

Medicare Managed Care

Chapter 16a – Private Fee-for-Service (PFFS) Plans

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10 – Introduction

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42 CFR 422.4(a)(3)

A Medicare Advantage private fee-for-service (PFFS) plan is an MA plan that:

- Pays providers of services at a payment rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;
- Does not vary the payment rates for a provider based on the utilization of that provider's services, except under the following two circumstances (refer to section 60 of this chapter):
 - A PFFS plan may vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization and do not violate the provider antidiscrimination rules under 42 CFR 422.205.
 - A PFFS plan may also increase the payment rates for a provider based on increased utilization of specified preventive or screening services.
- Does not restrict members' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment; and
- May not require prior notification (refer to section 90.3 of this chapter).

20 – General Requirements

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An MA organization that offers a PFFS plan must meet all applicable requirements for MA organizations as required by the Social Security Act (the Act) and the Code of Federal Regulations (CFR). This chapter is generally limited to the requirements specifically for PFFS plans as set forth in Part C of Title XVIII of the Act and Part 422 of Chapter 42 of the CFR.

Guidance on requirements that apply to all MA organizations, including organizations offering PFFS plans, may be found in other chapters of this manual, notably [Chapter 1](#) (General Provisions), [Chapter 2](#) (Enrollment and Disenrollment), [Chapter 3](#) (Marketing), [Chapter 4](#) (Benefits and Beneficiary Protections), [Chapter 5](#) (Quality Improvement Program), and [Chapter 13](#) (Beneficiary Grievances, Organization Determinations, and Appeals). Furthermore, PFFS plans that choose to provide qualified Part D prescription drug coverage must abide by applicable requirements of Part D of Title XVIII of the Act and Part 423 of Chapter 42 of the CFR. Guidance on Part D requirements may be found

in the Medicare Prescription Drug Benefit Manual (Publication 100-18) located at <http://www.cms.gov/Manuals/IOM/>.

Unless specified in [Chapter 9](#) of this manual or waived by CMS under employer/union plan waiver authority, employer/union sponsored PFFS plans are also required to meet the requirements described in this chapter.

The requirements that all MA organizations offering a PFFS plan must meet include, but are not limited to:

- Providing members with all medically necessary Original Medicare (Part A and Part B) covered items and services as described in section 10.2 of Chapter 4 of this manual. A PFFS plan may offer mandatory or optional supplemental benefits as well. In addition, a PFFS plan can choose to offer qualified Part D prescription drug coverage (as defined at 42 CFR 423.100 and section 20.1 of Chapter 5 of the Prescription Drug Benefit Manual).

This obligation to provide coverage applies to all PFFS plan types and provider types that can furnish services under a PFFS plan, as described in section 70 of this chapter.

- Allowing members to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States if (1) the provider agrees to accept the plan's terms and conditions of payment before providing services to the member, and (2) the provider is eligible to provide services under Medicare Part A and Part B.
- Meeting the requirement for access to services described in section 30.1 of this chapter.
- Paying deemed-contracting providers of all categories of Part A and Part B services at least the Original Medicare rates or higher. Specifically, including plan allowed cost sharing paid by the enrollee, PFFS plans must pay these providers at least the amounts they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services. Refer to sections 40.2, 70, and 80.1 of this chapter for more information.
- Establishing and disclosing a terms and conditions of payment for deemed-contracting providers. The terms and conditions of payment must be submitted to CMS and approved on an annual basis. Refer to section 50 of this chapter.
- Not requiring prior authorization, prior notification, or referral as a condition of coverage when medically necessary, plan-covered services are furnished to members. Refer to section 90 of this chapter.

- Abiding by the prompt payment requirements. Refer to section 110 of this chapter.
- Meeting the quality improvement program requirements described in section 150 of this chapter and [Chapter 5](#) of this manual.
- Complying with all applicable MA beneficiary grievances, organization determinations, and appeals requirements described in [Chapter 13](#) of this manual.

PFFS plans may, but are not required to, provide Part D coverage. As described in section 10.5 of [Chapter 4](#) of this manual, enrollees in a PFFS plan that does not elect to include Part D coverage may enroll in a stand-alone prescription drug plan (PDP) for their Part D coverage.

30 – Access to Services

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42 CFR 422.114

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.

30.2 – Access Standards for Full and Partial Network Plans

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42 CFR 422.114(a)(2)(ii)(A)

As discussed in section 30.1 of this chapter, a PFFS plan can meet the access to services requirement with respect to a particular category of 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. Section 1852(d)(1) of the Act describes the requirements that MA organizations offering a coordinated care plan (CCP) must meet when selecting providers to furnish benefits covered under the plan. The access standards for CCPs are described in 42 CFR 422.112(a) and section 110.1 of [Chapter 4](#) of this manual.

Full and partial (only for the categories of providers for which the plan is using a network of providers with signed contracts or agreements with the plan) network PFFS plans are required to meet the same access standards as CCPs. Providers with signed contracts or agreements with the plan are also known as direct-contracting providers or network providers. CMS reviewers follow the same procedure when reviewing the Health Service Delivery (HSD) Tables for initial and service area expansion applications for coordinated care, PFFS, and network MSA plans in order to determine whether an MA organization's proposed network meets the access standards. Full and partial network plans must submit information about their proposed provider networks to CMS. CMS reviews that information as part of the application approval process to ensure that timely, accessible, and appropriate care is provided.

30.3 - Requirement for Certain Non-Employer PFFS Plans to Use Contract Providers

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42 CFR 422.114(a)(3)

30.3.1 - General Requirements

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

Non-employer PFFS plans that are operating in a network area (as defined in section 1852(d)(5)(B) of the Act) must meet the access to services requirements through signed contracts with providers. These plans must establish signed contracts or agreements with a sufficient number and range of health care providers in their service area for all categories of Part A and Part B services in accordance with the access standards described in 1851(d)(1) of the Act and section 30.2 of this chapter.

Non-employer PFFS plans operating in network areas will not be allowed to meet the access to services requirement by establishing payment rates that are not less than the rates that apply under Original Medicare for a particular category of provider and having providers deemed to be contracted under the plan as provided under 42 CFR 422.216(f) and described in section 40.2 of this chapter. Consequently, these plans must operate as full network PFFS plans, instead of non-network or partial network plans.

While a non-employer PFFS plan operating in a network area must meet the access to services requirement by establishing signed contracts or agreements with providers and operate as a full network plan, providers who do not have a signed contract or agreement with the plan may continue to furnish out-of-network Part A and Part B services to members of the plan by agreeing to accept the PFFS plan's terms and conditions of payment and becoming a deemed provider as described in 42 CFR 422.216(f) and section 40.2 of this chapter. However, the plan may establish higher cost sharing requirements for members who obtain covered services from deemed providers instead of plan network providers.

CMS annually determines the location of the network areas for non-employer PFFS plans, which can be downloaded from the following CMS website:

<http://www.cms.hhs.gov/PrivateFeeForServicePlans/>.

30.3.2 - Methodology Used to Identify the Location of Network Areas

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

“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 (also known as the “Rate Announcement”) for the previous plan year) as “having at least 2 network-based plans (as defined in section 1852(d)(5)(C) of the Act) with enrollment as of the first day of the year in which the announcement is made.”

For purposes of this requirement, CMS interprets “having” a network-based plan with enrollment to mean having a network-based plan in an area that is generally open to enrollment. Thus, an area that has only one network-based plan that is generally open to enrollment, along with other limited enrollment network-based plans, such as a plan limited to members of an employer group or special needs population, would not meet this test. Therefore, employer/union sponsored group health plans and special needs plans (SNPs), which are not generally open to enrollment, are not considered network-based plans.

CMS also interprets the phrase “having at least 2 network-based plans” to mean that there are at least 2 plans (i.e. plan benefit packages (PBPs) each of which meets the definition of a network-based plan and that are offered by the same MAO or by different MAOs.

Additionally, CMS interprets the phrase “with enrollment” to mean that a network-based plan is required to have at least one beneficiary enrolled in the plan in order to be counted

for purposes of identifying the location of network areas. Therefore, if a plan has no members, it would not be counted as a network-based plan.

“Network-based plan” is defined as: (1) an MA plan that is a coordinated care plan as described in section 1851(a)(2)(A)(i) of the Act, excluding non-network regional PPOs (RPPOs); (2) a network-based MSA plan; or (3) a section 1876 cost plan.

The types of coordinated care plans that meet the definition of a network-based plan are HMOs, PSOs, local PPOs, and certain RPPOs (refer to section 30 of [Chapter 1](#) of this manual). An RPPO meets the definition of a network-based plan in only the portions of its service area where the RPPO meets access standards solely by establishing signed contracts or agreements with providers in accordance with section 110.1 of [Chapter 4](#) of this manual, and therefore, is operating as a network RPPO. 42 CFR 422.112(a)(1)(ii) permits RPPOs to meet access standards, upon CMS approval, using methods other than written agreements with providers (that is, the plan may allow members to see non-contracting providers at in-network cost sharing in areas where the plan has not established a network of direct-contracting providers). An RPPO that meets access standards in portions of its service area under the authority of 42 CFR 422.112(a)(1)(ii), rather than signed contracts, does not meet the definition of a network-based plan. These plans operate as non-network RPPOs.

For purposes of identifying the location of network areas for a given plan year, CMS will annually determine whether at least 2 network-based plans with enrollment exist in each of the counties in the United States, including its 5 territories and the District of Columbia. In some cases, network areas consist of partial counties and are identified by zip codes. Refer to the annual Advance Notice and the Rate Announcement for more information about the specific methodology used to identify the location of network areas for each plan year.

30.3.3 – Operational Impact on Non-Employer PFFS Plans

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

An existing PFFS plan may, in a subsequent contract year, have some counties (or partial counties) in its current service area that meet the definition of a network area and other counties (or partial counties) that do not. In order to preserve benefit uniformity under an MA plan, CMS will not permit an MA organization offering a PFFS plan to operate a mixed model where some counties (or partial counties) in the plan’s service area are considered network areas and other counties (or partial counties) that are non-network areas (where there are no network-based plan options or only one other network-based plan). In other words, a PFFS plan must be either a network based plan, a non-network plan, or a partial network plan.

PFFS Plans Operating in Both Network and Non-Network Areas. Current MA organizations offering PFFS plans with service areas spanning both network and non-network areas must complete the initial application process in order to bring the network portions of their service area into compliance with the access to services requirement.

These organizations will be issued a new contract (H) number through the application process to encompass the network portions of the service area. If the application is approved, the organization will be authorized to move the affected members to the new contract number. The current contract will continue to operate in the non-network areas.

PFSS Plans Operating in Network Areas. Current MA organizations offering PFSS plans whose service area lies solely in network areas must complete the initial application process in order to qualify to offer their PFSS plan to current and new members as a network PFSS plan. These organizations may NOT purport to meet the access to services requirement by moving their enrollees into a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) as it is not permissible to move affected members from the PFSS plan into other types of MA plans. The organizations that fail to complete the initial application process will be non-renewed or have their service area reduced and the affected members will be disenrolled to Original Medicare.

PFSS plans operating in network areas 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 PFSS plans. These PFSS plans may not use alternate methods to meet the access to services requirement in network areas. Specifically, these plans may not operate as non-network or partial network PFSS plans. If an MA organization is not able to establish a network of direct-contracting providers that CMS determines to be adequate in a network area, then it may not offer a PFSS plan in that area.

Current MA organizations offering PFSS plans that need to file an initial application to enable them to transition some or all of their plans to full network plans must first file a Notice of Intent to Apply (NOIA). CMS will not accept NOIAs and applications for non-network PFSS plans for those counties (or partial counties) determined to be network areas for a given plan year.

PFSS Plans Operating in Non-Network Areas. PFSS plans whose service areas lie solely in non-network areas can continue to operate as non-network plans, where the plan meets the access to services requirement by establishing payment rates that are not less than the rates that apply under Original Medicare (refer to section 70.2 of this chapter) and having providers deemed to be contracted under the plan as provided under 42 CFR 422.216(f) and described in section 40.2 of this chapter. PFSS plans in non-network areas may also choose to operate as full network plans (refer to section 70.3 of this chapter) or partial network plans (refer to section 70.4 of this chapter). No new application is required.

A network based PFSS plan must meet the access to services requirement by establishing signed contracts or agreements with a sufficient number and range of providers to furnish Part A and B services. However, providers who do not have a signed contract or agreement with the plan may continue to furnish out-of-network Part A and Part B services to those members of the plan who seek care with them by agreeing to accept the

PFFS plan's terms and conditions of payment and becoming a deemed providers as described in 42 CFR 422.216(f) and section 40.2 of this chapter. However, the plan may establish higher cost sharing requirements for members who obtain covered services from deemed providers instead of plan's network providers. Please note that all providers are still subject to balance billing limitations.

30.4 - Requirement for All Employer/Union Sponsored PFFS Plans to Use Contract Providers

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42 CFR 422.114(a)(4)

30.4.1 – General Requirements

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

All employer/union sponsored PFFS plans that have waivers under section 1857(i) of the Act must meet the access to services requirement by establishing signed contracts or agreements with a sufficient number and range of health care providers in their service area for Medicare Part A and Part B services in accordance with Medicare access and availability to health care services standards. Consequently, these plans must operate as full network PFFS plans, instead of non-network or partial network plans. Although CMS does not review the HSD tables for employer/union sponsored plans, these PFFS plans must ensure that their provider networks meet the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.

While (as described above) an employer/union sponsored PFFS plan must meet the access to services requirement by establishing signed contracts or agreements with providers and operating as a full network plan, providers who do not have a signed contract or agreement with the plan may continue to furnish out-of-network Part A and Part B services to members of the plan by agreeing to accept the PFFS plan's terms and conditions of payment and becoming a deemed provider as described in 42 CFR 422.216(f) and section 40.2 of this chapter. However, the PFFS plan may establish higher cost sharing requirements for members who obtain covered services from deemed providers instead of plan's network providers. Please note that all providers are still subject to balance billing limitations.

30.4.2 – Operational Impact on Employer PFFS Plans

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

In order to offer new employer/union sponsored PFFS plans, organizations must first file a notice of intent to apply (NOIA) and then complete the application for a new Medicare Advantage contract. Employer-only PFFS plans must be network based.

Employer/union sponsored PFFS plans that operate on a non-calendar year schedule must complete the initial application process on the same timeline as other MA applicants and pursuant to the same requirements as indicated in the initial application and related

materials. Organizations are not required to offer the approved network-based PFFS products, however, until the beginning of the organization's applicable plan year. For example, if an organization's 2011 plan year begins on July 1, 2011, then the organization must offer the network-based plan as of that date.

40 - Provider Types: Direct-Contracting, Deemed-Contracting, and Non-Contracting

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42 CFR 422.216

There are three types of providers that may furnish services to members of PFFS plans: direct-contracting, deemed-contracting, and non-contracting providers. Each is described in more detail sections 40.1, 40.2, and 40.3 of this chapter.

40.1 – Direct-Contracting Providers

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

A provider is a direct-contracting provider if the provider has a signed contract or agreement with a PFFS plan to deliver covered services to the plan's members. These providers are also known as network providers. Direct-contracting providers have already agreed to see members of the plan.

- Full network PFFS plans must establish direct-contracting providers for all categories of Part A and Part B services in accordance with the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.
- Partial network PFFS plans may have direct-contracting providers for one or more categories of Part A or Part B services in accordance with the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.
- Non-network PFFS plans generally do not have direct-contracting providers. However, non-network plans may establish signed contracts or agreements with some providers without meeting the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.

The payment rules for direct-contracting providers under the three types of PFFS plans are discussed in section 70 of this chapter.

40.2 – Deemed-Contracting Providers

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

42 CFR 422.216(f)

Members of PFFS plans can receive health care services from any provider in the United States, if (1) the provider agrees to accept the plan's terms and conditions of payment

before providing services to the member, and (2) the provider is eligible to provide services under Medicare Part A and Part B. If all of the deeming conditions described below are met, then the provider is deemed to have agreed to accept the PFFS plan's terms and conditions of payment for a member specific to the visit.

A provider that furnishes health care services to a PFFS plan member, except for emergency services, and does not have a signed contract or agreement with the plan is deemed to have a contract with the PFFS plan if the following conditions are met:

- The provider is aware in advance of furnishing health care services that the individual receiving the services is enrolled in a PFFS plan;
- The provider has reasonable access to the plan's terms and conditions of payment in advance of furnishing services (refer to section 50 of this chapter for more information on the PFFS terms and conditions of payment); and
- The provider furnishes services that are covered by the plan.

These providers are considered deemed-contracting providers (or deemed providers).

A provider is aware in advance of an individual's enrollment in a PFFS plan, if a notice of enrollment for the individual was obtained from:

- The individual (e.g., presentation of an enrollment card or other document attesting to enrollment in a PFFS plan);
- CMS;
- A Medicare intermediary, carrier or MAC; or
- The MA organization itself.

A provider has reasonable access to the plan's terms and conditions of payment if the plan makes the terms and conditions accessible through:

- The postal service;
- Electronic mail;
- Fax;
- Telephone; or
- The plan's website.

Announcements in newspapers, journals, magazines, radio, or television are not considered reasonable methods for allowing access to the terms and conditions of payment.

It is the provider's responsibility to call the PFFS plan or visit the plan's website to obtain the plan's terms and conditions of payment. The provider doesn't have to actually read the terms and conditions of payment; instead, if the provider had the opportunity to read them and treats the member, the law deems the provider to have agreed to accept the plan's terms and conditions of payment for that specific visit.

A deemed provider can decide whether or not to accept the PFFS plan's terms and conditions of payment each time the provider sees one of the plan's members. However, the provider cannot change his or her mind about accepting the terms and conditions of payment after providing services to the member. A decision to treat one plan member does not obligate the provider to treat other members of the same PFFS plan, nor does it obligate the provider to accept the same member for treatment at a subsequent visit.

A provider is not required to agree to accept a PFFS plan's terms and conditions of payment or agree to treat a PFFS plan member. If a provider does not agree to accept the plan's terms and conditions of payment or refuses to treat the member, then the member will need to find another provider that will accept the plan's terms and conditions of payment. PFFS plans should assist members to locate another provider in the member's area who will accept the plan's terms and conditions of payment. For example, if there are providers in the area that the PFFS plan knows have accepted its terms and conditions of payment it should identify those providers to its members who are seeking a provider willing to be deemed as possible sources of care.

A provider that decides not to accept the plan's terms and conditions of payment should not provide services to a member, except in emergencies. If the provider nonetheless furnishes non-emergency services, then the provider will become a deemed provider under the plan for that specific visit and be subject to the plan's terms and conditions whether the provider agrees to them or not.

If a member needs emergency care, then it is covered whether a provider agrees to accept the plan's terms and conditions of payment or not. Refer to section 40.3 of this chapter.

Example: If a PFFS plan member shows a provider an enrollment card identifying him or her as a member of a PFFS plan and the provider furnishes non-emergency services to that member, then the provider will be considered a deemed provider. Therefore, it is the provider's responsibility to obtain and review the terms and conditions of payment before providing services, except in the case of emergency services.

Members of full network and partial network (for categories of services for which network providers are available) PFFS plans can receive out-of-network Part A and Part B services from any provider who does not have a signed contract with the plan, as long as the provider agrees to accept the PFFS plan's terms and conditions of payment and

meets the deeming conditions described above. Note that a PFFS plan may establish higher cost sharing amounts for members who receive covered services from deemed (out-of-network) providers instead of network providers.

Members of partial network PFFS plans (for categories of services for which network providers are NOT available) can receive Part A and Part B services from any provider who does not have a signed contract with the plan, as long the provider agrees to accept the PFFS plan's terms and conditions of payment and meets the deeming conditions described above.

Non-network PFFS plans generally operate using deemed providers for all categories of Part A and Part B services.

The payment rules for deemed providers under the three types of PFFS plans are discussed in section 70 of this chapter.

40.3 – Non-Contracting Providers

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

A provider is a non-contracting provider if the provider is not a direct-contracting provider or a deemed provider. Generally, these providers furnish emergency services to PFFS plan members.

The following examples illustrate when a provider is considered non-contracting:

Example 1: A provider who provides care in an emergency to an unconscious individual is a non-contracting provider, if the provider did not know prior to furnishing services that the individual is a member of a PFFS plan.

Example 2: A provider who, prior to furnishing services, did not have reasonable access to the PFFS plan's terms and conditions of payment, is also considered non-contracting.

The payment rules for non-contracting providers under the three types of PFFS plans are discussed in sections 70 and 80.1 of this chapter. The rules for services furnished by non-contracting providers are also described in section 20.7 of [Chapter 4](#) of this manual.

50 – PFFS Terms and Conditions of Payment for Deemed Providers

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

42 CFR 422.216

50.1 – General Requirements

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

MA organizations offering full, partial, or non-network PFFS plans are required to make information on each PFFS plan's payment rates and provider requirements available to deemed providers that furnish services to their members. A PFFS plan's terms and conditions of payment is the primary means for deemed providers to obtain necessary information regarding a PFFS plan's payment rates for covered items and services and provider requirements in order to allow the providers to make a confident decision as to whether or not they will agree to accept the terms and conditions of payment.

All full, partial, and non-network PFFS plans, including employer/union sponsored PFFS plans, are required to implement the terms and conditions of payment for their deemed providers effective January 1 of the applicable contract year. Employer/union sponsored PFFS plans that operate on a non-calendar year schedule are expected to implement the terms and conditions of payment effective the beginning of the plan's applicable contract year.

The terms and conditions of payment establish the payment rates for plan-covered items and services that apply to deemed providers and the rules that deemed providers must follow in order to be paid by the PFFS plan for furnishing services to its members. PFFS plans must ensure that providers furnishing services to plan members are paid accurately and timely according to the terms and conditions of payment. At a minimum, PFFS plans are expected to include the following components in their term and conditions of payment:

- An explanation of the deeming process (refer to section 40.2 of this chapter);
- Provider qualifications and requirements (i.e., the provider is State-licensed and in compliance with other applicable State or Federal requirements, and the provider is eligible to provide services under Original Medicare);
- Explanation of provider payment rates (i.e., the amounts the plan will pay providers for covered items and services, the amounts providers are permitted to collect from members, balance billing rules, and hold harmless requirements);
- Provider billing requirements, including prompt payment requirements;
- Description of rules for maintaining medical records and allowing audits;
- How a provider can get an advance organization determination;
- Description of the plan's provider payment dispute resolution process;
- Description of member and provider rights for filing appeals and grievances; and
- Plan contact information.

Each component should contain sufficient information and instructions on how to obtain additional information if necessary.

50.2 - Model Terms and Conditions of Payment

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

CMS annually issues a model terms and conditions of payment for PFFS plans for each contract year. CMS expects all full, partial, and non-network PFFS plans, including employer/union sponsored PFFS plans, to implement the model terms and conditions of payment for their deemed providers effective January 1 of the applicable contract year. Employer/union sponsored PFFS plans that operate on a non-calendar year schedule are expected to implement the model terms and conditions of payment effective the beginning of the plan's applicable contract year.

The model terms and conditions of payment provide a uniform format and content, which is of particular benefit to providers treating members of different PFFS plans. Use of the model also expedites review by CMS Regional Offices (ROs). Refer to section 50.3 of this chapter for more information. The model terms and conditions of payment are posted on the CMS website at <http://www.cms.hhs.gov/PrivateFeeForServicePlans/>.

50.3 - Process for Submission and Review of Terms and Conditions of Payment

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

All terms and conditions of payment must be reviewed and approved by the appropriate CMS RO account manager prior to use by PFFS plans. Plans must update their terms and conditions of payment annually to reflect changes in their plan 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 change the contents of the terms and conditions of payment during the year without CMS approval.

PFFS plans should submit their 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, as defined in section 20 of [Chapter 3](#) of this manual, CMS will follow the standard 10-day review process described in section 90.5 of [Chapter 3](#) of this manual for the review and approval of the terms and conditions of payment when a plan uses the model provided by CMS. The 10-day period begins on the date on which the terms and conditions of payment are received by the RO account manager.

50.4 - Mid-year Changes to Terms and Conditions of Payment

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

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 can be made effective immediately at CMS' direction. Notification of changes to the terms and conditions must 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 members by electronic or direct mail.

50.5 - Availability of the Terms and Conditions of Payment

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

PFFS plans are required to make their terms and conditions of payment easily accessible to providers in the United States. CMS considers a provider to have reasonable access to a plan's terms and conditions of payment if the plan makes this information easily accessible through the postal service, electronic mail, fax, telephone, or the plan's 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.

50.6 - Terms and Conditions of Payment Identification System

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

All terms and conditions of payment are required to have a unique identifier. 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 approved items.

PFFS plans will be required to follow a specific format for the identifier similar to the format established for marketing materials in [Chapter 3](#) of this manual. The identifier must: (1) begin with the organization's contract number; (2) be followed by an underscore; (3) be followed by the three-character plan number; (4) be followed by an underscore; (5) be followed by a unique material-ID number (numbers or letters chosen at the discretion of the organization); and (6) be 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 have been approved). MA organizations that will use the same CMS approved terms and conditions of payment for multiple PFFS 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.

60 - Variations in Payment Rates to Providers

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

42 CFR 422.4(a)(3)(ii) and 42 CFR 422.216(a)

A PFFS plan cannot vary the payment rates for a provider based on the utilization of that provider's services, except under the following two circumstances:

- A PFFS plan may vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization and do not violate the provider antidiscrimination rules under 42 CFR 422.205; and
- A PFFS plan may also increase the payment rates for a provider based on increased utilization of specified preventive or screening services.

All three types of PFFS plans (full, partial, and non-network plans) are still required to establish uniform payment rates in their terms and conditions of payment for deemed providers of all categories of Part A and Part B services and are required to pay these deemed providers at least the Original Medicare rates or higher. However, plans also have the flexibility to establish through signed contracts or agreements with specific providers payment rates that are different than the rates listed in the terms and conditions that would otherwise apply, as long as the variations in payment rates are not based on utilization (as described above). As noted in section 40.1 of this chapter, providers with signed contracts or agreements with a PFFS plan are considered direct-contracting providers.

PFFS plans may vary payment rates for their direct-contracting providers as long as the rates are not based on utilization, with the payment rates being effective according to the terms of the contract or agreement between the plan and the provider. However, PFFS plans must continue to establish uniform payment rates for deemed providers in their terms and conditions of payment. As noted in section 40.2 of this chapter, all deemed providers have the right to decide, on a patient-by-patient and visit-by-visit basis, whether to treat plan members unless the provider becomes a direct-contracting provider by entering into a signed contract or agreement with the plan to see plan members over a certain period of time.

Example 1: PFFS plans may utilize the flexibility to establish provider-specific payment rates to encourage participation by providers who otherwise would not have agreed to accept the payment rates listed in the terms and conditions of payment. For example, a PFFS plan that lists a payment rate of 100% of Original Medicare for cardiology services in the terms and conditions of payment that apply to deemed providers can establish a higher provider-specific payment rate (e.g., 110% of Original Medicare) through a signed contract or agreement to encourage a provider in a rural area to provide these services.

Example 2: A PFFS plan that intends to increase payment rates to a provider based on increased utilization of specified preventive or screening services may establish the rates in its signed contracts or agreements with direct-contracting providers and/or in the terms and conditions of payment for deemed providers. The plan may also choose to apply this policy on a provider-by-provider basis.

PFFS plans must maintain a record of all provider-specific payment rates that they negotiate with direct-contracting providers along with the final rates paid. PFFS plans must also have the capacity to report this information to CMS or to an independent entity contracted by CMS upon request.

Section 70 of this chapter discusses the payment rules for direct-contracting and deemed providers in each of the three types of PFFS plans.

70 – PFFS Payment Rules for Providers and Cost Sharing Rules for Members

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

42 CFR 422.114 and 422.216

70.1 – General Rules

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

A PFFS plan can operate as one of three plan types depending on how the plan meets the access to services requirement. Specifically, a PFFS plan can operate as a non-network, full network, or a partial network PFFS plan depending on the method the plan uses to meet the access to services requirement described in section 30.1 of this chapter.

As discussed in section 60 of this chapter, a PFFS plan may vary the payment rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization. This flexibility allows PFFS plans to establish provider-specific payment rates that are different from the payment rates in their terms and conditions of payment for deemed providers, through signed contracts or agreements with providers.

Below we describe the access to services rules under each of the three types of PFFS plans, including their payment rules for deemed and direct-contracting providers and cost sharing rules for members.

Under each plan type, the plan must pay non-contracting providers, as defined in section 40.3 of this chapter, furnishing covered services an amount that the provider would have received under Original Medicare (including balance billing permitted under Original Medicare). Also, refer to section 80.1 of this chapter.

Providers may only collect the plan-allowed cost sharing from PFFS members, including any balance billing amounts permitted under the plan, and may not otherwise charge or bill members.

70.2 – Non-Network PFFS Plan Rules

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

70.2.1 - 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 paying all providers at least the Original Medicare rates or higher for all categories of Part A and Part B services.
- The plan must operate using deemed providers for all categories of Part A and Part B services, if the deeming conditions described in 42 CFR 422.216(f) and section 40.2 of this chapter are met.
- The plan may have some direct-contracting providers. The plan may establish signed contracts or agreements with some providers without meeting the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.

70.2.2 - Payment Rules for Deemed Providers

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

- 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.

70.2.3 - Payment Rules for Direct-Contracting Providers

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

- 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.

- Since the plan meets the access to services requirement by paying all providers at least the Original Medicare rates or higher, direct-contracting providers must also be paid at least the Original Medicare rates or higher.
- 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.

70.2.4 - Cost Sharing Rules for Members

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

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, regardless of whether the provider is a deemed or direct-contracting provider.

70.2.5 - Review of Provider Networks

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

A plan that has some direct-contracting providers is not required to meet the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.

The plan must disclose information about its direct-contracting providers to CMS upon request.

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

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

- 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

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

- 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

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

- 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.

70.4 – Partial Network PFFS Plan Rules

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

70.4.1 - 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 using a combination of the methods used by full network and non-network PFFS plans.
- The plan must operate a network of direct-contracting providers for one or more categories of Part A and Part B services that meets the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.
- For the categories of Part A and Part B services for which the plan uses direct-contracting providers, the plan must also cover out-of-network 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.
- The plan must pay all providers for the other categories of Part A and Part B services (i.e., those categories for which direct-contracting providers are not used) at least the Original Medicare rates or higher. The plan must operate using deemed providers for these categories of services; however, the plan may have some direct-contracting providers. The plan may establish signed contracts or

agreements with some providers without meeting the access standards described in section 1852(d)(1) of the Act and section 30.2 of this chapter.

70.4.2 - Payment Rules for Direct-Contracting Providers

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

The payment rules that apply under full network PFFS plans also apply to partial network plans. Refer to section 70.3.2 of this chapter.

70.4.3 - Payment Rules for Deemed Providers

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

The payment rules that apply under non-network and full network PFFS plans also apply for partial network plans. Refer to sections 70.2.2 and 70.3.3 of this chapter.

70.4.4 - Cost Sharing Rules for Members

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

The member cost sharing rules that apply under full network PFFS plans also apply to partial network plans. Refer to section 70.3.4 of this chapter.

70.4.5 - 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.

80 - Balance Billing Rules

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

80.1 – Original Medicare Balance Billing Rules that Apply to Deemed and Non-Contracting Providers under PFFS Plans

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

42 CFR 422.100(b)(2)

Non-contracting providers are required to accept as payment in full from a PFFS plan (including any member cost sharing) the amount they would have received under Original Medicare for a covered service (including any balance billing permitted under Original Medicare). While a non-contracting physician can only collect the plan-allowed cost sharing from a PFFS plan member, the difference that the plan must pay the provider varies depending on whether the provider is a participating or non-participating physician under Original Medicare. If a deemed provider collects more from an enrollee than is allowed under the PFFS plans terms and conditions of payment the PFFS plan must reimburse the member for their overpayment and seek the money the plan is still owed

from the provider. In the event the provider is non-cooperative the PFFS plan must report the provider to CMS and advise their plan member to not return to that provider until the provider has agreed to accept the plans terms and conditions of payment.

PFFS plans that are required to pay deemed physicians at least the Original Medicare payment rates must also take into account whether a physician is participating or non-participating under Original Medicare in order to determine the total amount due to the deemed physician.

The total amount due to the physician is as follows:

- Participating, deemed or non-contracting physicians: The physician is required to accept the fee schedule amount, including any plan-allowed member cost sharing, as payment in full.
- Non-participating, deemed or non-contracting physicians: The physician can charge an additional amount, up to the limiting charge, above the non-participating physician fee schedule amount. The limiting charge is defined as the maximum amount that non-participating physicians can charge above the non-participating physician fee schedule, which is 15%. The PFFS plan member is only required to pay the plan-allowed cost sharing. However, the PFFS plan must pay the provider the difference between the non-participating physician fee schedule amount (including any additional amount up to the limiting charge) and the member cost sharing.

80.2 - Additional Balance Billing Rules Allowed under PFFS Plans for Deemed and Direct-Contracting Providers

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

42 CFR 422.216(b)(1)(ii)

In addition to the Original Medicare balance billing rules described in section 80.1, there is a special rule that permits a PFFS plan to allow deemed and direct-contracting providers to charge the member up to 15% of the PFFS plan's total payment rate for a service, in addition to the plan-allowed member cost sharing. However, this special PFFS balance billing is only permitted if it is explicitly stated in the plan's terms and conditions of payment for deemed providers or in the signed contract or agreement between the plan and the direct-contracting providers. Providers are not permitted to balance bill a member who is also enrolled in a State Medicaid program, and as a result, the member is held harmless from Medicare cost sharing.

If a PFFS plan prohibits this special balance billing, then the deemed or direct-contracting providers may only collect the plan-allowed cost sharing from the member and may not otherwise charge or bill members.

80.2.1 - Advance Notice for Hospital Services

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

42 CFR 422.216(d)(2)

PFFS plans must require a deemed or direct-contracting hospital that intends to impose balance billing to provide members, before furnishing any hospital services for which the balance billing amount could be greater than \$500, with the following:

- (1) A notice that balance billing is permitted for those services;
- (2) A good faith estimate of the likely amount of balance billing based on the member's presenting condition; and
- (3) The amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billing amount.

The PFFS plan must include these requirements in its terms and conditions of payment for deemed hospitals or in the signed contract or agreement between the plan and the direct-contracting hospital.

90 – Prohibition on Prior Authorization, Prior Notification, and Referrals

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

42 CFR 422.4(a)(3)

90.1 – General Requirements

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

PFFS plans are prohibited from restricting a members' access to services by requiring prior authorization, prior notification, or referrals as a condition of coverage when medically necessary, plan-covered services are furnished to members. However, members and providers have the right to request a written advance organization determination from the plan, in accordance with Subpart M of Part 422, before a member receives a service in order to confirm that the service is medically necessary and will be covered by the plan. Refer to section 100 of this chapter for information on advance organization determinations. The requirements described below apply to all three types (full, partial, and non-network) of PFFS plans.

90.2 – Prior Authorization

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

PFFS plans can perform retrospective review of claims for the purpose of verifying medical necessity and that the service furnished is a covered service. However, PFFS plans may not require members or providers to obtain prior authorization from the plan as

a condition of coverage. Prior authorization occurs when a plan requires its members or their providers to seek approval from the plan before the member receives a service from the provider as a condition of coverage. However, as described below both enrollees and providers are entitled to request and receive an advance determination of coverage if they want to ensure that a particular service will be covered by the PFFS plan as described below under section 100.

90.3 – Prior Notification

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

Under prior notification, a plan reduces its standard cost sharing levels when the provider from whom a member is receiving plan-covered services voluntarily notifies the plan prior to furnishing those services, or the member voluntarily notifies the plan prior to receiving plan-covered services from a provider. PFFS plans may not require members or providers to prior notify the plan as a condition of coverage nor can PFFS plans establish voluntary prior notification rules.

90.4 – Referrals

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

PFFS plans may not require members to obtain referrals in order to receive medically necessary, plan-covered services. If a member receives a medically necessary, plan-covered service from a qualified provider, without a referral or prior authorization from the plan, the PFFS plan must pay for the service.

100 - Written Advance Organization Determinations

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

42 CFR 422.216(e)

If a member of a full, partial, or non-network PFFS plan sees a deemed provider who agrees to accept the plan's terms and conditions of payment, then the member and the provider have the right to request a written advance organization determination (also known as an advance coverage determination) from the plan before the member receives a service from the deemed provider. This allows the member and the provider to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by the plan. The PFFS plan must make advance organization determinations in accordance with Subpart M of Part 422 and [Chapter 13](#) of this manual.

In the absence of an advance organization determination, a PFFS plan can retroactively deny payment for a service furnished to a member only if the plan determines that the service was not covered by the plan or was not medically necessary. However, members and providers have the right to dispute the plan's decision by exercising member appeals rights. Refer to [Chapter 13](#) of this manual for more information.

PFFS plans should take an active role to educate their members and providers about their right to request a written advance organization determination from the plan before a

member receives a service in order to confirm that the service is medically necessary and will be covered by the plan. PFFS plans should clearly explain the process for requesting an initial organization determination in member materials and respond to requests from members and providers on a timely basis as described in subpart M section 422.568 and 422.572. PFFS plans should also encourage members and providers to request advance organization determinations prior to receiving costly services.

110 - Prompt Payment Requirements

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

42 CFR 422.520

MA organizations offering PFFS plans must establish prompt payment requirements for deemed providers in their terms and conditions of payment. At a minimum:

- The MA organization must pay 95 percent of the “clean claims” within 30 days of receipt, if they are submitted by or on behalf of a member of a PFFS plan; and
- The MA organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Act.

A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. PFFS plans will process all non-clean claims from deemed providers and notify providers of the determination within 60 days of receiving such claims.

MA organizations offering PFFS plans are also required to include a prompt payment provision in the signed contracts or agreements with their direct-contracting providers, the terms of which are developed and agreed to by both the MA organization and the relevant provider. The MA organization is obligated to pay direct-contracting providers under the terms of the contract between the MA organization and the provider.

120 – Timely Filing Requirement

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

For services furnished on or after January 1, 2010, deemed and non-contracting providers furnishing services to PFFS plan members must submit a claim to the plan for an Original Medicare-covered service within the same time frame the provider would have to submit under Original Medicare, which is within 1 calendar year after the date of service. The rules for submitting timely claims under Original Medicare can be found at <https://www.cms.gov/MLNMArticles/downloads/MM6960.pdf>.

130 – Provider Payment Dispute Resolution Process

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

130.1 – Process for Resolving Provider Payment Disputes through the PFFS Plan

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

Under its contract with CMS, PFFS plans are required to have a process in place to resolve provider payment disputes.

A PFFS plan is required to ensure that deemed providers are being paid according to its terms and conditions of payment. If a deemed provider believes that the payment amount the provider received from the PFFS plan is less than the amount indicated in the plan's terms and conditions of payment, then the provider has the right to dispute the payment amount following the plan's provider payment dispute resolution process.

The provider payment dispute resolution process must be explained in the PFFS plan's terms and conditions of payment. In its description of the provider payment dispute resolution process, the PFFS plan must describe how a provider can file a dispute with the plan and the appropriate documentation that the provider should submit to the plan to demonstrate that the plan paid the provider less than required under the PFFS plan's terms and conditions of payment.

The following guidelines identify some optimal features of a provider payment dispute resolution process, which CMS encourages all PFFS plans to implement. PFFS plans that follow the model features of the provider payment dispute process will meet CMS' requirements. CMS considers an effective provider payment dispute process a critical part of a PFFS plan since it will encourage provider participation in the plan.

Model Features of a Provider Payment Dispute Process:

1. The PFFS plan has a system for receiving provider payment disputes (e.g., dedicated phone line, e-mail address) and establishes a specific and reasonable timeline for resolution/adjudication of disputes. (CMS recommends 30 days from the time the provider payment dispute is first received by the plan.)
2. The PFFS plan maintains a record of provider payment disputes and documents its final decisions regarding provider payment disputes. The PFFS plan has the capacity to report this information to CMS upon request - including documentation of any corrective actions taken to prevent future payment errors.
3. If the PFFS plan finds for the provider (i.e., it agrees that it initially underpaid the provider), in addition to paying the provider the additional amount due in a timely manner, the plan should correct its payment system going forward, and identify similar claims for that contract year to ensure that it has paid them correctly.
4. The PFFS plan informs the provider in writing of its decision in cases where a provider payment dispute is denied by the plan.

CMS has provided language in its model terms and conditions of payment to describe a PFFS plan's provider payment dispute resolution process. Refer to section 50.2 of this chapter.

As discussed in section 110 of this chapter, PFFS plans must pay clean claims from deemed providers within 30 days. When reviewing a provider payment dispute process, CMS will review the PFFS plan's terms and conditions of payment and the rate at which it rejects provider claims from the clean-claim process. Specifically, the plan's terms and conditions of payment must furnish clear instructions telling providers how to bill the plan for services furnished to its members. CMS will pay particular attention to PFFS plans that reject a large percentage of claims because they are not clean (i.e., claims not paid because they were not billed according to plan instructions). CMS will determine what constitutes a large number of rejected claims based on comparisons with the average rejection rate of other PFFS plans. CMS will also review the terms and conditions of payment to ensure that it clearly informs providers how they can appeal to the plan if the provider believes the amount paid by the plan is less than what is described in its terms and conditions of payment. In its review, CMS will pay particular attention to how the plan documents its process and if it appropriately responds to provider appeals in a timely manner.

130.2 - Process for Resolving Provider Payment Disputes through the Payment Dispute Resolution Contractor

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

After completing the PFFS plan's provider payment dispute resolution process, if a deemed provider still believes that the plan has reached an incorrect decision regarding payment on a claim, the provider may file an additional request for review with an independent review organization contracted by CMS. To file this additional request for review of a payment dispute with the independent review organization, the provider may contact the Payment Dispute Resolution Contractor (PDRC) directly. Information on filing a dispute with the PDRC is available on the CMS website at https://www.cms.gov/HealthPlansGenInfo/18_ProviderPaymentDisputeResolution.asp.

The deemed provider must first complete the PFFS plan's provider payment dispute resolution process before requesting a review by the independent review organization.

Both deemed and non-contracting providers furnishing services to PFFS members may file payment disputes with the PDRC.

The provider payment dispute process cannot be used to challenge payment denials by organizations that result in zero payment being made to the non-contracted provider. Instead, these matters must be processed as appeals under 42 CFR Subpart M. In addition, the payment dispute process may not be used to resolve payment disputes between contracted network providers and organizations covered by this process. However, in cases where the plan makes a payment but the provider disputes the amount of the payment the provider may utilize the provider payment dispute process.

140 - Requirement for PFFS Plans to Provide an Explanation of Benefits to Members

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

42 CFR 422.216(d)(1)

MA organizations offering PFFS plans must provide plan members, for each claim filed by the member or the provider that furnished the service, with an appropriate explanation of benefits. The explanation of benefits must include a clear statement of the member's liability for deductibles, coinsurance, copayment, and balance billing.

150 - Requirement for PFFS Plans to have a Quality Improvement Program

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

42 CFR 422.152

150.1 – General Requirements

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

42 CFR 422.152(a)

MA organizations offering PFFS plans must meet the requirement that MA plans have an ongoing quality improvement program. As part of its ongoing quality improvement program, a PFFS must:

- Have chronic care improvement programs;
- Conduct quality improvement projects on an annual basis; and
- Encourage its providers to participate in CMS and HHS quality improvement initiatives. PFFS plans are required to meet this requirement only for their direct-contracting providers (i.e., providers who have a signed contract with the plan).

In order to implement the quality improvement program requirements, MA organizations should follow guidance in [Chapter 5](#) of this manual and seek assistance from State Quality Improvement Organizations as well as CMS.

150.2 – Quality Data Collection and Reporting Requirements

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

42 CFR 422.152(h)

PFFS plans must provide for the collection, analysis, and reporting of data that permits

the measurement of health outcomes and other indices of quality. The quality data collection and reporting requirements for PFFS plans cannot exceed the data collection and reporting requirements established for local PPO plans under 42 CFR 422.152(e). Refer to [Chapter 5](#) of this manual more information.

160 – PFFS Crosswalk Options

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

CMS has established specific rules that MA organizations must follow in order for CMS to allow non-network and partial network PFFS plans to transition to partial or full network PFFS plans. These rules are described below. Contract year-specific deadlines and processes associated with plan crosswalks are articulated in greater detail in the annual call letter and other CMS guidance.

160.1 - Non-Network PFFS Plan Transitioning to a Partial Network PFFS Plan

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

An MA organization with a PFFS non-network contract may consolidate one or more current non-network PFFS PBPs into a new or renewal partial network PFFS plan benefit package (PBP) under a separate contract held by the same legal entity.

Current members of a PFFS non-network plan or plans being consolidated into a new or renewal PFFS partial network plan will not be required to take any enrollment action, and the organization will not submit enrollment transactions to MARx for those current members, although it may need to submit updated 4Rx data to CMS for the current members affected by the consolidation. New members must complete enrollment requests, and the MA organization will submit enrollment transactions to MARx for those new members. Current members of the consolidated PFFS partial network plan must receive a standard annual notice of change (ANOC).

160.2 - Some Counties of a Non-Network PFFS Plan Transitioning to a Partial Network PFFS Plan

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

An MA organization with a PFFS non-network contract may consolidate some counties in the service area of a current non-network PFFS PBP into a single new or renewal partial network PFFS PBP under a separate contract held by the same legal entity. Current members in the remaining counties in the current year's non-network PFFS PBP may remain in the current non-network PBP provided the MA organization follows the rules for a renewal plan with a SAR described in section 140.6 of [Chapter 4](#) of this manual.

The MA organization must submit enrollment transactions to MARx for current members in the counties affected by the SAR who will be transitioned to a new or renewing partial network PBP under a separate contract held by the same legal entity. New members must

complete enrollment requests, and the MA organization will submit enrollment transactions to MARx for those new members as usual. Current members transitioned to the PFFS partial network plan must receive a standard ANOC.

160.3 - Non-Network PFFS Plan Transitioning to a Full Network PFFS Plan

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

An MA organization with a PFFS non-network contract may consolidate one or more current entire non-network PFFS PBPs into a new or renewal full network PFFS PBP under a separate contract held by the same legal entity.

Current members of a PFFS non-network plan or plans being consolidated into a new or renewal PFFS full network plan will not be required to take any enrollment action, and the organization will not submit enrollment transactions to MARx for those current members, although it may need to submit updated 4Rx data to CMS for the current members affected by the consolidation. New members must complete enrollment requests, and the MA organization will submit enrollment transactions to MARx for those new members. Current members of the consolidated PFFS full network plan must receive a standard ANOC.

160.4 - Some Counties of a Non-Network PFFS Plan Transitioning to a Full Network PFFS Plan

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

An MA organization with a PFFS non-network contract may consolidate some counties in the service area of a current non-network PFFS PBP into a single new or renewal full network PFFS PBP under a separate contract held by the same legal entity. Current members in the remaining counties in the current year non-network PFFS PBP may remain in subsequent year's non-network PBP provided the MA organization follows the rules for a renewal plan with a SAR described in section 140.6 of [Chapter 4](#) of this manual.

The MA organization must submit enrollment transactions to MARx for current members in the counties affected by the SAR who will be transitioned to a new or renewing full network PBP under a separate contract held by the same legal entity. New members must complete enrollment requests, and the MA organization will submit enrollment transactions to MARx for those new members. Current members transitioned to the PFFS full network plan must receive a standard ANOC.

160.5 - Partial Network PFFS Plan Transitioning to a Full Network PFFS Plan

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

An MA organization with a PFFS partial network contract may consolidate one or more current partial network PFFS PBPs into a new or renewal full network PFFS PBP under a separate contract held by the same legal entity.

Current members of a PFFS partial network plan or plans being consolidated into a new or renewal PFFS full network plan will not be required to take any enrollment action, and the organization will not submit enrollment transactions to MARx for those current members. New members must complete enrollment requests, and the MA organization will submit enrollment transactions to MARx for those new members. Current members of the consolidated PFFS full network plan must receive a standard ANOC.

160.6 - Some Counties of a Partial Network PFFS Plan Transitioning to a Full Network PFFS Plan

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

An MA organization with a PFFS partial network contract may consolidate some counties in the service area of a current partial network PFFS PBP into a single new or renewal full network PFFS PBP under a separate contract held by the same legal entity. Current members in the remaining counties in the current year's partial network PFFS PBP may remain in the subsequent year's partial network PBP provided the MA organization follows the rules for a renewal plan with a SAR described in section 140.6 of [Chapter 4](#) of this manual.

The MA organization must submit enrollment transactions to MARx for current members in the counties affected by the SAR who will be transitioned to a new or renewing full network PBP under a separate contract held by the same legal entity. New members must complete enrollment requests, and the MA organization will submit enrollment transactions to MARx for those new members. Current members transitioned to the PFFS full network plan must receive a standard ANOC.

Transmittals Issued for this Chapter

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