

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) The MA organization does not respond to a request for pre-approval within 1 hour;

(B) The MA organization cannot be contacted; or

(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

(3) *End of MA organization's financial responsibility.* The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(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; 80 FR 7959, Feb. 12, 2015; 87 FR 22428, Apr. 14, 2022; 88 FR 22330, Apr. 12, 2023]

§ 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)(i) 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]

§ 422.116 Network adequacy.

(a) *General rules—(1) Access.* (i) A network-based MA plan, as described in § 422.2 but not including MSA plans, must demonstrate that it has an adequate contracted provider network that is sufficient to provide access to covered services in accordance with access standards described in section 1852(d)(1) of the Act and in §§ 422.112(a) and 422.114(a)(1) and by meeting the standard in paragraph (a)(2) of this section. When required by CMS, an MA organization must attest that it has an adequate network for access and availability of a specific provider or facility type that CMS does not independently evaluate in a given year.

(ii) Beginning with contract year 2024, an applicant for a new or expanding service area must demonstrate compliance with this section as part of

its application for a new or expanding service area and CMS may deny an application on the basis of an evaluation of the applicant's network for the new or expanding service area.

(2) *Standards.* An MA plan must meet maximum time and distance standards and contract with a specified minimum number of each provider and facility-specialty type.

(i) Each contract provider type must be within maximum time and distance of at least one beneficiary (in the MA Medicare Sample Census) in order to count toward the minimum number.

(ii) The minimum number criteria and the time and distance criteria vary by the county type.

(3) *Applicability of MA network adequacy criteria.* (i) The following providers and facility types do not count toward meeting network adequacy criteria:

(A) Specialized, long-term care, and pediatric/children's hospitals.

(B) Providers that are only available in a residential facility.

(C) Providers and facilities contracted with the organization only for its commercial, Medicaid, or other products.

(ii) [Reserved]

(4) *Annual updates by CMS.* CMS annually updates and makes the following available:

(i) A Health Service Delivery (HSD) Reference file that identifies the following:

(A) All minimum provider and facility number requirements.

(B) All provider and facility time and distance standards.

(C) Ratios established in paragraph (e) of this section in advance of network reviews for the applicable year.

(ii) A Provider Supply file that lists available providers and facilities and their corresponding office locations and specialty types.

(A) The Provider Supply file is updated annually based on information in the Integrated Data Repository (IDR), which has comprehensive claims data, and information from public sources.

(B) CMS may also update the Provider Supply file based on findings from validation of provider information submitted on Exception Requests