

about whether the beneficiary should be discharged.

Response: Clearly, the hospital discharge decision-making process requires substantial coordination and cooperation between M+C organizations and hospitals. We recognize that requiring detailed discharge notices for all M+C inpatients would have potentially increased the difficulties in this regard without achieving any demonstrable benefits for enrollees. Thus, we have revised the requirements in this final rule to make clear that such notices, when needed, are the responsibility of M+C organizations. However, we continue to believe that it is inappropriate for CMS to interfere in the business relationships between M+C organizations and their hospital providers and that any tension between these parties largely parallels that in the private health insurance sector.

Comment: One commenter noted that under the original Medicare, hospitals must provide QIOs copies of all HINNs given to beneficiaries. In view of the proposal that a detailed discharge notice be given to each Medicare inpatient, the commenter suggested that we eliminate the requirement that QIOs receive copies of every discharge notice.

Response: We believe that hospitals should continue to provide QIOs with copies of all HINNs, and that M+C organization should provide QIOs with copies of the noncoverage notices that they provide to dissatisfied beneficiaries. This is consistent with the policy described above for expedited reviews of other provider terminations, where M+C organizations will furnish copies of their detailed termination notices to both the IRE and the enrollee when there is a dispute over a discharge or service termination.

D. Grievance Procedures (§§ 422.561 and 422.564)

Comment: Some commenters argued that the proposed grievance procedures were overly prescriptive, while others supported establishing the proposed new standards. One commenter believed that grievance procedures should be flexible, given our interpretation of the preemption provision under section 1856(b)(3)(B)(iii), *i.e.*, Federal rules do not specifically preempt State grievance requirements unless they relate to coverage determinations. One commenter stressed that any grievance requirements we imposed should be consistent with those applied by accrediting organizations, so that M+C organizations would not have to change current procedures to a great extent.

Response: In the June 26, 1998, interim final rule to establish the M+C program (63 FR 35,030), we set forth the general requirement that an M+C organization must resolve grievances in a timely manner and have grievance procedures to meet CMS guidelines. In both the interim final rule and the June 29, 2000, final rule (65 FR 40,170, 40,275), we indicated that we intended to establish more detailed requirements for grievance procedures.

We generally agree with the commenters that the regulations should not be overly prescriptive with respect to grievance procedures. We note that many States have processes to address complaints that involve issues other than coverage, and State grievance procedures, unlike appeal procedures, are not specifically preempted by Federal rules. We consulted with representatives of the managed care industry, beneficiary advocacy groups, and QIOs, and examined standards developed by the National Association of Insurance Commissioners (NAIC). We learned that M+C organizations already adhere to State requirements concerning grievances. Also, our experience has shown that enrollees overwhelmingly pursue appeals rather than grievances, and rarely raise concerns or problems associated with the existing grievance procedures. Therefore, as discussed below, we are not including in this final rule the proposed procedural provisions set forth in § 422.564(d) and (e), which pertain to the method for filing and the notification and time frames associated with grievances.

Nevertheless, we believe that a basic uniform grievance structure should be in place to address those issues that fall outside of the appeals process. In particular, we believe that grievance provisions are needed to address complaints involving procedural issues that arise during the appeals process. Thus § 422.564(d) establishes an expedited grievance process for the following circumstances: (1) The grievance involves an M+C organization's decision to invoke an extension related to an organization determination or reconsideration; or (2) the grievance involves an M+C organization's refusal to grant an enrollee's request for an expedited organization determination under § 422.570 or reconsideration under § 422.584.

We believe that the changes we are setting forth in this final rule either have a direct effect on the M+C appeals process, or provide clarification in existing requirements, but allow M+C organizations the flexibility needed to

maintain current procedures that comply with State requirements.

Comment: Several commenters strongly encouraged CMS to establish mandatory time frames and notification procedures for resolving grievances. One commenter suggested that grievance time frames mirror those for standard and expedited organization determinations. Two commenters suggested a 30-calendar day time frame to render a grievance decision, with an opportunity for a 14-calendar day extension for peer review. Another commenter argued that the grievance procedure must have a mechanism to resolve a dispute regarding an M+C organization's denial to grant an expedited review within 24 hours, so that an inappropriately denied request can proceed quickly in the appeals process. Finally, one commenter expressed concern about State privacy requirements, which, in some cases, prevent health plans from providing specific information on how grievances get resolved.

Response: As noted above, we have not in this final rule adopted the proposed provisions that prescribed time frames for responding to grievances generally. We do not believe that establishing Federal requirements for the manner and timeliness within which grievances must be disposed is necessary, and as we have noted it could be unduly burdensome in light of varying State requirements. Furthermore, we have not received any reports that enrollees have encountered frustration or problems in getting M+C organizations to respond to enrollees' grievances timely or communicate in an effective manner. Enrollees will continue to have regulated formal avenues to pursue complaints involving all payment, coverage and quality of care issues.

We also agree with the commenter who suggested that grievances involving expedited appeals needed to be addressed as quickly as possible. Therefore, as noted above, we are specifying under § 422.564(d) that an M+C organization must notify the enrollee within 24 hours of receiving a grievance about the M+C organization's refusal to expedite a review, or the M+C organization's decision to invoke an extension to the organization determination or reconsideration time frames. This will ensure that any inappropriate procedural actions under the appeals process are resolved and that the appeal proceeds without delay. In this situation, any extension would clearly be inappropriate, since it would constitute a *de facto* denial of the