to any termination of a covered service, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services.
- §405.1202(f) – When a QIO notifies a provider that a beneficiary has requested an expedited determination, the provider must send a detailed termination notice to the beneficiary by close of business of the day of the QIO's notification.

Pursuant to 42 CFR 422.624 (b)(1), providers 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 a detailed notice to the enrollee 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 notice procedures for their enrollees.

- §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 Independent Review Entity (IRE), currently the QIO, notifies a 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 beneficiaries/enrollees no later than two days prior to the end of Medicare-covered services in SNFs, HHAs, CORFs, and Hospices.

Beneficiaries/enrollees will use this information to determine whether they want to appeal the service termination to their QIO. If the beneficiary/enrollee decides to appeal, the Medicare provider/health plan will send the QIO and appellant a DENC detailing the rationale for the termination decision.

3. Use of Information Technology

SNFs, CORFs, HHAs and Hospices generally deliver advance written notices to beneficiaries/enrollees in person or by mail. Providers (and Medicare health plans) must deliver detailed written notices whenever a beneficiary/enrollee requests an appeal. 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 HHA, SNF, CORF, and Hospice 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 a beneficiary/enrollee receiving covered provider services, the beneficiary/enrollee needs to decide whether he/she believes services should continue after being notified that services will be terminated. 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 covered services being terminated decreases potential financial liability in the event the beneficiary/enrollee wants to appeal. Providing advance notices to less than 100% of all individuals who are facing service terminations would not afford all beneficiaries/enrollees equal protection of their rights.

7. Special Circumstances

There are no special circumstances to report. No statistical methods will be employed. The regulations at §405.1202(b) and §422.624(c) require that the notices be validly delivered to either beneficiaries/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 beneficiary/enrollee understands the notice or arranges to have the notice delivered to the representative. For Medicare health plan enrollees, 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 for compliance with the related regulations.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice published on June 13, 2014 (79 FR 33927). Comments were received. As explained in our response, no program changes or adjustments were made as a result of those comments. The comments and our response have been added to this package.

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 annual hourly burden for the NOMNC is: 885,699 hours

The total annual hourly burden for the DENC is: 42,232 hours (19,111 + 23,121)

The total annual cost burden for the NOMNC is: \$25,826,982

The total annual cost burden for the DENC is: \$1,231,838

These burden estimates were developed using CMS data from 2009, which is the latest single-year data available.

In 2009, 47.1 million Original Medicare beneficiaries requested 15,289 fast appeals. Thus, .03 percent of Original Medicare beneficiaries used the fast appeal process in 2009.

In 2009, 10,894,000 Medicare health plan enrollees, in 740 health plans, requested 18,497 fast appeals. Thus, 0.17 percent of Medicare health plan enrollees used the fast track appeal process in 2009.

Based on the 2009 CMS Data Compendium, we estimate that providers delivered 5,314,194 notices to Medicare beneficiaries and health plan enrollees. This estimate is based on the number of persons receiving home health services and persons discharged from SNFs.

The amount of Medicare business with CORFs is so small that Medicare statistical summaries do not include a separate line item for patient encounters with these facilities. Similarly, we do not have precise estimates of hospice discharges, but the number is considered to be an extremely small percentage of the total number of annual hospice patients. Accordingly, our analysis is necessarily limited to HHA and SNF services.

To arrive at the estimated annual hourly and cost burdens, we made the following assumptions and calculations for the individual notices:

NOMNC

Hourly Burden

As previously noted, 5,314,194 NOMCS were issued to Original Medicare beneficiaries and Medicare health plan enrollees in 2009. We estimate that provider staff spend 10 minutes per

NOMNC. This results in a total annual burden estimate of 885,699 hours (10 minutes/60 minutes x 5,314,194 NOMNCs).

Cost Burden

We estimate that these notices are most likely prepared by a staff person with professional skills at GS-12 Step 1 with an hourly salary of \$32.40. The cost burden per NOMNC is \$5.40 (10 minutes/60 minutes x \$32.40). The estimated annual cost burden for the NOMNC is \$28,696,647 (\$5.40 x 5,314,194 NOMNCs).

DENC

Original Medicare providers are responsible for delivering the DENC to beneficiaries and Medicare health plans are responsible for delivering the DENC to health plan enrollees. Therefore, we are breaking out the burden for the two Medicare programs.

Hourly Burden – Original Medicare

Original Medicare providers issue 15,289 DENCs on an annual basis. We estimate that provider staff spend 75 minutes per DENC, which results in an annual hourly burden for Original Medicare providers of 19,111 hours (75 minutes/60 minutes x 15,289 DENCs).

Cost Burden – Original Medicare

We estimate that these notices are most likely prepared by a staff person with professional skills at GS-12 Step 1 with an hourly salary of \$32.40. The cost burden per DENC is \$40.50 (75 minutes/60 minutes x \$32.40), which results in an estimated annual cost burden for Original Medicare providers of \$619,205 (\$40.50 x 15,289 DENCs).

Hourly Burden – Medicare Health Plans

Medicare health plans issue 18,497 DENCs on an annual basis. We estimate that health plan staff spend 75 minutes per DENC, which results in an annual hourly burden for Medicare health plans of 23,121 hours (75 minutes/60 minutes x 18,497 DENCs).

Cost Burden – Medicare Health Plans

We estimate that these notices are most likely prepared by a staff person with professional skills at GS-12 Step 1 with an hourly salary of \$32.40. The cost burden per DENC is \$40.50 (75 minutes/60 minutes x \$32.40), which results in an estimated annual cost burden for Medicare health plans of \$749,129 (\$40.50 x 18,497 DENCs).

Based on the above burden estimates for the DENC, the combined estimated hourly burden for Original Medicare providers and Medicare health plans is 42,232 hours and the combined annual cost burden of the DENC is \$1,368,334.

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

While there are no changes to the currently approved burden estimates, the form instructions contain nonsubstantive formatting and wording changes to support document clarity. The changes are set out in the accompanying Crosswalks.

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.

B. Collections of Information Employing Statistical Methods

n/a