

affords an M+C organization or provider the option of providing notice more than two days in advance if the second day before discharge is a non-business day (for example, for a Monday discharge). We have also provided that situations involving non-institutional settings, where the time-span between service delivery exceeds two days, an enrollee should be notified no later than the next to the last time services are furnished. We will work with provider and M+C organization representatives, and with the IRE to develop uniform procedures to deal with those rare situations where an enrollee needs to be given notice or discharged on a weekend. At a minimum, we intend to require, through its contract, that the IRE be able to accept expedited review requests on any day of the week and notify an M+C organization of that request.

3. Content and Delivery of the Termination Notice

Comment: Commenters raised a series of related concerns about both the delivery and content of the termination notices. Many commenters viewed as unnecessarily burdensome the requirement that each enrollee in a provider setting receive a detailed termination notice, regardless of whether the enrollee agreed with the termination of services. They generally believe that in most situations the contents of the required notice were too extensive and would provide little or no benefit to most enrollees.

Commenters were divided on the issue of who should be responsible for distributing the notices. Managed care industry commenters generally supported the proposed requirement that the providers of services deliver the notices, although they expressed concern over their liability in situations where the providers failed to do so. Commenters representing providers objected to being charged with this responsibility, particularly in view of the detailed nature of the notice. They indicated that it would be difficult to obtain all needed information from M+C organizations and that it was unfair to in effect shift the responsibilities of M+C organizations to providers. One commenter argued that a policy whereby providers would be responsible for giving notices does not comport with the settlement agreement.

Response: We continue to believe that providers clearly are in a better position than M+C organizations to carry out routine delivery of service termination notices to their patients. At the same time, although all enrollees need to be made aware of their appeal rights on a

timely basis, we recognize that only a small proportion are likely to object to the termination of their services. Thus, it is in the best interests of all parties that the notice delivery process be as streamlined and simple to administer as possible.

To that end, we are requiring a two-step notification procedure under this final rule. We are revising the proposed requirement that providers deliver a detailed termination notice to M+C enrollees. Instead, we are requiring under 422.624(b) that providers deliver a standardized, largely generic, notice to each M+C enrollee whose services are terminating that will explain the enrollee's appeal rights. The notice will contain only two enrollee-specific elements—the enrollee's name and the date services will end. These notices will contain standardized information on an enrollee's appeal rights and how to initiate an appeal if necessary. Unless the enrollee wishes to dispute the termination of services, no further notice will be required.

The notice will instruct the enrollee to contact the IRE if he or she believes that the services should continue. If the enrollee indicates to the IRE that he or she disagrees with the discharge, the IRE will immediately contact the M+C organization, which will be required under 422.626(e) to deliver a detailed notice to the dissatisfied enrollee and to the IRE. The detailed notice must contain the remaining elements required under the proposed rule, including an explanation of why services were no longer needed, a description of any applicable Medicare coverage rule or policy, a statement of any applicable M+C organization policy or rationale, and facts specific to the enrollee that establish the applicability of Medicare or M+C organization policies. We believe that M+C organizations are in the best position to give detailed notices regarding their specific policies and the criteria that they applied in deciding to terminate provider services. Moreover, in view of the fact that M+C organizations ultimately bear the responsibility for both the service termination/discharge decision and for paying for services covered under their plans, we believe that is appropriate that M+C organizations be responsible for preparing and delivering them under the limited circumstances when they are needed.

Comment: Commenters were concerned that providers would refuse to comply with instructions to deliver notices and wanted to know what incentives were in place to obligate providers to deliver notices.

Response: We believe that the streamlined notification process should greatly ameliorate this concern. Providers will be obligated to comply with notice requirements through the amendment of the provider agreement regulations at § 489.27(b), as well as through their contractual arrangements with M+C organizations. We recognize that M+C organizations may also choose to delegate to providers the responsibility for discharge and termination decisions, and for the delivery of detailed notices in disputed termination cases. M+C organizations may choose to offer incentives to providers for compliance with these responsibilities, or penalties for non-compliance, through these private contractual arrangements. However, consistent with 422.502(i), M+C organizations remain ultimately responsible for carrying out such delegated requirements.

We also note that section 1819(h) of the Act specifies remedies that may be used by the Secretary when a SNF is not in substantial compliance with the requirements for participation in the Medicare program. These penalties are applied on the basis of surveys conducted by CMS or by a survey agency. The regulations at § 488.406 include other penalties for non-compliance such as denials of payment, and corrective action plans. Also, HHAs are regulated in part by conditions of participation found at § 484.12, which indicate that HHAs must operate and furnish services in compliance with all applicable Federal, State and local laws and regulations.

Comment: Several commenters raised questions about financial liability in situations where a provider failed to deliver timely notice. They believe that it would be unfair for M+C organizations to be liable for services in such situations.

Response: Again, we believe that the prevalence of this sort of situation will be greatly lessened in light of the direction that we have taken in this final rule, which places a clear, reasonable obligation on both providers and M+C organizations with respect to informing enrollees of their rights. Nevertheless, the nature of the arrangement between an enrollee and a managed care organization dictates that the organization is ultimately responsible for payment for services that are found to be covered under the enrollee's plan. When an IRE makes a decision on an enrollee's appeal of a service termination, that decision will determine the extent to which liability rests on either the M+C organization or the enrollee. Consistent with