DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

MEMORANDUM

DATE: September 12, 2008

TO: MA Organizations Offering Private Fee-For-Service plans

FROM: Teresa A. DeCaro, RN, M.S. **/s/**
Acting Director,
Medicare Drug & Health Plan Contract Administration Group

SUBJECT: Instructions For Model Private Fee-For-Service Terms And Conditions of Payment

Federal regulations at 42 CFR §422.216 require MA organizations offering Private Fee-For-Service (PFFS) plan(s) to make information on each PFFS plan's payment rates and provider requirements available to providers that furnish services to its enrollees.

A PFFS plan's terms and conditions of payment are the primary means for providers to obtain necessary information regarding a PFFS organization's payment arrangements and provider requirements. The terms and conditions of payment establish the rules that providers must follow if they choose to furnish services to plan members. The terms and conditions of payment also specify the amounts the plan will pay providers for covered services and the amounts providers are permitted to collect from members. In order to allow providers to make a confident decision as to whether or not they will agree to accept the terms and conditions of payment it is essential that all terms and conditions of payment are accurate with clearly presented information and concise provider relations contact information.

Therefore, effective January 1, 2009, Centers for Medicare & Medicaid Services (CMS) expects all PFFS plans to have implemented the model terms and conditions of payment. We believe that the use of this model will benefit both providers and plans. For providers treating members of multiple PFFS plans, widespread adoption of the model by plans will allow providers to look in the same place for similar information in each PFFS plan's terms and conditions of payment and significantly improve ease of use. The use of this model will also result in faster review by the CMS regional office (as described below):

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

   All terms and conditions of payment must be reviewed and approved by the appropriate CMS Regional Office (RO) account manager prior to use by PFFS plans. Plans must

update their terms and conditions of payment annually to reflect changes in their benefit packages. The updated terms and conditions of payment must be submitted to the plan's RO account manager for review and approval. Plans may not use a terms and conditions of payment without prior approval by CMS. Similarly, plans may not, without CMS approval, change during the year the contents of the terms and conditions of payment.

For contract year 2009, PFFS plans should submit their terms and conditions of payment to their RO account manager via email. For contract year 2010, CMS will establish the capability to allow plans to submit their terms and conditions of payment via Health Plan Management System (HPMS). We will provide further guidance on submitting terms and conditions of payment via HPMS at a later time.

Although, the terms and conditions of payment is not classified as marketing material, we will follow the standard 10-day review process already established for the review of marketing material, as described in Chapter 9 of the Marketing Guidelines, for the review and approval of the terms and conditions of payment. The review time period begins the date on which a terms and conditions of payment is received by the RO account manager.

2. Mid-year Changes to Terms and Conditions of Payment

During the course of the year, it may be necessary for PFFS plans to update their terms and conditions of payment, for example, to reflect accurate payment rates for certain provider types, reflect changes to CMS policy (e.g., changes in coverage policy), or to correct errors. Accordingly, PFFS plans will be permitted to update their terms and conditions of payment under limited circumstances, subject to CMS review and approval.

Once CMS has approved mid-year changes to a PFFS plan's terms and conditions of payment, the plan must notify providers of the changes at least 30 days before the effective date of the updated terms and conditions of payment. However, in some cases, if the terms and conditions contain payment or other errors that could negatively impact beneficiaries or providers, changes will be made effective immediately at CMS direction. As described in the 2009 Call Letter, notification of changes to the terms and conditions can be effected by prominently noting the plan changes in the updated terms and conditions and by sending the updated terms and conditions of payment to providers who previously furnished services to plan enrollees, and/or by other appropriate means.

3. PFFS Member ID Card Guidance

To ensure provider access to the PFFS plan terms and conditions of payment, PFFS plans should include on their member ID cards (1) the web link to their terms and conditions of payment and (2) a phone number for providers to call the plan.

If the web link for the terms and conditions of payment is too long to fit on the member ID card then plans are encouraged to appropriately shorten the web link so that it will fit appropriately. We are currently in the process of updating the Marketing Guidelines, which will include member ID card requirements for all MA plans, including PFFS plans.

4. Relationship with Providers

We strongly encourage all PFFS plans to develop and implement a provider education and outreach program to encourage a wide range of providers to accept PFFS enrollees. We provided detailed guidance on this in the 2009 Call Letter. As indicated in the May 25, 2007, guidance titled "Ensuring Beneficiary Understanding of Private Fee-for-Service Plans, Actions and Best Practices," PFFS plans are required to have staff available to assist providers with questions concerning plan payment and payment accuracy. This guidance document also contained information on creating a provider education plan.

We encourage plans to better educate their provider relation staff on the rules of their terms and conditions of payment so that they can provide reliable information to providers accurately and quickly. Plans must be committed to providing accurate information to providers that is also easily accessible. For example, providers should be able to obtain accurate information on member cost sharing amounts (including applicable deductibles) and plan payment rates when they call the plan.

Plans should address in a timely manner any inadequate capacity of plan contacts, such as excessive busy signals or excessive lack of timely response to voicemail messages.

5. Accuracy of Payments

PFFS plans must ensure that providers furnishing services to their members are being paid accurately and in a timely manner according to their terms and conditions of payment. Plans that are paying at the same rates as Original Medicare can obtain information on Medicare payments from the document entitled "MA Payment Guide for Out of Network Payments," which is available on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats.

6. Availability of Terms and Conditions of Payment

PFFS plans are required to make their terms and conditions of payment easily accessible to U.S. providers. A provider has reasonable access to a plan's terms and conditions of payment if the plan makes this information easily accessible through electronic mail, fax, telephone, or the plan website. PFFS plans should post the terms and conditions of payment on their website in a way that requires minimal navigation from the plan's main webpage.

7. Terms and Conditions of Payment Identification System

PFFS plans are required to place on all CMS approved terms and conditions of payment, a unique identifier in order to allow CMS to track these documents in the marketplace, address provider inquiries and/or complaints, and allow immediate recognition of the documents as an approved item. PFFS plans will be required to follow a specific format for this identifier similar to the format established for marketing materials, as described in Chapter 9 of the Marketing Guidelines.

The required format for the identifier is as follows: The identifier must (1) begin with the organization's contract number; (2) followed by an underscore; (3) followed by the three-character plan number; (4) followed by an underscore; (5) followed by a unique material-ID number (numbers or letters chosen at the discretion of the organization); and (6) followed by a place-holder for the CMS approval date (the date when the plan is notified by CMS that the terms and conditions of payment has been approved). Organizations that will use the same terms and conditions of payment for multiple plans do not need to include the plan number in the identifier. PFFS plans must ensure that the identifier is prominently displayed on their terms and conditions of payment on the front page in the lower left- or lower right-hand corner of the document.