DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

This letter is intended to inform providers of a new option, not to endorse
Health Net Pearl

Dear Provider:

In the Centers for Medicare & Medicaid Services' (CMS) continuing mission to improve access to health care for the 44 million Medicare beneficiaries nationwide, we have worked with various organizations that have expressed an intent to contract with CMS as Medicare Advantage (MA) Organizations, and to offer MA plans to Medicare beneficiaries. Historically, all MA plans offered to beneficiaries were "managed care" products, under which beneficiaries who enrolled were limited, at least to some extent, to a specified network of providers.

On September 14, 2006, Health Net Life Insurance Company and Health Net Insurance of New York, Inc. received authorization from CMS to offer an MA "private fee-for-service" (PFFS) plan, under which a beneficiary who enrolls is free to seek services from any provider who is willing to accept the plan's terms & conditions of payment and treat the enrollee. Because this type of MA plan is new to many providers, the following information is furnished concerning some of the special features of a MA PFFS plan.

In order to offer a PFFS plan without entering into signed contracts with a sufficient number of providers to meet MA access standards, the MA Organization must agree to pay all Medicare eligible providers at least the current Medicare Allowable rates (including original Medicare deductibles and coinsurance) minus any MA plan specific enrollee cost sharing. This minimum payment rate for non-network PFFS plans is mandated via regulation (42 CFR 422.114) as well as the contract that CMS holds with an MA Organization. (For details on provider eligibility see Provider Q & A #1 on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans.)

If a PFFS plan establishes payment rates for any category of providers (e.g., physicians, hospitals, etc.) in its terms & conditions of payment that are less than original Medicare payment rates, it then must have that category or categories of providers under direct signed contract. The reason for this requirement is that if a PFFS plan establishes a payment rate that is less than that of original Medicare, the plan will need to have direct contracting providers to ensure that its enrollees can go to those providers to receive services. While enrollees in PFFS plans can always seek care from any eligible provider in the U.S. who is willing to accept the plan's terms & conditions of payment, if the plan's payment rate is less than original Medicare, many providers may decline to treat the enrollees.

The PFFS payment rules for providers are mandated via regulation (42 CFR 422.114 and 422.216) as well as the contract that CMS holds with an MA Organization. (For details on provider eligibility see Provider Q & A #1 on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans.)

Providers are prohibited from balance billing enrollees of the PFFS plan unless the PFFS plan allows the provider to do so in its terms & conditions of payment. PFFS plans have the option of allowing providers to balance bill members up to 15% of the plan payment rate (42 CFR 422.216 (b)). Other than any plan allowed "balance billing" amount, providers must bill only for copayments, deductibles or coinsurance described in the MA Organization's terms and conditions of payment. Providers must always abide by the PFFS plans terms & conditions of payment for any services he or she chooses to furnish to PFFS enrollees.

Other important aspects of PFFS plans include:

- If a provider decides to accept the PFFS plan, they must follow the PFFS plan terms and conditions of payment. Provider agreement to the plan terms and conditions of payment is inherent in their decision to treat a PFFS plan enrollee. If a provider

decides to treat a PFFS plan enrollee, then the provider must bill the PFFS plan for covered services. The provider has the right to decide, on a patient-by-patient and visit-by-visit basis, whether to treat PFFS plan enrollees. If a provider decides not to accept the PFFS plan terms and conditions of payment, then the provider should not provide services to the PFFS plan enrollees, except in an emergency.

- CMS audits the MA Organization to ensure that it pays providers the appropriate amount for services furnished to plan enrollees and that it pays clean claims within 30 days.
- An authorized MA Organization that offers a PFFS plan is subject to the same financial solvency requirement as any other MA Organization approved by CMS.
- Payments made by an MA Organization that offers a PFFS plan cannot place providers at risk by using such reimbursement methods as capitation or withholds; and correspondingly, cannot base payment on the organization's performance using bonuses or incentives.
- Any advertising, marketing collateral or marketing practice must be filed with CMS prior to their use.
- An organization that wants to offer a PFFS plan is required to seek and receive acknowledgement and approval from every State Department of Insurance prior to offering a PFFS plan. [note this does not apply to certain employer only PFFS plans which have used the EPOG state licensing waiver.]

We recognize that as with any new plan, there can be confusion both from the provider and beneficiary communities. We continue to work with Health Net Pearl to make sure all parties involved have sufficient information when deciding whether to accept the Health Net plan or any Medicare Advantage program available to them in the area. Additional information, including questions and answers addressing frequently asked beneficiary and provider questions can be found on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans/, as well as the Health Net web site at www.healthnet.com.

Sincerely,

David A. Lewis
Director
Medicare Advantage Group