

§ 422.553

(i) The proposed new owner is in fact a successor in interest to the contract;
(ii) Recognition of the new owner as a successor in interest to the contract is in the best interest of the Medicare program; and

(iii) The successor organization meets the requirements to qualify as an MA organization under subpart K of this part.

(b) *Provisions of a novation agreement*—(1) *Assumption of contract obligations.* The new owner must assume all obligations under the contract.

(2) *Waiver of right to reimbursement.* The previous owner must waive its rights to reimbursement for covered services furnished during the rest of the current contract period.

(3) *Guarantee of performance.* (i) The previous owner must guarantee performance of the contract by the new owner during the contract period; or

(ii) The new owner must post a performance bond that is satisfactory to CMS.

(4) *Records access.* The previous owner must agree to make its books and records and other necessary information available to the new owner and to CMS to permit an accurate determination of costs for the final settlement of the contract period.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38079, July 15, 1993; 60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998; 70 FR 52027, Sept. 1, 2005]

§ 422.553 Effect of leasing of an MA organization's facilities.

(a) *General effect of leasing.* If an MA organization leases all or part of its facilities to another entity, the other entity does not acquire MA organization status under section 1876 of the Act.

(b) *Effect of lease of all facilities.* (1) If an MA organization leases all of its facilities to another entity, the contract terminates.

(2) If the other entity wishes to participate in Medicare as an MA organization, it must apply for and enter into a contract in accordance with subpart K of this part.

(c) *Effect of partial lease of facilities.* If the MA organization leases part of its facilities to another entity, its contract with CMS remains in effect while

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CMS surveys the MA organization to determine whether it continues to be in compliance with the applicable requirements and qualifying conditions specified in subpart K of this part.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998; 70 FR 52027, Sept. 1, 2005]

Subpart M—Grievances, Organization Determinations and Appeals

SOURCE: 63 FR 35107, June 26, 1998, unless otherwise noted.

§ 422.560 Basis and scope.

(a) *Statutory basis.* (1) Section 1852(f) of the Act provides that an MA organization must establish meaningful grievance procedures.

(2) Section 1852(g) of the Act establishes requirements that an MA organization must meet concerning organization determinations and appeals.

(3) Section 1869 of the Act specifies the amount in controversy needed to pursue a hearing and judicial review and authorizes representatives to act on behalf of individuals that seek appeals. These provisions are incorporated for MA appeals by section 1852(g)(5) of the Act and part 405 of this chapter.

(4) Section 1859(f)(8) of the Act provides for, to the extent feasible, unifying grievances and appeals procedures under sections 1852(f), 1852(g), 1902(a)(3), 1902(a)(5), and 1932(b)(4) of the Act for Medicare and Medicaid covered items and services provided by specialized MA plans for special needs individuals described in subsection 1859(b)(6)(B)(ii) of the Act for individuals who are eligible under titles XVIII and XIX of the Act. Beginning January 1, 2021, procedures established under section 1859(f)(8) of the Act apply in place of otherwise applicable grievances and appeals procedures with respect to Medicare and Medicaid covered items and services provided by applicable integrated plans.

(b) *Scope.* This subpart sets forth—

(1) Requirements for MA organizations with respect to grievance procedures, organization determinations, and appeal procedures.

(2) The rights of MA enrollees with respect to organization determinations, and grievance and appeal procedures.

(3) The rules concerning notice of noncoverage of inpatient hospital care.

(4) The rules that apply when an MA enrollee requests immediate QIO review of a determination that he or she no longer needs inpatient hospital care.

(5) Requirements for applicable integrated plans with respect to procedures for integrated grievances, integrated organization determinations, and integrated reconsiderations.

(c) *Relation to ERISA requirements.* Consistent with section 1857(i)(2) of the Act, provisions of this subpart may, to the extent applicable under regulations adopted by the Secretary of Labor, apply to claims for benefits under group health plans subject to the Employee Retirement Income Security Act.

[63 FR 35107, June 26, 1998, as amended at 70 FR 4738, Jan. 28, 2005; 84 FR 15833, Apr. 16, 2019]

§ 422.561 Definitions.

As used in this subpart, unless the context indicates otherwise—

Appeal means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service, as defined under § 422.566(b). These procedures include reconsiderations by the MA organization, and if necessary, an independent review entity, hearings before ALJs, review by the Medicare Appeals Council (Council), and judicial review.

Applicable integrated plan means either of the following:

(1) *Before January 1, 2023.* (i) A fully integrated dual eligible special needs plan with exclusively aligned enrollment or a highly integrated dual eligi-

ble special needs plan with exclusively aligned enrollment; and

(ii) The Medicaid managed care organization, as defined in section 1903(m) of the Act, through which such dual eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual eligible special needs plan and such Medicaid managed care organization.

(2) *On or after January 1, 2023.* (i)(A) A fully integrated dual eligible special needs plan or highly integrated dual eligible special needs plan with exclusively aligned enrollment; and

(B) The Medicaid managed care organization, as defined in section 1903(m) of the Act, through which such dual eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual eligible special needs plan and such Medicaid managed care organization; or

(ii) A dual eligible special needs plan and affiliated Medicaid managed care plan where—

(A) The dual special needs plan, by State policy, has enrollment limited to those beneficiaries enrolled in a Medicaid managed care organization as described in paragraph (2)(ii)(B) of this definition;

(B) There is a capitated contract between the MA organization, the MA organization's parent organization, or another entity that is owned and controlled by its parent organization; and

(1) A Medicaid agency; or

(2) A Medicaid managed care organization as defined in section 1903(m) of the Act that contracts with the Medicaid agency; and

(C) Through the capitated contract described in paragraph (2)(ii)(B) of this definition, Medicaid benefits including primary care and acute care, including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries, and at a minimum, one of the following: Home health services as defined in § 440.70 of this chapter,