

422.624(a)(2), an IRE's review will be available with respect to termination decisions where an enrollee first was "authorized, either directly or by delegation, to receive an ongoing course of treatment from that provider." Thus, the IRE's determination is limited to whether continuation of an ongoing course of treatment is covered under an enrollee's plan. The IRE will not be expected to assign liability between the provider and the M+C organization.

Accomplishing proper advance notification of termination by the provider requires coordination and information sharing between the provider and the M+C organization to ensure that the enrollee receives the correct information at the proper time. We believe that the interdependence between M+C organizations and SNFs, HHAs, and CORFs reflects the typical daily reality of health plans and insurers.

*Comment:* Some commenters suggested that the 4-day advance notice requirement could result in the overutilization of services. They were concerned, for example, that an enrollee could be kept in a SNF unnecessarily even if the individual's condition had improved sufficiently to permit an unexpectedly early discharge. Commenters also asked about situations where an IRE determined that services should continue only one or two additional days. They questioned the need for additional notices in such situations.

*Response:* The notice requirement is not intended to impede or substitute for appropriate medical decision-making practices. Nothing in these requirements precludes an enrollee from being discharged from a SNF or HHA when an enrollee and his or her physician are in agreement that the discharge is medically appropriate. To clarify this point, we have revised section 422.624(d) to specify that, although an M+C organization is financially liable for continued services until 2 days after an enrollee receives a termination notice, the enrollee may waive the right to continued services if he or she agrees with being discharged sooner than 2 days after receiving the notice. However, an enrollee who objects to the service termination would not be liable for the services until 2 days after receiving the notice.

Similarly, it is not our intent to require M+C organizations to provide more care than an IRE determines would be appropriate. If an IRE specifies the number of days that coverage should continue, the IRE's decision itself takes the place of any further notice. However, there may be instances where

an IRE will defer to an M+C organization to determine when coverage should end. In those cases, another advance termination notice must be given to the enrollee within a time frame consistent with the circumstances involved. Again, we believe that this concern is lessened or eliminated under the change to a 2-day advance notice.

*Comment:* Several commenters were concerned about the length and complexity of the notice, believing that this would cause delays in its preparation and create noncompliance with the delivery and appeals timeframes. Some commenters also argued that preparing these detailed notices about policies, coverage rules and contract provisions for every enrollee prior to provider services terminating would be administratively burdensome.

*Response:* As discussed above, we agree that it is not necessary to provide a detailed notice to all enrollees. We have learned through consumer testing that Medicare beneficiaries prefer to receive relevant information timed according to when they need to act. Thus, we have revised the proposed policy from requiring 100 percent distribution of a detailed notice from providers to all enrollees, to 100 percent distribution of a largely generic notice that explains when services will end, where to appeal if the enrollee disagrees, and potential liability for continued coverage during an appeal. For those enrollees who choose to appeal, M+C organizations would be required to provide a detailed notice that: explains why services are no longer covered or medically necessary, describes any applicable coverage rules, policies, or contract provisions, and contains facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee about the enrollee's care. We believe that this two-step notification process meet the needs of the large majority of enrollees who need to know when their services will end and what their appeal rights are, as well as the small minority of enrollees who want more specific information about why their services are ending. This approach also ensures that providers and M+C organizations are not faced with unnecessary administrative costs and burdens. CMS will develop both notices—the advance termination notice, and the detailed termination notice, through OMB's PRA process.

*Comment:* Some commenters viewed our proposal to require providers to deliver termination notices as evidence that CMS was unfairly favoring M+C

organizations over providers, by allowing M+C organizations to avoid responsibility for providing notices. Some commenters believed that making providers responsible for termination notices simply because they were in the best position to deliver notices was unprecedented and argued that this violated the Administrative Procedure Act (APA).

*Response:* In developing these proposals, as well as in developing this final rule, we have attempted to arrive at policies that balance the rights and responsibilities of all the involved parties, including Medicare beneficiaries, providers, and M+C organizations. We continue to believe that beneficiaries need to be informed of their appeal rights and that providers are in the best position to carry out this function. At the same time, we are very cognizant of the need to accomplish such notification in the most cost-effective and least burdensome manner. Thus, as explained above, we have made adjustments to the proposed provisions to reflect concerns raised by commenters. This is the essence of notice and comment rulemaking, and thus we believe that implementing the notification requirement through this rulemaking process is entirely consistent with the APA. That is, the preamble to the proposed rule satisfied the requirements of the APA by describing our proposed policies and explaining the reasoning behind the proposal that providers deliver the termination notices. This final rule then reflects our careful consideration of the comments received. In response to comments on the burden imposed by the proposal on providers, we have in this final rule lessened that burden.

*Comment:* Various commenters raised questions regarding whether a notice needed to be provided in certain scenarios, such as when services did not meet Medicare coverage criteria, or where a provider or attending physician disagreed with an M+C organization's decision to terminate services.

*Response:* M+C organizations must determine when services should end on the basis that services are no longer medically necessary, or otherwise are not covered under Medicare or the M+C plan's coverage policies. Once an M+C organization determines that provider services should end, providers must deliver notices to enrollees at least two days in advance of services terminating. The requirement to provide the notice is independent of the basis for termination of a course of treatment. In other words, it applies whether the decision is based on a medical necessity judgment or the application of a Medicare coverage rule.