

This rule would not have a substantial effect on State or local governments.

In accordance with Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

#### List of Subjects

##### 42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare+Choice, Penalties, Privacy, Provider-sponsored organizations (PSO), Reporting and recordkeeping requirements.

##### 42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

■ For the reasons set forth in the pre-amble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

#### PART 422—MEDICARE+CHOICE PROGRAM

Part 422 is amended as set forth below:

■ 1. The authority citation for part 422 continues to read as follows:

**Authority:** Secs. 1102, 1851 through 1857, 1859, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395W–21 through 1395w–27, and 1395hh).

■ 2. In § 422.561, the definition of “grievance” is revised to read as follows:

##### § 422.561 Definitions.

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*Grievance* means 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, activities, or behavior, regardless of whether remedial action is requested.

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3. Section 422.564 is revised to read as follows:

##### § 422.564 Grievance procedures.

(a) *General rule.* Each M+C organization must provide meaningful procedures for timely hearing and resolving grievances between enrollees and the organization or any other entity or individual through which the organization provides health care services under any M+C plan it offers.

(b) *Distinguished from appeals.* Grievance procedures are separate and distinct from appeal procedures, which address organization determinations as defined in § 422.566(b). Upon receiving a complaint, an M+C organization must promptly determine and inform the enrollee whether the complaint is

subject to its grievance procedures or its appeal procedures.

(c) *Distinguished from the quality improvement organization (QIO) complaint process.* Under section 1154(a)(14) of the Act, the QIO must review beneficiaries' written complaints about the quality of services they have received under the Medicare program. This process is separate and distinct from the grievance procedures of the M+C organization. For quality of care issues, an enrollee may file a grievance with the M+C organization; file a written complaint with the QIO, or both. For any complaint submitted to a QIO, the M+C organization must cooperate with the QIO in resolving the complaint.

(d) *Expedited grievances.* An M+C organization must respond to an enrollee's grievance within 24 hours if:

(1) The complaint involves an M+C organization's decision to invoke an extension relating to an organization determination or reconsideration.

(2) The complaint 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.

(e) *Recordkeeping.* The M+C organization must have an established process to track and maintain records on all grievances received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the M+C organization notified the enrollee of the disposition.

■ 4. Section 422.620 is revised to read as follows:

##### § 422.620 How M+C enrollees must be notified of noncoverage of inpatient hospital care.

(a) *Enrollee's entitlement.* (1) Where an M+C organization has authorized coverage of the inpatient admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.113), the M+C organization (or hospital that has been delegated the authority to make the discharge decision) must provide a written notice of noncoverage when—

(i) The beneficiary disagrees with the discharge decision; or

(ii) The M+C organization (or the hospital that has been delegated the authority to make the discharge decision) is not discharging the individual but no longer intends to continue coverage of the inpatient stay.

(2) An enrollee is entitled to coverage until at least noon of the day after such notice is provided. If QIO review is

requested under § 422.622, coverage is extended as provided in that section.

(b) *Physician concurrence required.* Before notice of noncoverage is provided, the entity that makes the noncoverage/discharge determination (that is, the hospital by delegation or the M+C organization) must obtain the concurrence of the physician who is responsible for the enrollee's inpatient care.

(c) *Notice to the enrollee.* The written notice of non-coverage must be issued no later than the day before hospital coverage ends. The written notice must include the following elements:

(1) The reason why inpatient hospital care is no longer needed.

(2) The effective date and time of the enrollee's liability for continued inpatient care.

(3) The enrollee's appeal rights.

(4) Additional information specified by CMS.

■ 5. New §§ 422.624 and 422.626 are added to subpart M to read as follows:

##### § 422.624 Notifying enrollees of termination of provider services.

(a) *Applicability.* (1) For purposes of §§ 422.624 and 422.626, the term provider includes home health agencies (HHAs), skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs).

(2) *Termination of service defined.* For purposes of this section and § 422.626, a termination of service is the discharge of an enrollee from covered provider services, or discontinuation of covered provider services, when the enrollee has been authorized by the M+C organization, either directly or by delegation, to receive an ongoing course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end.

(b) *Advance written notification of termination.* Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the M+C organization's decision to terminate services. The provider must use a standardized notice, required by the Secretary, in accordance with the following procedures—

(1) *Timing of notice.* The provider must notify the enrollee of the M+C organization's decision to terminate covered services no later than two days before the proposed end of the services. If the enrollee's services are expected to be fewer than two days in duration, the provider should notify the enrollee at