

Similarly, the provider's obligation to give an advance termination notice to the enrollee exists even if a provider or attending physician disagrees with the M+C organization that services should terminate. The M+C organization's decision to end services is not an indication that the provider necessarily agrees that services should end, but it is necessary to ensure that the enrollee has the opportunity to appeal the M+C organization's decision.

Comment: Commenters recommended that CMS permit providers to request appeals on behalf of enrollees and recommended that an IRE's decision bind an M+C organization to pay a provider for necessary services.

Response: Providers have the ability to file appeals on behalf of enrollees as authorized representatives in accordance with § 422.562(d). We have not created any additional provider appeal rights in this regulation. The purpose of these regulations is to ensure that enrollees receive the services that they are entitled to under their M+C plans, through the implementation of appropriate notice and appeal. CMS generally does not specify the payment arrangements between M+C organizations and providers; therefore, an IRE's reversal of an M+C organization's decision to terminate services is not a ruling on whether, or the extent to which, an M+C organization is financially obligated to the provider. Instead, the relevance of an IRE's reversal is that the M+C organization is obligated to continue services for the enrollee beyond the services that the M+C organization previously authorized.

Comment: Some commenters suggested that the requirement for a 4-day advance notice in situations where an IRE determined that services should continue only one or two additional days would result in the overutilization of health care services. They questioned the need for additional notices in such situations.

Response: 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 two-day advance notice.

Comment: Commenters expressed concern that an IRE might delay making a decision if it believed that it needed additional information from the M+C organization. The commenter proposed that CMS require an IRE to inform the M+C organization promptly, by fax or e-mail, if an IRE believed that it needed more information to make a decision, and to specify the precise information it required to make a decision on the merits.

Response: Section 422.626(d)(5) specifies that if an M+C organization fails to provide sufficient information to support its decision to terminate an enrollee's services, an IRE may defer issuing a decision until it receives needed information about the case. If an IRE chooses to do so (rather than simply decide the case in the enrollee's favor based on the evidence at hand), we agree that an IRE should make best efforts to promptly notify an M+C organization of the information the IRE needs, and that the submission of this information could affect the IRE's decision on the merits. However, M+C organizations should not expect IREs to routinely follow-up to complete the record. It is the M+C organization's responsibility to provide all relevant material necessary to sustain its termination decision by close of business of the day that the IRE notifies the M+C organization that an enrollee has requested an appeal. Thus, we will instruct IREs through their contracts with CMS that in the event that the M+C organization fails to submit documentation that would sustain the M+C organization's decision, and the IRE either cannot obtain the prompt cooperation of the M+C organization, or does not deem it practical to obtain additional information, the IRE should issue a decision based on the information available and err on the side of the beneficiary.

Comment: One commenter suggested that CMS should extend the same provider notice requirements to original Medicare beneficiaries whose services are being terminated.

Response: As noted above, section 1869(b)(1)(F) of the Act, as amended by section 521 of BIPA, establishes appeal rights for beneficiaries under original Medicare that are largely parallel to those available to M+C enrollees under this final rule. As discussed in detail in our November 15, 2002, proposed rule concerning those provisions, we believe that existing Advance Beneficiary Notices (ABNs) that are now used in Medicare fee-for-service settings are the appropriate vehicle to trigger the right to

an expedited appeal of a provider termination of services. (*See* 67 FR 69337.)

Comment: Several commenters were concerned that the standard for "valid delivery" of a termination notices is difficult to meet. They indicated that it would require a clinician to deliver the notice in order to determine the enrollee's level of consciousness, and ability to read and comprehend it, which would be expensive and burdensome.

Response: Section 422.624(c) specifies that "delivery" of a notice is valid only if an enrollee has signed and dated the notice to indicate that he or she both received the notice and can comprehend its contents. This policy is consistent with other CMS requirements governing the delivery of similar notices such as those set forth in CMS program memoranda A-99-52 and A-99-54 for HHA advanced beneficiary notices under original Medicare. We have no indication that this standard has proven problematic and believe that it is appropriate to apply similar protections to enrollees in the M+C program. Note that this requirement for successful delivery does not permit an enrollee to extend coverage indefinitely by refusing to sign a notice of termination. If an enrollee refuses to sign a notice, the provider would annotate its copy of the notice to indicate the refusal, and the date of the refusal would be considered the date of receipt of the notice.

By the time that termination notices are issued, providers will have already needed to assess an enrollee's ability to accept delivery of a notice, based on typical admission assessments, care planning evaluations and discharge planning activities that have taken place during the course of treatment. In the event a provider believes that an enrollee is not capable to receive the notice, providers should be well-acquainted enough with the enrollee's particular situation to make alternative arrangements, if necessary, to deliver a valid notice. For example, an incapacitated enrollee is not able to act on his or her rights and, therefore, could not validly "receive" the notice. This situation could be remedied through the use of an authorized representative under Federal or State law.

4. Other Comments

Comment: Several commenters objected to the proposed requirement under § 422.502(i)(3)(iv) that M+C organizations include specific provisions in their contracts with providers to require providers to comply with the notice requirements in 422.624. They believe it is burdensome to reopen