

**§ 422.552**

or more other corporations, resulting in a new corporate body, constitutes a change of ownership.

(ii) Transfer of corporate stock or the merger of another corporation into the M+C organization's corporation, with the M+C organization surviving, does not ordinarily constitute change of ownership.

(b) *Advance notice requirement.* (1) An M+C organization that has a Medicare contract in effect and is considering or negotiating a change in ownership must notify HCFA at least 60 days before the anticipated effective date of the change. The M+C organization must also provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.

(2) If the M+C organization fails to give HCFA the required notice timely, it continues to be liable for capitation payments that HCFA makes to it on behalf of Medicare enrollees after the date of change of ownership.

(c) *Novation agreement defined.* A novation agreement is an agreement among the current owner of the M+C organization, the prospective new owner, and HCFA—

(1) That is embodied in a document executed and signed by all three parties;

(2) That meets the requirements of § 422.552; and

(3) Under which HCFA recognizes the new owner as the successor in interest to the current owner's Medicare contract.

(d) *Effect of change of ownership without novation agreement.* Except to the extent provided in paragraph (b)(2) of this section, the effect of a change of ownership without a novation agreement is that—

(1) The existing contract becomes invalid; and

(2) If the new owner wishes to participate in the Medicare program, it must apply for, and enter into, a contract in accordance with subpart K of this part.

(e) *Effect of change of ownership with novation agreement.* If the M+C organization submits a novation agreement that meets the requirements of § 422.552, and HCFA signs it, the new owner becomes the successor in inter-

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est to the current owner's Medicare contract.

[60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998; 63 FR 52614, Oct. 1, 1998]

**§ 422.552 Novation agreement requirements.**

(a) *Conditions for HCFA approval of a novation agreement.* HCFA approves a novation agreement if the following conditions are met:

(1) *Advance notification.* The M+C organization notifies HCFA at least 60 days before the date of the proposed change of ownership. The M+C organization also provides HCFA with updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.

(2) *Advance submittal of agreement.* The M+C organization submits to HCFA, at least 30 days before the proposed change of ownership date, three signed copies of the novation agreement containing the provisions specified in paragraph (b) of this section, and one copy of other relevant documents required by HCFA.

(3) *HCFA's determination.* HCFA determines that—

(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 M+C organization under subpart J 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 HCFA.

(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 HCFA 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]

**§ 422.553 Effect of leasing of an M+C organization's facilities.**

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

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

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

(c) *Effect of partial lease of facilities.* If the M+C organization leases part of its facilities to another entity, its contract with HCFA remains in effect while HCFA surveys the M+C 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]

**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 M+C organization must establish meaningful grievance procedures.

(2) Section 1852(g) of the Act establishes requirements that an M+C orga-

nization must meet concerning organization determinations and appeals.

(b) *Scope.* This subpart sets forth—

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

(2) The rights of M+C 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 M+C enrollee requests immediate PRO review of a determination that he or she no longer needs inpatient hospital care.

**§ 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 an enrollee is entitled to receive or any amounts the enrollee must pay for a service, as defined under § 422.566(b). These procedures include reconsiderations by the M+C organization, and if necessary, an independent review entity, hearings before ALJs, review by the Departmental Appeals Board (DAB), and judicial review.

*Authorized representative* means an individual authorized by an enrollee to act on his or her behalf in obtaining an organization determination or in dealing with any of the levels of the appeal process, subject to the rules described in 20 CFR part 404, subpart R, unless otherwise stated in this subpart.

*Enrollee* means an M+C eligible individual who has elected an M+C plan offered by an M+C organization, or his or her authorized representative.

*Grievance* means any complaint or dispute other than one involving an organization determination, as defined in § 422.566(b).

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

**§ 422.562 General provisions.**

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

(i) A grievance procedure as described in § 422.564 for addressing issues