

legislatively and, thus, does not set a precedent for other benefits of this type unless the Congress extends the benefit to other benefits by similar legislation.

9. Increased Civil Money Penalty for Medicare+Choice Organizations That Terminate Contracts Mid-Year

Section 1857(g)(3) of the Act provides us with the authority to impose intermediate sanctions, including civil money penalties, on M+C organizations for the same reasons for which we can terminate an M+C organization's contract. Section 1857(c)(2) of the Act provides that we may, at any time, terminate an M+C organization's contract if we determine that the M+C organization—

- Failed substantially to carry out the contract;
- Is carrying out the contract in a manner inconsistent with the efficient and effective administration of the M+C program; or
- No longer substantially meets the applicable conditions of the M+C program.

Section 623 of the BIPA amended section 1857(g)(3) of the Act by providing us the authority to establish and levy separate and distinct civil money penalties when we determine that an M+C organization has failed to substantially carry out the terms of its contract based upon the M+C organization's termination of its contract with us in a manner other than that provided in the M+C contract and in § 422.512.

Under section 1857(g)(3)(D) of the Act, in such cases, we may impose a civil money penalty of “\$100,000 or such higher amount as the Secretary may establish by regulation.” We believe that the Congress provided us with the authority to provide for a higher civil money penalty amount than \$100,000 in recognition of the fact that the \$100,000 specified in the Act may not provide an effective deterrent in some instances to discourage M+C organizations from terminating their contracts in a manner inconsistent with the procedures described in the regulations. In developing regulations providing for a potentially higher civil money penalty amount, it is appropriate for us to consider the number of Medicare beneficiaries who could be adversely affected by an M+C organization's decision to terminate its contract with us in a manner that violates M+C rules.

Thus, we proposed to establish the amount of this civil money penalty as either \$250 per Medicare member enrolled in the terminated M+C plan or plans at the time the M+C organization

terminated its contract with us, or \$100,000, whichever is greater. We added the “whichever is greater” provision to discourage violations of the contract termination provisions by M+C organizations with lower M+C plan enrollment. In either instance, this new civil money penalty represents a substantial increase over the current civil money penalty of \$25,000 for similar violations, and serves as an effective deterrent against M+C contract terminations violations that could potentially harm Medicare beneficiaries.

We received one comment on this change in civil money penalties.

Comment: The commenter seeks affirmation that we will not impose civil money penalties when the mid-year termination is caused by an event that is not within the control of the M+C organization (for example, substantial loss of network capability).

Response: We will not create an exception to waive the civil money penalties at § 422.758(b) because an M+C organization is experiencing network problems. If an M+C organization loses network capacity during the year, we expect that the M+C organization will establish new provider contracts or pay for services on a fee-for-service basis. There may be situations that require us to terminate a contract mid-year. For example, we have used our immediate termination authority at § 422.510(a)(5) to protect beneficiary access to health care when an M+C organization experiences financial difficulties so severe that access to health care is endangered. Section 623 of the BIPA was not written to permit us to levy a civil money penalty if we, not the M+C organization, take the termination action. The law was designed to prohibit M+C organizations from inappropriately ending their contractual commitments without our consent.

10. Eliminating Health Disparities in Medicare+Choice Program

Section 616 of the BIPA amended section 1852(e) of the Act by requiring that an M+C organization's Quality Assurance Program have a separate focus on racial and ethnic minorities. This provision was not included in the October 2002 proposed rule because we had not developed any policies to propose. Although we are still evaluating implementation issues, we are adding a new paragraph (4) to § 422.152(f) to reflect this BIPA provision. Prior notice and comment is not necessary in the case of this change, because merely adding the statutory requirements to the regulations text has no legal effect. We have included a good

cause statement below for waiving prior notice and comment with respect to this change.

B. Skilled Nursing Facility Care Under Medicare+Choice

Under section 1814(a)(2)(B) of the Act, the Medicare extended care skilled nursing facility (SNF) benefit covers skilled nursing care or other skilled rehabilitation services that the beneficiary requires on a daily basis and that are only available in a SNF on an inpatient basis.

Generally, we will only cover this benefit following a hospital stay of not less than 3 days. Under section 1812(f) of the Act, however, we may authorize coverage of SNF care without a prior hospital stay if two conditions are met. First, the coverage of these services must not result in any increase in Medicare program payments, and second, the coverage must not alter the acute care nature of the benefit.

We have determined that these conditions are met in the case of SNF services furnished by an M+C organization that covers SNF services. Accordingly, we proposed changes in the regulations to reflect this determination, specifically, adding a new § 409.20(c)(4), revising § 409.30(b) and § 409.31(b), and adding a new § 422.101(c).

Several organizations, representing both providers and consumers, stated that they agreed with our proposed changes.

Comment: One commenter recommended that we clarify that after voluntarily disenrolling from the M+C program, the beneficiary may receive Part A SNF care if he or she meets the skilled level of care requirement.

Response: The commenter is correct that under this final rule, Part A SNF care would be covered for an individual who meets the skilled level of care requirement if he or she voluntarily disenrolls from a M+C program that was covering the care without a prior 3-day hospital stay. We believe that § 409.30(b)(2)(ii) makes this sufficiently clear that no further clarification is needed.

Comment: A major organization recommended that we clarify that when a beneficiary converts from a M+C stay in a SNF to a fee-for-service stay, a new 100 day period begins, unless the prior days under M+C were skilled care.

Response: We agree with this recommendation. If skilled care is provided to the beneficiary while he or she is enrolled in the M+C organization, then this time period counts towards the 100 days. If it is unknown whether or not skilled care is provided or the care