DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

DATE: April 15, 2005

TO: Medicare Advantage Organizations
Section 1876 Cost-based Contractors
Demonstrations

FROM: Patricia P. Smith /s/
Director, Medicare Advantage Group
Center for Beneficiary Choices

SUBJECT: Instructions for the 2006 Contract Year

I am pleased to send you these instructions for the 2006 contract year. The guidance in this 2006 "Call Letter" applies to all Medicare Advantage organizations, cost-based organizations, and capitated care demonstration plans that expect to be operating in contract year 2006, including those that are currently applying to enter the program. This call letter is a key element of the guidance that CMS is providing to help organizations bid and contract for the upcoming contract year. Please note, however, that while we have tried to capture some of the Final Rule highlights in this call letter, a complete understanding of the regulatory requirements related to the Part C and Part D programs can only be acquired through an in depth familiarity with our recently published regulations.

Again this year, we have placed the contract renewal and non-renewal instructions in the same document. Parts I-III contain the information necessary for renewing contracts. Parts IV and V describe the non-renewal process. Part VI lists important contacts and Part VII provides key web-page references.

We at CMS are looking forward to making the 2006 contract year a very positive symbol of the combined efforts of CMS and the coordinated care industry to implement the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). An aggressive schedule of critical dates and deadlines were distributed to the industry as part of these instructions last year. These milestones were largely achieved through our collaborative effort with you in preparation for this landmark year.

As a result of the significant changes in the Medicare coordinated care program that will become effective in 2006, it is impractical to delineate all of the improvements and changes in this Call Letter. For example, this Letter does not specifically discuss the new prescription drug benefit or the guidance for plans transitioning to the MMA requirements that become effective on January 1, 2006. Significant guidance and information has already been distributed on these and other topics and is available on the web at http://www.cms.hhs.gov/medicarereform/pdbma. In addition, CMS fully

anticipates releasing additional operational guidance on a number of topics, including for example, the use of "essential" hospitals by regional MA plans. This and other information will be distributed through HPMS and posted on the CMS web-site. Please also note that we have included current web-site addresses in Section VII of the letter for ready reference.

Again, we further strongly encourage all existing contracting organizations to read the regulations that were published on January 28, 2005 – CMS-4069-F (the MA regulation) and CMS-4068-F (the Part D regulation). Particular attention should be paid to the preamble discussion and the comment response portion of the document. CMS has also conducted a number of conferences and tele-conferences to discuss important issues. This outreach will continue throughout 2005 and we encourage your participation. CMS will conduct a conference call to discuss this Call Letter on April 25, 2005, from 1:00 p.m. to 3:00 p.m. Eastern Daylight Savings Time. Additional information will be forthcoming.

As in past years the 2006 Call Letter includes a calendar of important dates. From time to time there is a need to provide additional information on this calendar so we urge you to regularly check for updates at http://www.cms.hhs.gov/medicarereform/mma-t1t2-calendar.pdf.

There were a number of improvements under the MMA that we wish to highlight. The introduction of the new Medicare prescription drug benefit enables Medicare to begin paying for a benefit that will support higher quality and better coordinated care for Medicare health plan enrollees. The new Regional PPO option that also becomes effective January 1, 2006 will bring additional choices to more Medicare beneficiaries, especially those residing in rural areas. In addition, the 2006 contract year marks the beginning of the new competitive bidding methodology for reimbursement to MA organizations. This new methodology has already invigorated the Medicare coordinated care program and ushered in many more choices for the Medicare population.

Please note that 2006 will also bring the start of annual contracting. With limited exception, new contracts will be effective on January 1 of each year beginning in 2006. Part II of these instructions includes a detailed discussion of annual contracting and the implications for current contractors, new organizations, regional/local plans and employer group plans. Further, with the publication of the final rule on January 21, 2005, MA organizations can submit proposals for Special Needs Plans (SNPs) to serve individuals with chronically disabling conditions. SNPs were previously offered only to the dual eligible or institutionalized beneficiary populations.

Thank you for your continued service to Medicare beneficiaries. If you have specific questions about any of these instruction, please contact the analyst listed in Part VI or send an e-mail to PDoerr@cms.hhs.gov. He will distribute your inquiry to the appropriate contact person for a response.

We look forward to your continued participation in the Medicare managed care program.