

## § 422.562

enrollee must pay for a service. Integrated appeals cover procedures that would otherwise be defined and covered, for non-applicable integrated plans, as an appeal defined in § 422.561 or the procedures required for appeals in accordance with §§ 438.400 through 438.424 of this chapter. Such procedures include integrated reconsiderations.

*Integrated grievance* means a dispute or complaint that would be defined and covered, for grievances filed by an enrollee in non-applicable integrated plans, under § 422.564 or §§ 438.400 through 438.416 of this chapter. Integrated grievances do not include appeals procedures and QIO complaints, as described in § 422.564(b) and (c). An integrated grievance made by an enrollee in an applicable integrated plan is subject to the integrated grievance procedures in §§ 422.629 and 422.630.

*Integrated organization determination* means an organization determination that would otherwise be defined and covered, for a non-applicable integrated plan, as an organization determination under § 422.566, an adverse benefit determination under § 438.400(b), or an action under § 431.201 of this chapter. An integrated organization determination is made by an applicable integrated plan and is subject to the integrated organization determination procedures in §§ 422.629, 422.631, and 422.634.

*Integrated reconsideration* means a reconsideration that would otherwise be defined and covered, for a non-applicable integrated plan, as a reconsideration under § 422.580 and appeal under § 438.400(b) of this chapter. An integrated reconsideration is made by an applicable integrated plan and is subject to the integrated reconsideration procedures in §§ 422.629 and 422.632 through 422.634.

*Physician* has the meaning given the term in section 1861(r) of the Act.

*Representative* means an individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in the grievance or appeal. Unless otherwise stated in this subpart, the representative will have all the rights and responsibilities of an enrollee or party in filing a grievance, and in obtaining

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an organization determination or in dealing with any of the levels of the appeals process, subject to the applicable rules described in part 405 of this chapter.

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### § 422.562 General provisions.

(a) *Responsibilities of the MA organization.* (1) An MA organization, with respect to each MA plan that it offers, must establish and maintain—

(i) A grievance procedure as described in § 422.564 or, beginning January 1, 2021, § 422.630 as applicable, for addressing issues that do not involve organization determinations;

(ii) A procedure for making timely organization determinations;

(iii) Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(2) An MA organization must ensure that all enrollees receive written information about the—

(i) Grievance and appeal procedures that are available to them through the MA organization; and

(ii) Complaint process available to the enrollee under the QIO process as set forth under section 1154(a)(14) of the Act.

(3) In accordance with subpart K of this part, if the MA organization delegates any of its responsibilities under this subpart to another entity or individual through which the organization provides health care services, the MA organization is ultimately responsible for ensuring that the entity or individual satisfies the relevant requirements of this subpart.

(4) An MA organization must employ a medical director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. The medical director must be a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

(5) An MA organization that offers a dual eligible special needs plan has the following additional responsibilities:

(i) The dual eligible special needs plan must offer to assist an enrollee in that dual eligible special needs plan with obtaining Medicaid covered services and resolving grievances, including requesting authorization of Medicaid services, as applicable, and navigating Medicaid appeals and grievances in connection with the enrollee's own Medicaid coverage, regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid managed care plan, such as a Medicaid MCO, PIHP, or PAHP as defined in § 438.2 of this chapter. If the enrollee accepts the offer of assistance, the plan must provide the assistance. Examples of such assistance include the following:

(A) Explaining to an enrollee how to make a request for Medicaid authorization of a service and how to file appeal following an adverse benefit determination, such as—

(1) Assisting the enrollee in identifying the enrollee's specific Medicaid managed care plan or fee-for-service point of contact;

(2) Providing specific instructions for contacting the appropriate agency in a fee-for-service setting or for contacting the enrollee's Medicaid managed care plan, regardless of whether the Medicaid managed care plan is affiliated with the enrollee's dual eligible special needs plan; and

(3) Assisting the enrollee in making contact with the enrollee's fee-for-service contact or Medicaid managed care plan.

(B) Assisting a beneficiary in filing a Medicaid grievance or a Medicaid appeal.

(C) Assisting an enrollee in obtaining documentation to support a request for authorization of Medicaid services or a Medicaid appeal.

(ii) The dual eligible special needs plan must offer to provide the assistance described in paragraph (a)(5)(i) of this section whenever it becomes aware of an enrollee's need for a Medicaid-covered service. Offering such assistance is not dependent on an enrollee's specific request.

(iii) The dual eligible special needs plan must offer to provide and actually

provide assistance as required by paragraph (a)(5)(i) of this section using multiple methods.

(A) When an enrollee accepts the offer of assistance described in paragraph (a)(5)(i) of this section, the dual eligible special needs plan may coach the enrollee on how to self-advocate.

(B) The dual eligible special needs plan must also provide an enrollee reasonable assistance in completing forms and taking procedural steps related to Medicaid grievances and appeals.

(iv) The dual eligible special needs plan must, upon request from CMS, provide documentation demonstrating its compliance with this paragraph (a)(5).

(v) The obligation to provide assistance under paragraph (a)(5)(i) of this section does not create an obligation for a dual eligible special needs plan to represent an enrollee in a Medicaid appeal.

(b) *Rights of MA enrollees.* In accordance with the provisions of this subpart, enrollees have the following rights:

(1) The right to have grievances between the enrollee and the MA organization heard and resolved, as described in § 422.564 or, beginning January 1, 2021, § 422.630, as applicable.

(2) The right to a timely organization determination, as provided under § 422.566 or, beginning January 1, 2021, § 422.631(c), as applicable.

(3) The right to request an expedited organization determination, as provided under §§ 422.570 or, beginning January 1, 2021, § 422.631(e), as applicable.

(4) If dissatisfied with any part of an organization determination, the following appeal rights:

(i) The right to a reconsideration of the adverse organization determination by the MA organization, as provided under § 422.578 or, beginning January 1, 2021, § 422.633, as applicable.

(ii) The right to request an expedited reconsideration, as provided under § 422.584 or, beginning January 1, 2021, § 422.633(e), as applicable.

(iii) If, as a result of a reconsideration, an MA organization affirms, in whole or in part, its adverse organization determination, the right to an automatic reconsidered determination made by an independent, outside entity

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contracted by CMS, as provided in § 422.592.

(iv) The right to an ALJ hearing if the amount in controversy is met, as provided in § 422.600.

(v) The right to request Council review of the ALJ hearing decision, as provided in § 422.608.

(vi) The right to judicial review of the hearing decision if the amount in controversy is met, as provided in § 422.612.

(c) *Limits on when this subpart applies.*

(1) If an enrollee receives immediate QIO review (as provided in § 422.622) of a determination of noncoverage of inpatient hospital care the enrollee is not entitled to review of that issue by the MA organization.

(2) If an enrollee has no further liability to pay for services that were furnished by an MA organization, a determination regarding these services is not subject to appeal.

(d) *When other regulations apply.* (1) Unless this subpart provides otherwise and subject to paragraph (d)(2) of this section, the regulations in part 405 of this chapter (concerning the administrative review and hearing processes and representation of parties under titles II and XVIII of the Act) apply under this subpart to the extent they are appropriate.

(2) The following regulations in part 405 of this chapter, and any references thereto, specifically do not apply under this subpart:

(i) Section 405.950 (time frames for making a redetermination).

(ii) Section 405.970 (time frames for making a reconsideration following a contractor redetermination, including the option to escalate an appeal to the OMHA level).

(iii) Section 405.1016 (time frames for deciding an appeal of a QIC reconsideration, or escalated request for a QIC reconsideration, including the option to escalate an appeal to the Council).

(iv) The option to request that an appeal be escalated from the OMHA level to the Council as provided in § 405.1100(b), and time frames for the Council to decide an appeal of an ALJ's or attorney adjudicator's decision or an appeal that is escalated from the OMHA level to the Council as provided in § 405.1100(c) and (d).

(v) Section 405.1132 (request for escalation to Federal court).

(vi) Sections 405.956(b)(8), 405.966(a)(2), 405.976(b)(5)(ii), 405.1018(c), 405.1028(a), and 405.1122(c), and any other reference to requiring a determination of good cause for the introduction of new evidence by a provider, supplier, or a beneficiary represented by a provider or supplier.

(3) For the sole purpose of applying the regulations at § 405.1038(c) of this chapter, an MA organization is included in the definition of “contractors” as it relates to stipulated decisions.

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### § 422.564 Grievance procedures.

(a) *General rule.* Each MA organization must provide meaningful procedures for timely hearing and resolving grievances between enrollees and the organization or any other entity or individual through which the organization provides health care services under any MA plan it offers.

(b) *Distinguished from appeals.* Grievance procedures are separate and distinct from appeal procedures, which address organization determinations as defined in § 422.566(b). Upon receiving a complaint, an MA organization must promptly determine and inform the enrollee whether the complaint is subject to its grievance procedures or its appeal procedures.

(c) *Distinguished from the quality improvement organization (QIO) complaint process.* Under section 1154(a)(14) of the Act, the QIO must review beneficiaries' written complaints about the quality of services they have received under the Medicare program. This process is separate and distinct from the grievance procedures of the MA organization. For quality of care issues, an enrollee may file a grievance with the MA organization; file a written complaint with the QIO, or both. For any complaint submitted to a QIO, the MA organization must cooperate with the QIO in resolving the complaint.