

any other remedies authorized by law, for any of the remedies described in paragraph (2) * * * .” Because the OIG has the traditional authority to investigate fraud complaints, the regulation should ensure that it is understood that the OIG stands in the place of “the Secretary” when civil money penalties are imposed for such violations. We (CMS) would have authority for other intermediate sanctions under M+C. Currently, § 422.752(a) states, “For the violations listed below, CMS may impose *any* of the sanctions specified in § 422.750 * * * .” *Any* of the sanctions presupposes that we may freeze marketing, enrollment, payment *and impose civil money penalties*. This stands in contrast to the statutory intent and it clearly contrasts with § 422.756(f)(2) where, in discussing civil money penalties, the regulation currently reads, “In the case of a violation described in § 422.752(a) * * * in accordance with 42 CFR parts 1003 and 1005, the OIG may impose CMPs on M+C organizations * * * .” We are changing § 422.752(a) to clarify when the OIG has the sole authority to impose civil money penalties.

Section 422.756(f)(3) references the OIG’s regulations at parts 1003 and 1005. This cross-reference creates confusion without further clarification. The civil money penalty provisions included in the OIG’s regulations at parts 1003 and 1005 implement section 1876 of the Act, not the M+C program under the BBA. We are proposing a regulatory change to eliminate any reference to part 1003 for information about which level of civil money penalty might apply.

Section 422.758 states that civil money penalties can be \$25,000 or \$10,000 per each determination. According to the statute at section 1857(g) of the Act, the actual amount could be lower. For example, section 1857(g)(3)(A) of the Act states that we may impose civil money penalties “of not more than \$25,000.” The same applies to § 422.758(b), which references “up to \$10,000” not “\$10,000.” Section 422.750 states that the OIG can impose civil money penalties ranging from \$10,000 to \$100,000. Section 1128A of the Act continually uses the “up to” language. We are revising the regulatory language to clarify statutory intent.

4. Correcting a Cross-Reference in Subpart E (Relationships With Providers)

In § 422.202(a)(4), a change is needed to correct a cross-reference. Specifically, the text “must conform to the rules in

§ 422.204(c)” is being revised to read “must conform to the rules in § 422.202(d).” (§ 422.204(c) does not exist.)

III. Provisions of This Final Rule

The provisions of this final rule are as follows:

- In § 409.20, we added paragraph (c)(4) to define the term “post-hospital SNF care” to include SNF care that does not follow a hospital stay if the beneficiary is enrolled in an M+C plan.
- In § 409.30, we revised paragraph (b)(2) to add an exception to the preadmission requirements for enrollees of M+C organization plans.
- In § 409.31, we added paragraph (b)(2)(iii) to add a condition to the level of care requirements which states that, for an M+C enrollee, a physician has determined that a direct admission to a SNF without an inpatient hospital stay would be medically appropriate.
- In § 417.479, we revised paragraph (h) to modify the reporting requirements concerning physician incentive plans.
- In § 422.2, we revised the definition of additional benefits to include a reduction in the Medicare beneficiary’s standard Part B premium.
- In § 422.50, we revised paragraph (a)(2) to include a new condition in the exception that a beneficiary with ESRD is not eligible to elect an M+C plan. An individual with ESRD whose enrollment in an M+C plan is discontinued because we or the M+C organization terminated the organization’s contract for the plan, is now eligible to elect another M+C plan, if the original enrollment was terminated after December 31, 1998.
- In § 422.74, we revised paragraph (d)(1)(ii) to reflect that an M+C organization may only disenroll a Medicare enrollee when the organization has not received payment within 90 days after the date the premium payment was due.
- In § 422.74, we revised paragraph (d)(4) to allow M+C organizations to operate “visitor” or “traveler” programs that provide benefits beyond urgent and emergent care to their enrollees who are out of the service area for more than 6 months but less than 12 months.
- In § 422.101, we revised paragraph (b)(3) to reflect the provisions in section 1852(a)(2)(C) of the Act that permit M+C organizations with plans that cover large areas encompassing more than one local coverage policy area to elect to have the local coverage policy for the part of the area that is the most beneficial to the M+C enrollees apply to all M+C enrollees in the plan. his policy allows M+C organizations to standardize coverage decisions and provider contracts across the entire plan, rather

than having different policies apply to different geographic areas of the same plan.

- In § 422.101, we added paragraph (c) to include in the requirements relating to Medicare covered benefits the option to provide for coverage as a Medicare benefit post-hospital SNF care in the absence of a prior hospital stay.

- In § 422.106, we added new paragraph (c) to reflect the provisions in section 1857(i) of the Act that permits us to grant a waiver or modification of requirements in part 422 that hinder the design of, the offering of, or the enrollment in, M+C plans under contracts between M+C organizations and employers, labor organizations, or the trustees of benefits funds.

- In § 422.109, we revised the definition of “significant cost” (which was in § 422.109(c), but is now in § 422.109(a)) to provide that, for purposes of determining whether to make an adjustment under § 422.256, the tests in definition of “significant cost” are applied to the aggregate costs of all NCDs and legislative changes in benefits made in the contract year. Under this test, the “average cost” of every NCD and legislative change in benefits would be added together. If the sum of all these average amounts exceeds the threshold under § 422.109(a)(1), then an adjustment to payment will be made under § 422.256 to reflect these costs. Alternatively, if the costs of the NCDs and legislative changes in benefits, in the aggregate, exceed the level set forth in § 422.109(a)(2), an adjustment to payment will be made under § 422.526. We also added language to explain that an NCD or legislative change in benefits that does not meet the “significant cost” threshold must be provided, and paid for, by the M+C organization as of the effective date of the NCD or legislative change in benefits.

- In § 422.111, we added paragraph (f)(8)(iii) to add any reduction in Part B premiums to the list of information that must be disclosed to each enrollee electing an M+C plan.

- We added § 422.133 to contain the new requirement that M+C organizations return residents of SNFs to their home SNF for post-hospital extended care services after discharge from a hospital. This new section contains the definition of home SNF, the requirements for return to the home SNF, and the exceptions to the general rule.

- In § 422.152(f), we added section (4) to reflect the requirement that M+C organizations’ Quality Assurance Programs have a separate focus on racial and ethnic minorities.