

provider terminations whether the beneficiary is enrolled in M+C or original Medicare.

2. Timing of the Termination Notices

Comment: Many commenters stated that it is clinically improbable that an M+C organization or provider could accurately predict four days in advance when a discharge would be appropriate, particularly in the nursing home setting where discharge decisions are made "at most 48 hours prior to discharge." They argued that requiring delivery of the termination notices four days in advance would result in unnecessary appeals being initiated in situations where there could be a subsequent decision that services should not be terminated. They also believe that the four-day advance notice would greatly complicate the appeals decision-making process, since appeals would need to be decided as much as two days before the actual termination of services. Commenters suggested a number of alternative requirements for delivery of the termination notice, including: three days before termination of services, two days before termination, one day before termination of services, and "promptly" after the M+C organization decides that termination is appropriate.

Several commenters representing home health providers expressed concern that providers of such intermittent care in effect would be required to arrange for their staff to make extra visits solely to deliver termination notices. Commenters also suggested that if CMS retained the four-day advance notice requirement, the requirement should be more flexible, *i.e.*, delivery could be carried out before the proposed four-day deadline if circumstances permitted.

Response: The primary intent of the proposed four-day advance notification requirement was to enable the appeals process to be completed by the time services were scheduled to end, and thus to protect enrollees from any financial liability during the course of the appeal process. However, we have become convinced based on our review of the comments and further research into medical practice patterns that providing these notices four days in advance of termination is often not practical, particularly in institutional settings. Therefore, in this final rule, we are requiring under 422.624(b)(1) that enrollees receive notices *no later than two days* in advance of termination of services. We are also revising the proposed requirements to state explicitly that if, in a noninstitutional setting, the span of time between services exceeds two days, the notice

may be provided the next to last time services are furnished.

We recognize that the result of this change would be that in some situations, enrollees will be exposed to potential liability for services that are found unnecessary by the independent review entity. However, we have concluded that it is not possible to construct a system that in all situations provides a meaningful notice about termination of services and still builds in complete financial protection for enrollees during the course of an appeal to an IRE. Note that we are also revising the appeals process itself (by shortening the time frame for records to be sent to the IRE, under 422.626(e)(3)) to ensure that it is completed within three days of the notice of termination. The effect of these changes is that an enrollee will face a maximum of one day of financial liability if the IRE rules that the disputed discharge date is appropriate.

In establishing this policy, we carefully considered how to balance two conflicting responsibilities—the need to ensure that an M+C enrollee has an opportunity to a meaningful appeal without undue financial exposure with the obligation not to impose inappropriate financial burdens on M+C organizations. Clearly, except in the inpatient hospital setting, the Medicare statute generally does not provide financial liability protection for either M+C enrollees or other Medicare beneficiaries who have chosen to continue to receive services pending the result of an appeal or claim determination. Absent a statutory mandate, we do not believe we have the authority to require M+C organizations to pay for services that are subsequently determined by an independent review entity not to be medically necessary, or otherwise covered, for the enrollee in question. (As noted above, section 521 of BIPA establishes a similar right to a fast track appeal of a termination of provider services (under section 1869(b)(1)(F) of the Act), but did not provide for continuation of Medicare coverage during the pendency of the appeal.)

It is important to note that an enrollee's potential financial liability for continuing provider services occurs only after valid delivery of the advance termination notice. That is, consistent with the requirements outlined at § 422.624(b), a standardized, signed and dated advance termination notice is required for financial liability to accrue to the enrollee. Providing this notice as soon as the termination date is known (rather than waiting until two days in advance of service termination) will in many cases serve the best interests of

both plan enrollees and the M+C organizations who are responsible for payment for the services.

Comment: Several commenters responded to our specific request for comments on what constituted four-day notice and expressed confusion over whether the deadline for notice delivery would be 3 p.m. or "close of business." Commenters indicated that requiring that the notices be delivered by 3 p.m. was not appropriate, given for example that physicians frequently visit nursing homes late in the afternoon or early in the evening after their office hours are over. Commenters recommended that CMS clarify that termination notices could be given until the end of the business day, which would still enable enrollees to request an appeal by noon of the next day.

Response: We agree with commenters that the deadline for notice delivery needs to be later than 3 p.m. to allow physicians and other practitioners enough time to visit nursing homes or other service settings late in the day. We recognize that practice patterns are different in these settings than in inpatient hospitals and thus that it may not be appropriate to apply the same standard across all provider settings. Thus, rather than establish a more precise time standard in regulations, the regulations will continue to indicate *the latest day* that a notice must be delivered. We intend to issue further program guidance that will be based on the prevalent practice patterns for the various service types. This guidance will reflect our general agreement that delivery of the advance termination notice by "close of business" will provide sufficient time for an enrollee to appeal by noon of the next day.

Comment: Two commenters raised concern over whether the four-day advance notice requirement should include weekends and holidays. One commenter asked that we consider the fact that many of the notices may be given on a day that would place the fourth day on a Saturday, Sunday, or holiday. Another commenter stated that since HHA and CORF services are not usually rendered on weekends or holidays, and M+C organizations have limited staff available on these days, CMS should consider using business rather than calendar days, where appropriate.

Response: As noted above, this final rule changes the requirement for advance notification of termination of services or discharge from the four day standard in the proposed rule to no later than two calendar days prior to termination of services or discharge. The new standard of "at least" two days