

terminations and their appeal rights at least four days before a service termination. The proposed appeal process would be carried out during those four days. (See our January 24, 2001, proposed rule, 66 FR 7594, for a more detailed description of the settlement agreement.)

The settlement agreement contained a great deal of specificity with respect to both the notice and appeal procedures to be set forth in the proposed rule, and the timeframes for publication of proposed and final rules. However, consistent with Administrative Procedure Act (APA) standards for notice and comment rulemaking, the agreement explicitly established that publication of the proposed requirements "[should] not be construed as a promise or predetermination regarding the content of [the] final rule \* \* \* on notice and appeal procedures for M+C organization decisions to terminate provider services."

## II. Provisions of the Proposed Rule

On January 24, 2001, we published an NPRM (66 FR 7593) that, consistent with the settlement agreement, proposed regulations that would establish that an M+C enrollee who is dissatisfied with an M+C organization's decision to terminate SNF, HHA, or CORF services would have the right to a fast-track review by an independent entity. As described below, the proposed rule set forth the notification and appeals procedures for implementing this new appeal right. The proposed rule also addressed the notification procedures associated with similar appeal rights available to Medicare beneficiaries receiving inpatient hospital services as well as M+C beneficiary grievance procedures.

### A. Proposed Notice and Appeal Procedures

We proposed that for any termination of services furnished by one of the affected types of providers, the enrollee would receive a standardized notice informing them of the M+C organization's decision to terminate the services. Under our proposal, the provider would be charged with the delivery of the notice four calendar days before the scheduled termination. If the services were expected to be furnished to an enrollee for a time span of fewer than four calendar days in duration, the enrollee would be given the notice upon admission. Valid delivery of the notice required the enrollee to sign the notice to indicate that he or she had received the notice and could comprehend it.

We proposed that the termination notice contain the following information:

A specific and detailed explanation why services were either no longer medically necessary or were no longer covered (with a description of any applicable Medicare coverage rule).

Any applicable M+C organization policy, contract provision, or rationale upon which the termination decision was based.

Specific, relevant information to an extent sufficient to advise the enrollee of how a Medicare or M+C organization policy applied to the enrollee's case, as well as the date and time that the organization's coverage of services would end (and the enrollee's liability would begin).

A description of the enrollee's fast-track appeal rights, including how to contact the IRE to initiate an appeal, as well as the availability of other M+C appeal procedures if the enrollee failed to meet the deadline for (or decided not to pursue) a fast-track IRE appeal.

Under our proposal, an enrollee who wanted to appeal a termination decision to the IRE needed to contact the IRE by noon of the first calendar day after receiving the termination notice. We specified that an enrollee who timely sought IRE review would be protected from liability for the costs of services during the fast-track appeals process. Coverage of provider services would continue until noon of the day after an enrollee received notice of an IRE's decision upholding the M+C organization's determination, or until the time and date designated on the termination notice, whichever was later.

We proposed that when an enrollee appealed an M+C organization's decision to terminate provider services, the burden was on the M+C organization to prove that the termination was the correct decision. The M+C organization would be required to supply any information that the IRE required to sustain the termination decision, including a copy of the termination notice. The M+C organization would be required to supply this information as soon as possible, but no later than the close of business of the first day after the day the IRE notified the M+C organization that the enrollee had requested a review.

Assuming that the IRE received all needed information on a timely basis, the proposed process would have resulted in a decision by the close of business on the second full day after the deadline for an enrollee's appeal request, with the following possible results:

If the IRE decided that services should not be terminated, a new termination notice would be required, with attendant appeal rights, before the M+C organization could terminate services.

If the IRE deferred its decision, coverage of the services would continue until the decision was made but no additional termination notice would be required.

If the IRE decided to uphold the M+C organization's decision to discontinue services, coverage of the enrollee's services would end at noon on the day after the IRE made its decision or as specified in the termination notice, whichever is later.

In the event that the M+C organization's decision was upheld, the enrollee would be financially liable for any services provided after the effective date identified in the notice. The proposed rule outlined that an enrollee's first recourse after an unfavorable IRE decision would be to request, within 60 days, that the IRE reconsider its decision. The IRE would have up to 14 calendar days from the date of the request for reconsideration to issue its reconsidered determination, with subsequent appeals possible to an ALJ and the MAC, consistent with the procedures set forth in the existing M+C regulations.

### B. Hospital Notification Procedures

We also proposed in the January 24, 2001, rule requirements regarding hospitals' responsibility for issuing discharge notices under both the original Medicare and the M+C program. Specifically, we proposed that hospitals be required to provide to all Medicare beneficiaries (including those enrolled in M+C plans) a notice that includes the reasons for a discharge and information on their appeal rights. Under the proposed rule, hospitals would be responsible for delivering such a notice to each beneficiary the day before the date of the discharge. We noted that these notices would have to be approved by the Office of Management and Budget under section 3506(c)(2)(A) of the Paperwork Reduction Act.

### C. Grievance Procedures

The January 2001 rule also proposed to revise the existing definition of a "grievance," and proposed that an M+C organization be required to notify the enrollee of its decision as expeditiously as the case required, but no later than 30 calendar days after the date the organization received the grievance. In conjunction with this timeframe, we also proposed that the M+C organization be permitted to extend the timeframe by