NYS Medicare Savings Coalition
Meeting Minutes
February 2nd, 2012
9:30am – 11:00am

Present or called in: Mitchell Clark (Medicare Rights Center), Heather Bates (Medicare Rights Center), Dan Reedy (Medicare Rights Center), Debra Smith (CMS), Eric Hausman (NYC DFTA), Pat Esposito (Westchester Seniors out Speaking), Linda Petrosino (NYS Office for the Aging), Brenda LaMere (NYS Office for the Aging), Bethene Trexel (ACES), Diana Graham (NYC HIICAP), Laura Mulvihill (EPIC), Rita Zink (NYS DOH), Denise Urbano (NYS DOH), Jill Bell (NYS DOH), Joanne Martinez (NYS DOH), Mary Houlihan (NYS DOH), Paul Collura, (CMS)

NYSDOH Update:

The Federal Poverty Level (FPL) for 2012 has been released. The FPL is the basis for MSP and Extra Help income limits.

The new levels can be found here: http://aspe.hhs.gov/poverty/12poverty.shtml and a breakdown based on the percentage of FPL can be found here: www.medicarerights.org/pdf/2012-federal-poverty-levels.pdf.

-MSP Limits for 2012

- DOH reported that a GIS, outlining the new limits for the MSP, is currently going through the approval process and will be transmitted to the districts once approved.
- Systems are also being updated to reflect the new levels.

-COLA Related MSP Disenrollment
The following took place after the February 2nd call:

As a result of the most recent Cost of Living Adjustment (COLA), some MSP beneficiaries were re-budgeted and disenrolled if their increased Social Security benefit put them over the MSP income limits for 2011. As we now know, the MSP limits for 2012 are set to go up based on the new Federal Poverty Level and these clients may still be eligible for the benefit. The new limits are currently being programmed into state systems, and they will be effective January 1st, 2012 once they are released by DOH later this month. A breakdown of the imminent 2012 income limits has been attached to this email.

We have received word from DOH that they are pulling together lists of the clients who were recently disenrolled from the MSP after their income went up due to the COLA. These lists will be transmitted to the districts for re-budgeting and the client will be put back on the MSP if they are eligible based on the 2012 limits. It was advised that clients be patient while they are being placed back on the benefit. If there is no change to their status within 30 days from today, then those cases can be referred directly to DOH. The re-budgeting process should not result in the client paying the Part B premium, but if they are billed the premium and pay, then they will be reimbursed.

NOTE: Only clients who lost the MSP because of the COLA increase will be pulled for re-budgeting. The discontinue notice sent out to clients states that the individual is being disenrolled from the MSP because of the increase in their income due to the COLA. I have attached a redacted version of this notice. As a precaution, it might be a good idea to also request a fair hearing for your clients who are in this situation.

CMS Update:

Paul Collura gave the following update about the CMS plan complaint process:

Paul.Collura@cms.hhs.gov. 212-616-2515
Consortium for Medicare Health Plan Operations, Nationally Focused, Regionally Based

Paul's department is responsible for daily oversight of private plans under Medicare C & D nationwide. While he is based in the NY CMS Office, he is responsible for implementing and overseeing casework and complaints about private plans since 2006. As he presented during the Denver Regional Health Plan conference in 2011:
http://www.cmsdrughealthplanevents.org/cms/media/1110denver/media/d1_06_Beneficiary_Casework_Transcript.pdf

He sets up general procedures and complaints and monitors the volume and types of issues that beneficiaries are reporting about private plans which influences their bonus payments and star ratings. During a future call this spring, Paul agreed to come back and review the star ratings with the Coalition.

Based on complaints received, this helps CMS decide which plans to monitor closely, review trends and analyze data. The CTMs are viewed by the plans and typically, the plans resolve the problems directly. Overall volume has dropped in the last year when it comes to complaints because the initial complaints were overwhelmingly about premium withhold issues and enrollment timeframes. CMS attributes the overall decrease in plan complaints as beneficiaries better understanding both C and D programs. They primarily receive CTMs in the following categories: enrollment, access to care, payments and customer care. They do not record CTMs for general issues such as the doughnut hole, plans change yearly, but rather they have to include a plan and action that the plan has taken, or not. While they have used the CTM process to track IRMAA issues for example, these are not part of plan analytics nor is this information used when calculating star ratings or shared with the plans because this is the responsibility of CMS.

In general, CTMs are an internal CMS process that has been adapted to use with private plans and shared with 35 SHIPs nationwide, 1-800 Medicare and their fraud contractors in order to track private plan problems.

The ACA establishes a complaint mechanism requirement and CMS launched this early by requiring plans to have their medicare.gov logo prominently displayed on the plan's home page and access to the Medicare.gov version of the CTM – which is not exactly the same as filing a formal CTM. The online complaint form, found here:

https://www.medicare.gov/medicarecomplaintform/home.aspx?AspxAutoDetectCookieSupport=1
can lead to a formal CTM however and serves as a gateway to the CTM process which is as follows:

- If you use the internet complaint form, and you need the issue resolved in less than ten days which is asked, then the process stops and you are asked to call 1-800 Medicare to file your complaint.
- If you call 1-800 Medicare to file a CTM or complaint, the CSRs will triage the problem and if it is urgent, they will institute timeframes for plans to respond.
- If you answer no, that the problem does not need to be fixed within ten days, you can complete the form but it does not automatically get filed as a formal CTM complaint, rather, depending on the issue (their main categories that are tracked are enrollment, payment, access to care and customer care thus far) 1-800 Medicare staff review the online complaint form and problem solve. It may never get filed as a formal CTM – and therefore – never affect the plans star ratings or bonus payments and trends are not analyzed. If there is no resolution when the staff try to solve the problem with the plan, than it is filed as a CTM.

This internet form launched in December 2010 and Paul said that the volume so far, has been manageable, but that is because people do not know about the form yet. Currently, they receive about one complaint per day. In the last year, they averaged about 80,000 complaints on behalf of 31 million beneficiaries enrolled in private C and D plans. Paul stated that the number of complaints is down by 20%.

CMS monitors whether plans resolve the issues brought forth through CTMs to ensure they are resolved but also from a regulatory standpoint to monitor systemic problems.

One problem that we see is that a few plans overuse their file and use privileges and send enormous amounts of mail, letters, marketing materials, etc. to people throughout the year and that this is not monitored through CTMs, he was interested in seeing one letter in particular that Deb Smith mentioned from Emblem, as an example of this and would follow up about it.

There is not data publicly available about the types of issues that present as the highest volume of complaints, but 20% of complaints are about payment issues (copayment problems, bills) and 50-60% percent are about enrollment issues.

EPIC Update:

Eric Hausman provided the following client strategies for dealing with the cut to EPIC:
Apply for Extra Help through the Social Security Administration. Register online at:
www.ssa.gov/ or call 1-800-772-1213

1. Apply for a Medicare Savings Program
2. Ask beneficiary if they can switch to a more affordable generic prescription

3. Ask the plan for a request in Tier exception – to a lower tier
4. Change pharmacy – there are co-pay difference in preferred and non-preferred pharmacies
5. Switch to mail order
6. Change Part D Plans –
   - By using the person's EPIC SEP (may use this one time during the year)
   - By enrolling in the new 5-Star plan – Simply Prescriptions
7. Work Outside of Medicare by:
   - Ask the doctor for free samples
   - Contact drug manufacturer if they have a Patient's Assistance Program.
   - Go to www.needymeds.org
   - Contact charities – some available due to disease, illness. Income limits may apply.
8. Discount Cards – these are usually no cost. Use like coupons. Ask pharmacist to use the discount card that offers the lower cost!!
9. Federally Qualified Health Centers
   - Pay on sliding scale
10. Spending-Down for Medicaid – A person needs to meet the spend-down for just one-month to obtain full extra help ($6.50/$2.60) co-pays for the remaining calendar year.
11. Veteran's Benefits – for those that qualify.

Case Story

Dan Reedy provided the following case story about QMB Balance Billing:

Ms. A is enrolled in the Medicare Savings Program QMB. In addition to paying for the Part B premium, QMB also protects Ms. A from billed for Part A and B coinsurances and deductibles when she received Medicare covered services. Ms. A was not aware of the assistance QMB affords and neither were her doctors. As a result, Ms. A was being billed a total of $360 in co-payments for various primary care visits.

The advocacy strategy used was to contact the provider's office and explain the QMB benefit. I sent them the CMS memo and the Medicare Learning Network article about QMB Balance Billing. The doctors appreciated the information and said they would contact the CMS provider helpline to get more information and will make a decision about the client's responsibility for payment.

Linked below is an Informational Bulletin that provides information for State Medicaid Agencies and other interested parties regarding the prohibition on "balance-billing" Qualified Medicare Beneficiaries (QMB) for Medicare cost-sharing, including deductible, coinsurance, and copayments.

http://www.medicarerights.org/pdf/CMS-QMB-Billing-2012.pdf

The following points are taken from the memo:

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the State's discretion, Medicaid may also pay Part C Medicare Advantage premiums for those who join a Medicare Advantage plan that covers Medicare Part A and B benefits and Mandatory Supplemental Benefits.
- Regardless of whether the State Medicaid Agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.
- States also have the authority to pay cost-sharing for QMBs for either the Medicare cost-sharing amount, the Medicaid State plan rate for the same service, or a rate between those amounts that is established by the State and approved by CMS.

Our next meeting is tentatively scheduled for Wednesday, March 7th, 2012 at 2:00 p.m.

****The preceding minutes are Medicare Rights Center's account of the New York State Medicare Savings Coalition meeting held February 2nd, 2012****