70.3 – Full Network PFFS Plan Rules

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

70.3.1 - General Rules

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

- The plan must meet the access to services requirement by establishing signed contracts or agreements with a sufficient number and range of providers that meet the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.

- The plan must operate a network of direct-contracting providers (also known as network providers) for all categories of Part A and Part B services.

- This access method is required for a plan that establishes payment rates for all categories of Part A and Part B services that are less than the rates paid under Original Medicare.

- As discussed in sections 30.3 and 30.4 of this chapter, beginning in plan year 2011, non-employer PFFS plans located in network areas and all employer/union sponsored PFFS plans must meet the access to services requirement by operating as full network plans.

- The plan must also cover out-of-network Part A and Part B services furnished by providers who do not have a signed contract or agreement with the plan, if the provider agrees to accept the plan's terms and conditions of payment and becomes a deemed provider as described in 42 CFR 422.216(f) and section 40.2 of this chapter.

70.3.2 - Payment Rules for Direct-Contracting Providers

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- The plan may establish payment rates for direct-contracting providers that are different than the rates established in the terms and conditions of payment for deemed providers. The plan may also vary the payment rates among the direct-contracting providers within a particular category of Part A or Part B service.

- The payment rates for direct-contracting providers may be higher, lower, or equal to the Original Medicare rates.

- The payment rates for direct-contracting providers must be established in the signed contract or agreement between the plan and the provider.

- The payment rates can be provider-specific, and public disclosure of the rates is not required.

70.3.3 - Payment Rules for Deemed Providers

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- The plan must pay all deemed providers at least the Original Medicare rates or higher. Specifically, the total payment rates for these providers (plan and member portions) must be at least the amounts they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services, including balance billing up to the limiting charge for non-participating physicians. Refer to section 80.1 of this chapter.

- The plan must establish the payment rates for deemed providers in its terms and conditions of payment and cannot vary the rates for deemed providers within a particular category of Part A or Part B service.

70.3.4 - Cost Sharing Rules for Members

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- The plan cannot vary a member's actual out-of-pocket costs (regardless of whether copayment or coinsurance applies) with respect to a particular category of Part A or Part B service for direct-contracting providers.

- The plan cannot vary a member's actual out-of-pocket costs (regardless of whether copayment or coinsurance applies) with respect to a particular category of Part A or Part B service for deemed providers.

- The member's actual out-of-pocket costs (regardless of whether copayment or coinsurance applies) with respect to a particular category of Part A or Part B service may be higher when the member receives out-of-network services from a deemed provider instead of in-network services from a direct-contracting provider.

70.3.5 – Review of Provider Networks

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

Review of all direct-contracting provider networks is required in accordance with section 30.2 of this chapter.