

cases involving imminent health risks. Thus, as proposed, we are adding § 422.618(c)(2) and § 422.619(c)(2) to allow for an exception to the 60-day effectuation standard when an M+C organization requests DAB review. An M+C organization may await the outcome of the DAB's review before it pays for, authorizes or provides the service under dispute.

*Comment:* One commenter was concerned with our statement that “\* \* \* the M+C organization would have to meet the medical exigency standard for providing or authorizing services as expeditiously as the enrollee's health condition requires regardless of the 60-day time frame.” The commenter interpreted this statement to mean that a M+C organization that intends to appeal an ALJ decision would still have to apply the medical exigency standard, and provide services if warranted under this standard notwithstanding the filing of a DAB appeal. The commenter thought that this would undercut the exception to the effectuation time frames and undermine a M+C organization's right under both the appeals process and, though it is not clear to us why, the Administrative Procedure Act (APA). Instead, the commenter recommends that we permit the exception to the effectuation rule under all circumstances, and promulgate an expedited review process for the DAB to follow in medically exigent cases. Another commenter urged us to monitor whether M+C organizations take the maximum 60 days to implement a decision that they do not intend to appeal.

*Response:* The section of the proposed rule that the commenter references is a discussion about our reason for maintaining a 60-day effectuation requirement for expedited appeals, as opposed to 72 hours. We wanted to make clear that, despite our intention to maintain the 60-day requirement, M+C organizations still would be held to the medical exigency standard if they did not intend to pursue an appeal of an ALJ decision. In other words, just because we had retained the 60-day time-frame for appealing, this did not mean that an M+C organization could take 60 days to effectuate if it was not pursuing an appeal. Rather, in this instance, it must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the determination.

We agree with the commenter, however, that when a M+C organization is appealing the ALJ decision, it should

not be required to effectuate the ALJ decision, and would not apply the medical exigency standard until it was time to effectuate a decision from the DAB. We also agree with the commenter that the DAB should expedite cases in which there is a medical exigency, and inform the commenter that the DAB has procedures in place to do so. Finally, with respect to monitoring, we agree that M+C organizations should be monitored to see whether they are delaying effectuation 60 days in cases in which they are not appealing the ALJ decision.

*Comment:* Some commenters were pleased with our proposal that M+C organizations notify enrollees and the independent review entity (IRE) in the event of an appeal to the DAB. They believed that such notification would enable enrollees to file evidence, arguments or legal memoranda to the DAB in support of an ALJ decision.

*Response:* We agree with the commenters and are retaining this proposal which requires a M+C organization to concurrently send a copy of its appeal request and the accompanying documents to the enrollee and the IRE at § 422.618(c)(2) and § 422.619(c)(2) in this final rule.

*Comment:* One commenter recommended that we apply an exception to the effectuation provision for cases in which the M+C organization intends to dispute determinations made by the IRE.

*Response:* The regulations only provide for appeals by M+C organizations at the ALJ level or higher. The only way for an M+C organization to “challenge” the IRE's decision is to request a reopening in accordance with § 422.616. A reopening is an administrative action outside of the realm of the appeals process and we do not believe that delaying effectuation under these circumstances is warranted.

#### *F. Requiring Health Care Prepayment Plans (HCPPs) and Remaining Cost Plans To Follow the M+C Appeals Process*

In the proposed rule, we solicited comments on whether HCPPs and the remaining cost plans should follow the M+C appeals and grievance processes under subpart M of part 422. We have not included these provisions in this final regulation, because we need more time to analyze the comments and evaluate implementation issues.

#### *G. Technical Clarifications*

##### *1. Grace Period for Late Premium Payments*

We are making a technical change to address concerns that M+C

organizations have raised concerning the starting date for the 90-day grace period for late premium payments. Section 422.74(d)(1)(ii) provides that an M+C organization may disenroll a Medicare beneficiary when the organization has not received payment within 90 days after it has sent a written notice of nonpayment to the individual. Several M+C organizations requested that the 90-day grace period start on the day the premium payment was due, rather than the day the notice was sent. Since the notice has to be provided within 20 days of the premium due date, starting the grace period on the premium due date would ensure that the beneficiary has at least 70 days following receipt of the notice to pay the premium and avoid disenrollment. We believe that this constitutes an appropriate grace period and proposed to change the regulation accordingly. We received one comment supporting this change and are adopting it as proposed.

##### *2. Payment for Hospice Care*

In the proposed rule, we proposed to clarify information concerning changes in M+C payments when an individual has elected hospice care.

Specifically, we proposed to revise § 422.266(d) to make clear that when enrollees of M+C plans elect to receive hospice care under § 418.24, we will not make any payment for the hospice care to the M+C plan beginning with the next month's payment after the election, except for the portion of the payment applicable to additional benefits, as described in § 422.312. Currently, the regulation refers to capitation payments being reduced to this amount which produces the same result. However, this language was changed from the language that applies to health maintenance organizations and competitive medical plans, and we believe the latter language makes the policy clearer.

We received no comments on this change and have revised § 422.266(c) to reflect this clarification.

##### *3. Clarification of Subpart O to Effectuate Statutory Intent*

We are making minor changes to Subpart O in an attempt to clarify information regarding our sanction authority. These changes do not add any new requirements. They serve to improve the wording of certain areas to more clearly reflect statutory intent.

Section 1857(g)(1) of the Act contemplates violations that are generally considered “fraud and abuse.” This section further states, “\* \* \* the Secretary may provide, in addition to