

(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,

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medical supplies, equipment, and appliances as described in § 440.70(b)(3) of this chapter, or nursing facility services are covered for the enrollees.

Enrollee means an MA eligible individual who has elected an MA plan offered by an MA organization.

Grievance means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

Integrated appeal means any of the procedures that deal with, or result from, adverse integrated organization determinations by an applicable integrated plan 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. 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 in-

tegrated 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 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.

[63 FR 35067, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 68 FR 16667, Apr. 4, 2003; 70 FR 4738, Jan. 28, 2005; 75 FR 19812, Apr. 15, 2010; 82 FR 5124, Jan. 17, 2017; 84 FR 15833, Apr. 16, 2019; 84 FR 26579, June 7, 2019; 87 FR 27897, May 9, 2022]

§ 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—

(I) 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: