30.1 - General Requirements

(Rev.99, Issued: 05-27-11, Effective: 05-27-11, Implementation: 05-27-11)

42 CFR 422.114(a)(1) and (2)

An MA organization that offers a PFFS plan must provide sufficient access to health care services by demonstrating to CMS that it has a sufficient number and range of providers willing to furnish services under the plan. CMS will find that an MA organization meets this access to services requirement if, with respect to a particular category of health care providers, the PFFS plan has—

> (1) Payment rates that are not less than the rates that apply under Original Medicare for the provider in question. (These plans are called non-network PFFS plans. Refer to section 70.2 of this chapter.); OR
>
> (2) Signed 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. (These plans are called full network PFFS plans. Refer to sections 30.2 and 70.3 of this chapter.); OR
>
> (3) A combination of (1) and (2). (These plans are called partial network PFFS plans. Refer to sections 30.2 and 70.4 of this chapter.)

Non-employer PFFS plans offered in network areas and all employer/union sponsored PFFS plans must meet the access to services requirement for all categories of Part A and Part B health care providers by establishing signed 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 and section 30.2 of this chapter. Consequently, these plans must operate as full network PFFS plans. Refer to sections 30.3 and 30.4 of this chapter for more information about these requirements.