

§ 422.114

42 CFR Ch. IV (10–1–12 Edition)

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) A plan physician assumes responsibility for the enrollee's care through transfer;

(iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged.

[65 FR 40322, June 29, 2000, as amended at 70 FR 4723, Jan. 28, 2005; 76 FR 21563, Apr. 15, 2011]

§ 422.114 Access to services under an MA private fee-for-service plan.

(a) *Sufficient access.* (1) An MA organization that offers an MA private fee-for-service plan must demonstrate to CMS that it has sufficient number and range of providers willing to furnish services under the plan.

(2) Subject to paragraphs (a)(3) and (a)(4) of this section, CMS finds that an MA organization meets the requirement in paragraph (a)(1) of this section if, with respect to a particular category of health care providers, the MA organization has—

(i) Payment rates that are not less than the rates that apply under original Medicare for the provider in question;

(ii) Subject to paragraph (A) of section (a)(2)(ii), contracts or agreements with a sufficient number and range of providers to furnish the services covered under the MA private fee-for-service plan; or

(A) For plan year 2010 and subsequent plan years, contracts or agreements with a sufficient number and range of providers to meet the access standards described in section 1852(d)(1) of the Act.

(B) [Reserved]

(iii) A combination of paragraphs (a)(2)(i) and (a)(2)(ii) of this section.

(3) For plan year 2011 and subsequent plan years, an MA organization that offers an MA private fee-for-service plan (other than a plan described in section 1857(i)(1) or (2) of the Act) that is operating in a network area (as defined in paragraph (a)(3)(i) of this section) meets the requirement in paragraph (a)(1) of this section only if the MA organization has contracts or agreements

with providers in accordance with paragraph (a)(2)(ii)(A) of this section.

(i) Network area is defined, for a given plan year, as the area that the Secretary identifies in the announcement of the risk and other factors to be used in adjusting MA capitation rates for each MA payment area for the previous plan year as having at least 2 network-based plans (as defined in paragraph (a)(3)(ii) of this section) with enrollment as of the first day of the year in which the announcement is made.

(ii) Network-based plan is defined as a coordinated care plan as described in § 422.4(a)(1)(ii), a network-based MSA plan, or a section 1876 reasonable cost plan. A network-based plan excludes a MA regional plan that meets access requirements substantially through the authority of § 422.112(a)(1)(ii) instead of written contracts.

(4) For plan year 2011 and subsequent plan years, an MA organization that offers an MA private fee-for-service plan that is described in section 1857(i)(1) or (2) of the Act meets the requirement in paragraph (a)(1) of this section only if the MA organization has contracts or agreements with providers in accordance with paragraph (a)(2)(ii)(A) of this section.

(b) *Freedom of choice.* MA fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.

(c) *Contracted network.* Private fee-for-service plans that meet network adequacy requirements for a category of health care professional or provider by meeting the requirements in paragraph (a)(2)(ii) of this section may provide for a higher beneficiary copayment in the case of health care professionals or providers of that same category who do not have contracts or agreements to provide covered services under the terms of the plan.

[63 FR 35077, June 26, 1998, as amended at 70 FR 4723, Jan. 28, 2005; 73 FR 54249, Sept. 18, 2008]