

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare and Medicaid Services

#### 42 CFR Parts 422 and 489

[CMS-4024-FC]

RIN 0938-AK48

### Medicare Program; Improvements to the Medicare+Choice Appeal and Grievance Procedures

**AGENCY:** The Centers for Medicare & Medicaid Services, HHS.

**ACTION:** Final rule with comment period.

**SUMMARY:** This final rule with comment period responds to comments on the January 24, 2001, proposed rule regarding improvements to the Medicare+Choice (M+C) appeal and grievance procedures. It establishes new notice and appeal procedures for enrollees when an M+C organization decides to terminate coverage of provider services. The January 24, 2001 proposed rule was published as a required element of an agreement entered into between the parties in *Grijalva v. Shalala*, civ. 93-711 (U.S.D.C. Az.), to settle a class action lawsuit.

This rule also specifies a Medicare-participating hospital's responsibility for issuing discharge or termination notices under both the original Medicare and M+C programs, amends the Medicare provider agreement regulations with regard to beneficiary notification requirements, and amends M+C enrollee grievance procedures.

**DATES:** *Effective date:* Except for §§ 422.564, 422.620, 422.624, and 422.626, which are subject to the Paperwork Reduction Act (PRA), this final rule with comment period is effective May 5, 2003. We will publish the effective dates of those sections of the rule that are subject to the PRA in the **Federal Register** when the sections have been approved by the Office of Management and Budget.

*Comment date:* We will consider comments on this final rule if received at the appropriate address, as provided below, no later than 5 p.m. on June 3, 2003.

**ADDRESSES:** Mail written comments (one original and three copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-4024-FC, P.O. Box 8013, Baltimore, MD 21244-8013. To insure that mailed comments are received in time for us to consider them,

please allow for possible delays in delivering them.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room 443G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-16-03, 7500 Security Boulevard, Baltimore, MD 21244-8013.

Comments mailed to the above addresses may be delayed and received too late for us to consider them.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code CMS-4024-FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443-G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

**FOR FURTHER INFORMATION CONTACT:** Chris Gayhead, (410) 786-6429 (for issues concerning improvements to the M+C appeals and grievance procedures); Rhonda Greene Bruce, (410) 786-7579 (for issues related to hospital discharge notices).

### I. Background

#### A. *Balanced Budget Act of 1997*

Section 4001 of the Balanced Budget Act of 1997, (BBA) (Pub. L. 105-33), enacted August 5, 1997, added sections 1851 through 1859 to the Social Security Act (the Act) to establish a new Part C of the Medicare program, known as the "Medicare+Choice (M+C) Program." Implementing regulations for the M+C program are set forth in 42 CFR part 422. Subpart M of part 422 implements sections 1852(f) and (g), which set forth the procedures M+C organizations must follow with respect to grievances, organization determinations, and reconsiderations and other appeals. Under section 1852(f) of the Act, an M+C organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any other entity or individual through which the organization provides health care services) and enrollees in its M+C plans.

Section 1852(g) of the Act addresses the procedural requirements concerning coverage determinations (called "organization determinations") and reconsiderations and other appeals of such determinations. In general, organization determinations involve the

question of whether an enrollee is entitled to receive, or should continue to receive, a health service, and the amount the enrollee is expected to pay for the service. An organization determination may also involve an enrollee's request for reimbursement for services obtained with or without prior authorization. Only disputes concerning organization determinations are subject to the reconsideration and other appeal requirements under section 1852(g) of the Act. All other disputes are subject to the grievance requirements under section 1852(f) of the Act. For purposes of this final rule, a reconsideration consists of a review of an adverse organization determination (a decision that is unfavorable to the M+C enrollee, in whole or in part) by either the M+C organization or an independent review entity (IRE) or entities. We use the term "appeal" to denote any of the procedures that deal with the reviews of organization determinations, including reconsiderations, hearings before administrative law judges (ALJs), reviews by the Medicare Appeals Council (MAC) and judicial review.

#### B. *Grijalva v. Shalala*

*Grijalva v. Shalala* is a 1993 class action lawsuit brought by beneficiaries enrolled in Medicare risk-based managed care organizations. The plaintiffs challenged the adequacy of the managed care appeals process and claimed that CMS failed to assure that contracting managed care organizations afforded enrollees rights to which plaintiffs contended enrollees were entitled when the organization denied, reduced, or terminated health care coverage.

The Secretary and the plaintiffs reached a settlement agreement in the case, which the Arizona District Court approved on December 4, 2000. Under the settlement agreement, we agreed to publish a notice of proposed rulemaking (NPRM) proposing regulations that would establish new notice and appeal procedures when an M+C organization decides to terminate coverage of provider services to an enrollee. Providers that would be affected under the proposed rules published pursuant to the settlement agreement included skilled nursing facilities (SNFs), home health agencies (HHAs) and comprehensive outpatient rehabilitation facilities (CORFs). A key element of the agreement was that CMS would propose to establish an independent review entity to conduct fast-track reviews of appeals of decisions to terminate services. Under the proposed process, M+C enrollees would receive detailed written notices concerning their service