

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 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.

(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.

(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]

§ 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 (MAC), and judicial review.

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