

is unskilled, then the 100 days starts when the fee-for-service stay begins. We will clarify this provision in the Intermediary Manual.

Comment: Two commenters proposed that the waiver of the 3-day hospital requirement for SNF care also be applied to cost contractors (health maintenance organizations and competitive medical plans) under section 1876 of the Act. One commenter argued “* * * that expanding the provision to cost contractors will result in a substantial reduction in Medicare costs for inpatient hospitalization. These savings will more than counterbalance any increases in SNF costs. We believe that inpatient admissions may occur when perhaps the more appropriate level of care is in a skilled nursing facility. We believe that allowing an exception to the three-day prior hospitalization requirement will result in net savings to the Medicare program.”

Another commenter noted that, “Organizations participating in the Medicare program as cost plans are structured in the same manner as M+C organizations and have the same inherent incentives for the provision of quality care in the most appropriate setting. Since this structure promotes similar patterns of practice regardless of the type of Medicare contract, we believe that the criteria described above would be met if this policy were applied to cost plans.”

Response: M+C organizations are paid on a capitated basis, so they have an incentive to contain costs. However, cost contractors under section 1876 of the Act do not have such an incentive. We have no evidence to indicate that they would reduce hospital admissions if we were to waive the 3-day prior hospital stay requirement. Therefore, we have decided not to accept this recommendation at this time.

C. Disenrollment by the M+C Organization

Section 422.74(d)(4) provides that, except where continuation of enrollment under § 422.54 applies, an individual must be disenrolled from an M+C plan if he or she is out of the service area for over 6 months. The proposed rule included a revision to § 422.74(d)(4) creating an exception to this 6-month rule for “visitor” or “traveler” type programs. Under the proposed exception, M+C organizations could continue to offer extended “visitor” or “traveler” programs to members who have been out of the service area for up to 12 months, provided that the plan included the full range of services available to other

members. M+C organizations offering these programs may limit their availability to certain areas and may impose restrictions on obtaining benefits, except for urgent, emergent, and post-stabilization care, and renal dialysis. These organizations do not have to disenroll members in these extended programs who remain out of the service area for up to 12 months. However, those M+C organizations without this program must continue to disenroll members once they have been out of the service area for more than 6 months. We received one comment supporting this change, and are adopting it as proposed.

D. Reporting Requirements for Physician Incentive Plans

Section 1852(j)(4)(A)(iii) of the Act requires M+C organizations to provide us with descriptive information regarding their physician incentive plans (PIP) sufficient to permit us to determine whether the plan is in compliance with the applicable requirements. The current regulations interpreted this provision to require that an M+C organization submit the CMS PIP Disclosure Form (OMB No. 0938-0700) to us with its contract application and annually thereafter. We are changing the reporting requirement to allow M+C organizations to maintain the required PIP information in their files and submit that information to us upon request. Several commenters agreed with this change.

Comment: A commenter requested that we provide clear guidance on what information managed care organizations should maintain in their files.

Response: Section 417.479(h)(3) and § 422.210(b) provide details on the information that should be maintained in either the contractor or subcontractor files for purposes of responding to inquiries from beneficiaries. Since there will no longer be routine reporting of PIP information to us, the cost-contracting health maintenance organizations/competitive medical plans and M+C organizations should simply maintain sufficient information “...to permit CMS to determine whether the plan is in compliance with the applicable requirements,” should we request it.

Comment: A commenter requested that, under the cost program, two types of entities, health maintenance organizations and competitive medical plans, are eligible for contracting. The proposal omits a reference to competitive medical plans.

Response: We will revise the regulation to cover competitive medical plans.

Comment: A commenter suggested that the instructions for amending § 417.479(h) appear incorrect. The disclosure to beneficiaries provision is in paragraph (h)(3), not (h)(2). Thus, we should replace paragraph (h)(1) and (h)(2) with the new (h)(1). Then paragraph (h)(3) would be designated (h)(2).

Response: The commenter is correct in noting an inconsistency in our proposed revision. Therefore, § 417.479(h)(1) will remain as written in the proposed regulation, with the addition of a reference to competitive medical plans, as noted above. Section 417.479(h)(2) will be revised to include only the rules on pooling of patients. Finally, § 417.479(h)(3), related to disclosure to Medicare beneficiaries, will remain as part of the regulation with a minor, editorial change.

E. M+C Appeals Process

1. Defining Who Can Request Organization Determinations

Currently, the M+C regulations at § 422.566(c) specify that any of the parties listed in § 422.574 can request an M+C organization determination. It has come to our attention that, in some cases, the use of this cross-reference has been misconstrued to mean that, in order to request an organization determination on behalf of an enrollee, an affiliated provider would need to be an authorized representative, and a non-affiliated provider would need to be an assignee. Although we discussed this issue in our June 29, 2000 final rule (65 FR 40282), some confusion has continued.

We have always intended for requests for organization determinations to be more inclusive than requests for appeals. To clarify this point, we have eliminated the existing cross-reference to § 422.574 and we are listing those who may request an M+C organization determination under § 422.566(c). Determination requests may be made by—

- The enrollee (including his or her authorized representative);
- Any provider that furnished, or intends to furnish, services to the enrollee; or
- The legal representative of a deceased enrollee's estate.

The fact that an individual or entity may request an organization determination does not necessarily entitle that individual or entity the right to request an appeal, unless the conditions for party status under § 422.574 are met.

Comment: We received two comments regarding who can request an