DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE DRUG & HEALTH PLAN CONTRACT ADMINISTRATION GROUP

DATE: November 9, 2011

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

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

SUBJECT: Contract Year 2012 Model Private Fee-For-Service Terms and Conditions of Payment

The purpose of this memorandum is to provide updated language for the model Private Fee-for-Service (PFFS) terms and conditions of payment for contract year 2012. These updates clarify existing policies and allow plans to provide more specific information to providers, and include the following:

- Clarification of the two existing PFFS balance billing scenarios.
- Clarification that plans may not hold members accountable for any cost-sharing for Medicare-covered preventive services, and inclusion of examples of Medicare-covered preventive services for which there is no cost sharing.

CMS expects all full, partial, and non-network 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, 2012. Employer/union sponsored PFFS plans that operate on a non-calendar year schedule are expected to have implemented the model terms and conditions of payment effective at the beginning of the plan's 2012 contract year.

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). The model will be posted on the CMS website at http://www.cms.hhs.gov/PrivateFeeforServicePlans/.

Payment rates for deemed providers under PFFS (full, partial, and non-network) plans

Full and partial network PFFS plans have signed contracts with some providers, who are known as network providers. Full network plans have a network of direct-contracting providers for all categories of Medicare Part A and Part B services that meet the access and availability standards described in section 1852(d)(1) of the Act. Partial network plans have a network of direct-contracting providers for one or more categories of Medicare Part A and Part B services that meet the access and availability standards described in section 1852(d)(1) of the Act. Members of full and partial network

plans can also receive “out-of-network” services from non-contracting providers who do not have a signed contract with the plan, as long as the provider meets the deeming conditions described in 42 CFR 422.216(f). These providers are known as deemed providers. The deeming conditions are also described in section 2 of the model terms and conditions of payment. Non-network PFFS plans operate using deemed providers.

All three types of PFFS plans must establish the terms and conditions of payment for the deemed providers that furnish services to their members and are required to pay deemed providers of all categories of Medicare Part A and Part B services at least at the Original Medicare rates or higher. Full and partial network PFFS plans may establish higher cost sharing requirements for members who obtain covered services from deemed providers instead of network providers.

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 Regional Office (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 2012 terms and conditions of payment to their RO Account Manager via email.

Although the terms and conditions of payment document do not meet the definition of marketing material, as defined in section 20 of the Medicare Marketing Guidelines, CMS will follow the standard 10-day review process described in section 90.5 of the Medicare Marketing 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 section 50.6 of Chapter 16a (Private Fee-for-Service) of the Medicare Managed Care Manual for additional guidance, which remains applicable for contract year 2012.

Please direct questions regarding this memorandum to your RO Account Manager.