

up to 14 calendar days if the enrollee requested the extension or if the organization justified a need for additional information and the delay was in the interest of the enrollee.

Our proposal would require an M+C organization to inform the enrollee of the disposition of the grievance in writing if the grievance was submitted in writing. Grievances submitted orally could under the proposal be responded to either orally or in writing unless a written response was specifically requested by the M+C enrollee.

We proposed that the M+C organization's written response to a grievance involving quality of care issues or concerns must describe the enrollee's right to seek Quality Improvement Organization (QIO) review. For any complaint involving a QIO, the M+C organization must cooperate with the QIO in resolving the complaint.

The proposed rule specified that an M+C organization would be required to expedite a grievance if: (1) The grievance involved an M+C organization's decision to invoke an extension relating to an organization determination or reconsideration; (2) the grievance involved an M+C organization's refusal to grant an enrollee's request for an expedited organization determination; or (3) applying the standard timeframe could seriously jeopardize the enrollee's life, health or ability to regain maximum function. We proposed that the M+C organization notify the enrollee of its decision on an expedited grievance within 72 hours of receipt of the enrollee's grievance. The proposed grievance procedures concluded with the requirement that the M+C organization have a system to track and maintain records on all grievances received both orally and in writing, including the final disposition of the grievance. The tracking system would be required to maintain, at a minimum, date of receipt, disposition and date the response was given.

D. Reductions of Service

As part of the *Grijalva* settlement, we agreed to solicit comments in the January 2001 rule on how to provide notice and appeal procedures for decisions by M+C organizations to reduce provider services. We stated in the January 2001 proposed rule that, based on our review of this issue, we were considering adopting the position that a written notice should be required whenever there was a reduction in previously authorized ongoing course of treatment. We did not put forth specific regulatory language to implement this

approach, but instead asked for public comments on the appropriateness of such a requirement and recommendations on specific regulatory revisions in this regard.

III. Analysis of and Responses to Public Comments

A. Overview of Comments on January 24, 2001 Proposed Rule

We received 33 timely comments from organizations representing hospitals and other providers, M+C organizations, beneficiary advocacy groups and others. Commenters representing providers and managed care organizations uniformly agreed that the new appeals procedures were unworkable as proposed. They raised a series of objections to the proposed provisions, with concerns focusing on the following areas:

- Creation of a fast-track appeals process.
- Timing of the termination notices.
- Content and delivery of the notices.

The commenters representing beneficiary groups generally supported the procedures as proposed and urged CMS to finalize the proposed provisions. Commenters also expressed concern over the revised procedures for notifying Medicare beneficiaries of their right to appeal when discharged from an inpatient hospital. We also received comments on the proposed grievance procedures and the appropriateness of establishing notice and appeal procedures for reductions in provider services. These comments and our responses are discussed below.

B. The Proposed Fast-Track Review Process (Sections 422.624 and 422.626)

1. Need for a New Fast-Track Appeals Process

Comment: Several commenters opposed the creation of a fast-track, independent appeals process. These commenters argued that the current expedited appeals process is effective to handle appeals of provider terminations. They pointed out that the appeals process had changed considerably since the *Grijalva* lawsuit was first filed in 1993, including the implementation of an expedited appeals process for Medicare managed care enrollees (through an April 30, 1997, final rule (62 FR 23375)) and the subsequent establishment of the M+C program appeals procedures (under the BBA and implementing regulations). They asserted that the new fast-track appeals process would be confusing, duplicative, burdensome and expensive.

Response: We recognize that many of the problems that led to the original

Grijalva lawsuit have been rectified through subsequent statutory and regulatory changes, and we believe that the existing expedited appeals process constitutes an important and effective beneficiary protection. However, the current expedited appeals process was designed primarily to address denials of the initiation of a service. The fast-track appeals process proposed in the January 24, 2001, rule would deal with decisions about the termination of provider services. Moreover, obtaining an independent review of an M+C organization's decision to terminate an enrollee's provider services now takes at least 6 days to complete, under a process where both the M+C organization and CMS's independent contractor must review an adverse organization determination about the need for further services. Our experience has been that decisions involving the termination of provider services, particularly in nursing homes, have been among the most contentious, and have often exposed enrollees to potentially significant financial liability for continuation of services. Under the fast-track process, an enrollee may appeal directly to an IRE, with greatly limited, if any, financial liability. This one-step process, carried out at government expense, can limit appeal processing costs for both the enrollee and the M+C organization.

We also note that section 1869(b) of the Act, as amended by section 521 of the Medicare Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), has introduced significant new appeal requirements for beneficiaries under the original Medicare program that substantially parallel those proposed pursuant to the *Grijalva* settlement. BIPA requires the Secretary to establish a new fast-track appeal process when a provider of services plans to terminate an individual's services or discharge the individual from the provider. Currently, this right to an expedited review only exists with respect to hospital discharges under sections 1154 and 1155 of the Act. Our decision to implement an independent review process for terminations of provider services furnished to M+C enrollees is entirely consistent with, and bolstered by, the Congressional intent and direction evidenced by the BIPA provisions. (See our November 15, 2002, proposed rule, at 67 CFR 69312 for further details on the BIPA statute and our proposed new appeal provisions.) We believe that CMS must assure that all Medicare beneficiaries are afforded a fair and equitable process to appeal