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**MEMORANDUM**

**DATE:** January 26, 2006

**FROM:** Director, Medicare Enrollment and Appeals Group  
Center for Beneficiary Choices

Director, Medicare Provider Communications Group  
Center for Medicare Management

Director, Medicare Contractor Management Group  
Center for Medicare Management

**SUBJECT:** Message to All Medicare Providers in Pennsylvania – **ACTION**

**TO:** See Addressees

Please immediately distribute the attached information to your Medicare providers. Issue through your provider listservs within 2 days of receipt of this memorandum and post on your website within 5 days. Also add to your next provider bulletins, and include in any educational activities.

If you have any questions, please contact Barbara Cerbone at (215) 861-4320.

/s/ Anthony Culotta                      /s/ Geraldine Nicholson                      /s/ Karen Jackson

Addressees:  
Mr. Patrick Kiley, Senior Medicare Executive, Highmark, Inc.  
Ms. Janet Kyle, Director and First Vice President/Medicare & Financial Officer, Mutual of Omaha  
Ms. Lynda Northcutt, President and Chief Operating Officer, Cahaba Government Benefit Administrators

cc:  
Nancy O'Connor, Philadelphia RA  
John Delaney, CCMO  
Daly Vargas, CCMO  
Patricia Volk, CCMO  
Jeff Hinson, CMM/MCMG

## Important Message to All Medicare Participating Providers in Pennsylvania

As you may be aware, many Medicare beneficiaries who also have Medicaid coverage from the State of Pennsylvania (also known as “full benefit dual eligibles,” or “dual eligibles”) have been enrolled into Medicare “Special Needs Plans” (SNPs) and coverage began January 1, 2006. These Medicare SNPs (shown in the attached document) are managed care plans operated by the same organization that provided these beneficiaries’ Medicaid managed care coverage, and are specifically designed to provide coordinated care (including Medicare prescription drug coverage) for the dually eligible population.

You may or may not participate in any or all of these plans’ networks. **Regardless, please do not let this stop you from seeing your Medicare patients.** Here’s why:

- 1) For the first 90 days of this year (through March 31, 2006), you may provide Medicare-covered services to these individuals and submit a claim to your patient’s Medicare SNP even though you do not participate in its network. The SNP is required to pay you the Medicare fee-for-service (FFS) rate or billed charge, whichever is lower, for any Medicare-covered services provided during the period beginning January 1, 2006, and ending on March 31, 2006.
- 2) You may sign up to be a participating provider with the plan, should you so desire. You should contact the plan for further details about becoming a participating provider.
- 3) Your dual eligible patients are allowed to disenroll from the SNP and return to Original (FFS) Medicare or choose a different Medicare managed care plan at any time.

The Centers for Medicare & Medicaid Services (CMS) has worked closely with the SNPs to clarify their obligations to continue to pay for services provided by out-of-network providers through March 31, 2006, and to ensure that these “transition policies” are appropriately disseminated throughout their organizations. These policies are further described in Attachment C, and each of the SNPs has signed this document, thereby attesting to their intent to implement these policies. If you have any questions about these policies, or encounter any difficulties receiving payment for care provided during this time period, please contact the appropriate plan in the attached document. You may also contact CMS’ Philadelphia Regional Office if you encounter problems with this process.

All affected beneficiaries received notice of the prospective enrollment into a SNP earlier in the fall, including an explanation of their ability to disenroll from the plan and choose Original Medicare or another Medicare managed care plan. This notice also explained the changes in the way they would be able to access their benefits, including the need to generally obtain services from network providers. They will soon receive another notice explaining their enrollment options and clarifying plan transition policies. That is, these beneficiaries may disenroll from their SNP by calling the plan directly at the number included above, or by calling 1-800-MEDICARE (1-800-633-4227). TYY users should call 1-877-486-2048. Staff at 1-800-MEDICARE will also help them to enroll in a Medicare Prescription Drug Plan, to make sure that retain Medicare prescription drug coverage.

## List of Medicare Special Needs Plans

### AmeriHealth 65

Member Services: 1-800-645-3965

Provider Services: 1-888-850-9200

### Gateway Health Plan

Member Services: 1-800-685-5209

Provider Services: 1-800-685-5205

### Health Partners

Member Services General: 1-800-553-0784

Medicare Specific: 1-888-667-7367

Provider Services: 1-888-991-9023

### Keystone 65 Complete

Member Services: 1-800-645-3965

Provider Services: 1-888-850-9200

### Unison Health Plan

Member Services: 1-800-290-4009

Provider Services: 1-800-600-9007

### UPMC Health Plan

Members and Providers: 1-800-606-8648

## Special Needs Plans' Attestation

[Insert Name of Plan] (the "Plan") has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006 for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, covered services furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS' January 6 and January 13, 2006 memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D-covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.