

unaffected by these changes in regulation text. Although we are still sorting through implementation issues associated with this provision, we wanted to ensure that Congressional intent on this issue is reflected in M+C regulations.

In addition, we have made some minor revisions to Subpart O in an attempt to clarify information concerning our sanction authority. These changes do not add any new requirements, but serve to improve the regulatory language to more clearly affect the intent of the existing regulations (and statutory intent). We discuss these changes in the preamble and have modified the regulations accordingly.

II. Analysis of and Responses to Public Comments

In addition to the Response to Comments made above in reference to the BBRA, we received 10 letters containing over 100 specific comments. Comment letters were received from trade associations that represent providers and consumers, managed care organizations, and one individual. Below is a list of the areas that generated the most concern.

- Part 422 Subpart M—Grievances, Organization Determinations, and Appeals
- Part 422 Subpart C—Benefits and Beneficiary Protections
- Part 422 Subpart B—Eligibility, Election, and Enrollment
- Part 417 Subpart L—Medicare Contract Requirements.

A. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

1. Revision of Payment Rates for End-Stage Renal Disease (ESRD) Patients Enrolled in Medicare+Choice Plans

Section 605(a) of the BIPA amended section 1853(a)(1)(B) of the Act by requiring us to provide for appropriate adjustments to the M+C ESRD payment rates, effective January 1, 2002, to reflect the demonstration rate (including the risk adjustment methodology associated with the demonstration rate) of the social health maintenance organization ESRD capitation demonstration. This demonstration assessed whether it would be feasible to allow Medicare ESRD patients of all ages to enroll in M+C plans and to test risk-adjusted capitation payments for ESRD beneficiaries.

Before January 1, 2002, M+C ESRD capitation payments were based on State level base rates that were not risk-adjusted. The base payment rates were

based on a base year (1997) amount that represented 95 percent of projected State average fee-for-service costs, as determined at that time.

Under section 605(c) of the BIPA, we were required to publish for public comment a description of the adjustments we proposed to make in accordance with section 605(a) of the BIPA. We published a proposed notice on May 1, 2001 (66 FR 21770) soliciting comments on the proposed adjustments. Section 605(c) of the BIPA further required us to publish these adjustments in final form so that the amendment made by section 605(a) of the BIPA would be implemented consistent with section 605(b) of the BIPA (which provided that the adjustments were to become effective with payments made for January 2002). We published this final notice in the **Federal Register** on October 1, 2001 (66 FR 49958). The foregoing process was separate from this rulemaking. In the October 2002 proposed rule, however, we proposed revisions to § 422.250(a)(2)(i)(B) to reflect our approach to implementing the requirements of section 605(a) of the BIPA.

The new ESRD payment methodology set forth in the final notice published on October 1, 2001—

- Increased the ESRD base payment rate for CY 2002 by 3 percent. We determined in the final notice that a 3 percent increase in the base rate was the most appropriate proxy for 100 percent of the estimated per capita fee-for-service expenditures for ESRD beneficiaries, and the most appropriate way to reflect the demonstration rates; and
- Adjusted State per capita rates by age and sex factors, in order to reflect differences in costs among ESRD patients.

These adjustment factors and rates for CY 2002 for enrollees with ESRD can be found on our Web site at <http://www.cms.gov/stats/hmorates/aapccpg.htm#2002rates>.

For the purpose of M+C payment, ESRD beneficiaries include all beneficiaries with ESRD, whether entitled to Medicare because of ESRD, disability, or age. Under the new M+C ESRD payment methodology published on October 1, 2001, rates would continue to include the costs of beneficiaries with Medicare as Secondary Payer (MSP) status. (Costs to Medicare of M+C ESRD enrollees with MSP status do not include payments made by other primary payers such as employer group health plans or other insurers.)

Several organizations commented on the revision of § 422.250(a)(2)(i).

Comment: Several commenters believe that the proposed revision to ESRD rates at § 422.250(a)(2)(i) should include payments made by primary payers other than Medicare, such as employer group health plans or other insurers. Since the M+C ESRD rates include the costs of beneficiaries with Medicare as Secondary Payer (MSP) status but exclude payments made by other primary payers such as employer group health plans or other insurers, the M+C ESRD rates are artificially low and do not reflect the actual health care costs. Two commenters also contended that the proposed payment methodology appears to be contrary to the provisions set forth in section 605(a) of the BIPA, which requires us to “provide for appropriate adjustments to the M+C ESRD payment rates * * * to reflect the demonstration rate of the social health maintenance organization ESRD capitation demonstration.” These commenters refer to a statement in the proposed Notice that the Demonstration rates were about 20 percent over rates paid outside the Demonstration because beneficiaries with MSP were not allowed to enroll in the Demonstration. The commenters conclude that the revisions to the ESRD payment methodology will significantly decrease the payment rates for M+C ESRD enrollees.

Response: As we stated in the October 1, 2001 final notice, we recognize that MSP for M+C ESRD enrollees is an issue. We noted that we would explore options within our payment system for addressing MSP status while proceeding to implement in CY 2002 the 3 percent base rate increase and the age and sex adjusters.

The ESRD Demonstration did not allow ESRD beneficiaries with MSP to enroll, and thus these beneficiaries were excluded from calculation of Demonstration payment rates. We are unable to exclude from the M+C program any beneficiaries with MSP who develop ESRD. Thus, we had to find a way to adapt the ESRD demonstration methodology to this different population. The provision for “adjustments” to “reflect” the demonstration rates and methodology does not mean that we must necessarily pay the same amount where the applicable circumstances, in this case the presence of beneficiaries with MSP, are different.

To assess whether the proposed M+C ESRD payment rates would increase or decrease payments to M+C organizations, the appropriate comparison would be M+C ESRD rates in effect prior to 2002, not the rates paid the ESRD Demonstration sites. The M+C