

significant financial burden on these individuals. The impact of the final rule on M+C organizations and providers is discussed below.

*C. New Notice and Appeal Procedures for Provider Terminations (§§ 422.624 and 422.626)*

As explained in detail in the proposed rule, we examined available appeals data from the Center for Health Dispute Resolution (CHDR), the organization with whom CMS now contracts to conduct appeals of M+C reconsiderations to project the likely number of appeals that may be expected under these new provisions. (Under existing § 422.592, any case where an M+C organization's reconsideration results in affirming an adverse organization determination is automatically sent to CHDR for review.) Based on this analysis, we estimated that the annual number of possible appeals that will be heard by an IRE under the procedures set forth in this final rule will be approximately 12,000 cases. We received no comments on the validity of this estimate and continue to believe that it is realistic. (See our January 24, 2001, proposed rule for further details—66 FR 6600–6602.)

Although commenters generally did not object to this volume estimate, both provider and M+C industry commenters found the procedures associated with implementing the new expedited appeals very problematic. Throughout this preamble, we have acknowledged and responded to the comments concerning the unnecessarily burdensome nature of these procedures. As discussed in detail above, we have made several significant changes to the notification procedures that we believe should ameliorate these concerns. Most notably, this final rule greatly simplifies the notice that providers furnish to enrollees whose services are ending and provides that M+C organizations must furnish detailed termination notices only to enrollees who timely request a fast-track appeal.

Thus, for approximately 12,000 cases, M+C organizations will be required under this final rule to make available to the enrollee a copy of the detailed termination notice, and to the IRE, and to the enrollee upon request, a copy of any documentation needed to decide on the appeal. Although we recognize that there is an administrative burden associated with this requirement, we believe that the existing M+C reconsideration process would already result in the M+C organization gathering and reviewing the case file to reach a termination decision. Moreover, we note that this burden on M+C organizations

is largely offset by the fact that M+C organizations will no longer be responsible for conduct internal reconsiderations of any cases covered under this final rule. That is, IREs will conduct reviews not just of the 3,000 cases that now go to CHDR but also of the 9,000 cases that are now subject to the M+C organization reconsideration process.

Similarly, with respect to providers, the requirements of this final rule should prove much easier to implement than those in the proposed rule. The required termination notices will be largely standardized, requiring only the insertion of the enrollee's name and discharge date. We estimate that it should take no more than 5 minutes to deliver such a notice, at a per-notice cost of no more than \$7.50 (based on a \$30 per hour rate if the notice is delivered by health care personnel). Based on an estimated 600,000 notices annually, we estimate the aggregate cost of delivering these notices should be less than \$5 million.

Thus, we believe that the new notice and appeal provisions of this final rule should have minimal financial impact on M+C organizations and providers. We note that both the advance termination notice and the detailed termination notice will be developed through OMB's Paperwork Reduction Act process and thus will be the subject of further opportunity for public comment.

*D. Hospital Discharge Notices (§§ 422.620 and 489.27)*

Under the proposed rule, hospitals would have been required to issue a standardized discharge notice to each Medicare beneficiary twice during an inpatient stay, that is, once at or near the time of admission and again before discharge. The second notice (a revised version of the Important Message from Medicare now required under section 1866(a)(1)(M) of the Act and 489.27) would have included more detailed information about the reason for the discharge. Comments on this proposal, many of which focused on the administrative burden associated with this notice, are discussed in detail above. We estimated that the additional aggregate burden on hospitals would exceed \$100 million.

Under this final rule, hospitals instead will continue to be responsible for issuing the Important Message from Medicare to all Medicare inpatients, as well as for issuing HINNs to inpatients covered under the original Medicare program when they indicate that they disagree with a hospital's discharge decision. These requirements are

identical to those currently in effect and thus will entail no additional burden for hospitals.

All inpatient enrollees in the M+C program will also continue to receive the Important Message from their hospital during an admission. In addition, consistent with the notice requirement for other Medicare beneficiaries, we are revising 422.620 to specify that M+C organizations are responsible for providing a written notice of noncoverage when an enrollee disagrees with a discharge decision. The notice must be issued no later than the day before hospital coverage ends and must explain the reason why care is no longer needed, the enrollee's appeal rights, and the effective date of time of the enrollee's liability for continued inpatient care. Again, we estimate that the incidence of this notice will be no more than 0.1 to 0.2 percent of all M+C enrollee discharges, or roughly 1800 to 3600 notices, at an estimate aggregate annual cost to M+C organizations of \$15,000–\$30,000. Again, all of the required notices for hospital inpatient discharges will be published through the OMB PRA process.

*E. Grievance Procedures (§ 422.564)*

Grievances essentially include any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an M+C organization's or provider's operations. As discussed in detail above, the primary new requirements set forth under this final rule (422.564(d) and (e)) are that an M+C organization establish specific procedures for handling expedited grievances and for record-keeping with respect to grievances, respectively.

Again, we have carefully examined the grievance procedures now in use by M+C organizations, and in particular the grievance procedures spelled out in the NAIC's Model Grievance Act, in developing these procedures. We believe that M+C organizations are in large measure already in compliance with the grievance procedures set forth here, and thus these requirements will have no substantial impact on most M+C organizations.

*F. Federalism Summary Impact Statement*

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications.