DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Drug and Health Plan Choice
7500 Security Boulevard, Mail Stop C4-22-04
Baltimore, Maryland 21244-1850

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: November 16, 2009

TO: All Medicare Advantage Organizations Offering Private Fee-For-Service Plans

FROM: Danielle R. Moon J.D., M.P.A.
Acting Director

SUBJECT: Contract Year 2010 Model Private Fee-For-Service Terms and Conditions of Payment

On September 12, 2008, CMS released a memorandum via HPMS titled "Instructions for Model Private Fee-For-Service (PFFS) Terms and Conditions of Payment," which provided PFFS plans with model terms and conditions of payment and instructions for the submission and review of the document for contract year 2009. The memorandum is also available on the CMS website at http://www.cms.hhs.gov/PrivateFeeforServicePlans/.

The purpose of this memorandum is to provide updated language for the model terms and conditions of payment for contract year 2010. These updates clarify existing policies and allow plans to provide more specific information to providers, and include the following items:

- Language added to describe partial and full network PFFS plans;
- Changes based on guidance in the 2010 Call Letter related to the Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to providers and cost sharing limitations for dual eligible beneficiaries;
- Updates to the contact information for the PFFS independent review organization; and
- Updates to the member and provider appeals and grievances processes.

CMS expects all PFFS plans, including employer/union sponsored PFFS plans, to have implemented the updated model terms and conditions of payment included with this memorandum effective January 1, 2010. This model provides a uniform format and content, which will be of particular benefit to providers treating members of different PFFS plans. Use of this model will also expedite review by CMS Regional Offices (ROs).

1. Process for Submission and Review of Terms and Conditions of Payment

All terms and conditions of payment must be updated annually to reflect changes in plan benefit packages and be reviewed and approved by the appropriate CMS RO account manager prior to

use. Plans may not change these terms and conditions of payment during the year without prior CMS approval. PFFS plans should submit their 2010 terms and conditions of payment to their RO account manager via email.

Although the terms and conditions of payment do not meet the definition of marketing material in Section 20 of the Medicare Marketing Guidelines, CMS will follow the standard 10-day review process described in Section 90 of the Guidelines. The 10-day period begins on the date on which the terms and conditions of payment are received by the RO account manager.

As a reminder, the terms and conditions of payment are required to have a unique identifier. Please refer to our September 12, 2008 memorandum for additional guidance, which remains applicable for contract year 2010.

2. **Dual Eligibles and Cost Sharing**

Federal regulations at 42 CFR §422.504(g)(1)(iii) describe new cost sharing limitations on all MA plans that have dual eligible enrollees and on all dual eligible categories for which a State provides coverage, such that these beneficiaries are protected from cost sharing for Medicare Part A and Part B services. Our regulations also require that MA organizations inform providers of Medicare and Medicaid benefits and rules for dual eligible enrollees. These requirements are also described on page 12 of the 2010 Call Letter located on the CMS website at http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/2010CallLetter.pdf.

Please direct questions regarding this memorandum to your RO account manager.