

**Note: The following is a template of the letter sent to Family Care Partnership MCO members who are eligible for default enrollment into a Dual Eligible Special Needs Plan (D-SNP) when they become Medicare eligible. All letters used will contain the required Centers for Medicare and Medicaid Services (CMS) disclaimers, materials ID, and appropriate CMS submission approval prior to use.**

## **KEEP THIS NOTICE FOR YOUR RECORDS**

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

### **IMPORTANT: Your health and drug plan coverage is changing.**

Dear <Name of Member>:

We are writing to let you know about important changes to your medical and prescription drug coverage. As your Medicaid plan, we'd like to thank you for your membership in <Medicaid MCO Plan Name>, offered by <Parent Organization Name>.

Because you will be eligible for Medicare soon, <Parent Organization Name> will **automatically enroll you into the Medicare benefit of <Family Care Partnership> for your Medicare benefits. This coverage will start on <insert effective date = Part A and B effective date>, the same day your Medicare benefits start.**

You currently have <Family Care Partnership> (Medicaid). <Family Care Partnership>, offered by <parent organization name>, also covers the Medicare benefit for eligible individuals and helps your Medicare and Medicaid benefits work together.

If you don't want <parent organization name> to provide your Medicare coverage, you can choose to get your Medicare coverage through another plan or Original Medicare. However, by enrolling with <parent organization name> for your Medicare coverage your Medicaid and Medicare services will be coordinated by one organization. **If you don't make another choice by <insert date before effective date>, you'll be enrolled with <parent organization Family Care Partnership> Medicare benefit starting <insert effective date>.**

**You don't have to do anything unless you don't want to be automatically enrolled in the Medicare benefit of <parent organization><Family Care Partnership name>.** If you don't make another choice by <insert day before effective date>, your new coverage will start on <insert effective date> and you will receive coverage for both your Medicaid and Medicare benefits through <parent organization Family Care Partnership>.

Because Family Care Partnership requires coverage for Medicaid and Medicare by the same organization, you must have both your Medicare and Medicaid from <Family Care Partnership>. If you choose to opt out of enrollment into Medicare with <Family Care Partnership> Plan, you

will be disenrolled from your current <Family Care Partnership> Medicaid plan and will need to choose another Medicaid program for your Medicaid.

For more information about your Medicare option through <parent organization Family Care Partnership> and the benefits and services your new plan covers, or **to find out if you can still see your current providers in your new plan and whether your new plan covers all of your prescription drugs**, call <Family Care Partnership name> at <phone number>. TTY users should call <TTY number>. We are open <days/hours of operation and, if different, TTY hours of operation>.

## **Frequently Asked Questions**

### **What is <D-SNP name>?**

For those eligible for Medicare, <Family Care Partnership> is a Medicare Advantage health plan that includes prescription drug coverage *<if applicable, insert “and other supplemental benefits”>*. Enrolling in the Medicare benefit of <Family Care Partnership> will allow us to coordinate all of your Medicare and Medicaid benefits, including your hospital, medical, prescription drug, and long-term care needs. You will be eligible for both benefits through Family Care Partnership as long as you have both Medicare and <Medicaid > coverage and continue to live within the approved plan service area.

### **How much will I pay for <D-SNP name>?**

Like with <Family Care Partnership Medicaid benefit>, you won't have any monthly premium by adding the Medicare benefit.

Your costs for prescription drugs in Medicare, including in the Medicare benefit of <Family Care Partnership name> will be no more than:

- \$0/\$X.xx/ \$X.xx for each prescription of generic/preferred multi source drugs and \$0/\$X.xx/ \$X.xx for each prescription for all other drugs. This is *[insert as appropriate: <more> <less>]* than what you pay now under <Medicaid MCO name>, which is *<insert per prescriptions costs>*.
- *[If there are costs in either Medicaid MCO or D-SNP, insert the following (for Qualified Medicare Beneficiaries always use \$0 for the costs below. For Dual Eligible beneficiaries subject to cost-sharing, include applicable cost-sharing or range in cost-sharing.):* Your costs for doctor visits <D-SNP name> will be *<insert costs>*. Right now, you pay *<insert costs>* for doctor visits in <Family Care Partnership>.
- For hospital stays, you will pay *<insert costs>* in <Family Care Partnership>. You now pay *<insert costs>* for hospital visits in <Family Care Partnership>.]
- *[If there are zero costs under either the Medicaid MCO and the D-SNP, insert the following:* Like with <Family Care Partnership>, you won't pay to see a doctor or for hospital visits by adding the Medicare benefit with <Family Care Partnership D-SNP name>.]

## How do I get Medicare services through <D-SNP Name>?

*[If true, insert <You can continue to see your current Primary Care Physician (PCP) for your health care needs with <Family Care Partnership D-SNP Name>].*

*[If true, insert <You will need to choose a new Primary Care Physician for your health care needs with <Family Care Partnership D-SNP Name>, Your current Primary Care Physician is not in our network.]*

Beginning on the date your Medicare coverage begins, you must get all of your Medicare health care services from <parent organization><Family Care Partnership>, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by <parent organization Family Care Partnership> and other services contained in the Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **If you go to a provider not in <parent organization><Family Care Partnership> without authorization, neither Medicare nor <Family Care Partnership> will pay for Medicare-covered services.**

Once you are a member of <parent organization> <Family Care Partnership> Medicare benefit, you have the right to appeal plan decisions about payment or services if you disagree. Read the Evidence of Coverage from <parent organization> <Family Care Partnership> when you get it to know which plan rules you must follow to get coverage with this plan.

## What if Medicaid pays for my prescription drugs now?

Medicaid won't cover drugs after <effective date for Medicare coverage.> **Now you must get drug coverage from Medicare.** *[Insert if applicable <Family Care Partnership Medicaid benefit> may cover a few prescriptions that won't be covered under your Medicare prescription drug coverage].* To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan. By enrolling in the Medicare benefit of <Family Care Partnership Name>, you will get this coverage.

## Do I have to join <parent organization Family Care Partnership Medicare benefit>?

**No.** You can decide to join a different Medicare Advantage plan or Original Medicare. If you do not want to get your Medicare benefits through <parent organization Family Care Partnership D-SNP Name>, please call us at <phone number(s)> by <insert date before effective date>. TTY/TDD users should call <phone number>. Our hours of operation are <insert days and hours of operation>.

*[Insert if applicable <You can also return the enclosed opt-out form to:*

*<Insert Address>]*

If you choose not to enroll in <parent organization Family Care Partnership Name> for your Medicare benefits at this time, you will not be able to keep your <Family Care Partnership Medicaid> membership.

## Do I have other choices for how I get my Medicare?

**Yes.** If you don't want to be enrolled in the Medicare benefit of **<Family Care Partnership name>**, you have other choices in how you get your Medicare coverage, including:

**Option 1: You can join another Medicare Advantage health plan.** You will want to check whether your providers and prescription drugs are covered by the plan.

A Medicare health plan is offered by a private company that contracts with Medicare to provide benefits. Medicare health plans cover all services that Original Medicare covers and most also include prescription drug coverage. They may also offer extra coverage such as vision, hearing, or dental services.

Make sure the plan you want to join receives your enrollment request before **<insert effective date>**.

If you don't join another Medicare health plan during this time, you'll only be able to change plans during certain times of the year or in certain situations.

**Option 2: You can change to Original Medicare and join a Medicare Part D drug plan.** Original Medicare is coverage managed directly by the Federal government.

- To change to Original Medicare, call **<plan name>** at **<toll-free phone number>**. Call **<TTY number>** if you use TTY. We are open **<days/hours of operation and, if different, TTY hours of operation>**. Tell them you don't want to be in **<plan name>** (you want to "opt-out").
- If you change to Original Medicare, you need to enroll in a separate Medicare Part D prescription drug plan. You should pick a plan that covers the drugs you take. (See the question below for help in choosing.) If you don't enroll in a drug plan yourself, Medicare will enroll you in a Medicare Part D prescription drug plan and send you a letter telling you the name of your new drug plan.

## How can I get help comparing my Medicare plan choices?

It's important to find a plan that covers your doctor visits and prescription drugs.

You can get help comparing your plan choices if you:

- **Call the Wisconsin State Health Insurance Program (SHIP).** SHIP counselors are not affiliated with any health plan and so are unbiased; they provide free, personalized health insurance counseling. You can call a toll-free SHIP helpline or meet with a counselor in person:
  - Call the **Medigap Helpline** at 1-800-242-1060 if you are over 60 years old.
  - Call the **Disability Rights Wisconsin Medicare Part D Helpline** at 1-800-926-4862 if you are under 60 years old.
  - **Find your local benefit specialist** by going to <https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm>.

- **Visit [Medicare.gov](https://www.Medicare.gov).** Medicare’s web site has tools that can help you compare plans and answer your questions. **Click** “Find plans” to compare plans in your area.
- **Call 1-800-MEDICARE (1-800-633-4227).** Tell them you got a letter saying you have Medicaid now and are going to be eligible for Medicare. Say that you want help with your Medicare choices. This toll-free helpline is available 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Refer to your Medicare & You Handbook** for a list of all Medicare health and prescription drug plans in your area. If you want to join one of these plans, you can call the plan to get information about their costs, rules, and coverage.

## Why am I being offered this option?

As an individual eligible for both Medicaid and Medicare coverage, this automatic enrollment into a Medicare D-SNP will allow for better coordination of care and services with your Medicaid and Medicare benefits.

If you have questions about your Family Care Partnership coverage, please call your local ADRC at **xxx-xxx-xxxx**. This includes questions about staying enrolled in **<plan name parent organization>** for your Family Care Partnership benefits. Call 711 if you use TTY. ADRC Offices are open Monday–Friday from 8am–4:30pm CST. Free interpreter services are available.

## What’s next? *[Provide a roadmap of mailings and actions expected in the next few weeks, for example:*

We **<insert as applicable: will send, have already sent>** you a membership card to show when you use health services or go the pharmacy after **<effective date.>**

We will send you an Evidence of Coverage to explain the benefits of our plan.

We will call you to welcome you and answer any questions you have.

If you have any other questions, call **<plan name>** at **<phone number>**. Call **<TTY number>** if you use TTY. We are open **<days/hours of operation and, if different, TTY hours of operation>**.

## Keep a copy of this letter for your records.

Sincerely,

**<Signature>**

*[Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines.]*