NYS Medicare Savings Coalition
Meeting Minutes
November 14th, 2012
9:30am – 11:00am

Present or called in:

Doug Goggin-Callahan (Medicare Rights Center), Heather Bates (Medicare Rights Center), Dan Reedy (Medicare Rights Center), Allison Cook (Medicare Rights Center), Krystal Knight (Medicare Rights Center), Eric Sollod (Medicare Rights Center), Paul Collura (CMS), Gary Wirth (CMS), Michelle Ketchum (CMS), Rhonda Cooper (NYS EPIC), Laura Mulvihill (NYS EPIC), Joanne Martinez (NYS DOH), Rita Zink (NYS DOH), Mary Lou Festa (NYS DOH), Mary Harper (NYC HRA), Linda Hacker (NYC HRA), Veneze Smart-Ferreira (NYC HRA), Maurice Jones (Lenox Hill Neighborhood House), Kelly Gerin (Institute for Community Living), Irina Goyfman (Institute for Community Living), Al Macaltao (Institute for Community Living), Brenda LaMere (NYS OFA), Linda Petrosino (NYS OFA), Alexandra Remmel (GMHC), Ilyse Reif (SelfHelp Community Services), Bethene Trexel (ACES), Helen Ruan (Lenox Hill Neighborhood House), Cathy Roberts (Empire Justice Center), Kathleen Foster (Nassau County DSS), Paula Arboleda (SelfHelp Community Services), Julia Pilosov (SelfHelp Community Services), Arlene Suero (Diana Jones Senior Center)

Contents

NYS DOH Update:

Passive Recertification:

- An automatic (passive) recertification process was planned to begin for MSP recipients and Aged, Blind, and Disabled Medicaid recipients living in New York City in October, 2012.
    - This project has been delayed, and will likely begin in February or March, 2013.

    - Doug Goggin-Callahan: Do we know what accounts for this delay?

    - Rita Zink: The delay is at least in part a result of issues related to testing the automated recertification systems, and because the Department has been focused on other projects.

- Passive recertification for Aged, Blind, and Disabled Medicaid recipients and MSP-only recipients
    - Only Medicaid and MSP recipients located upstate are passively recertified.
    - Those who are passively recertified receive only Social Security income. Anyone who receives other types of income will need to actively recertify

- About 1000 Medicaid recipients are passively recertified each month
- Between 700-100 MSP recipients are passively recertified each month.

Rebudgeting for MSP Recipients after the Release of Social Security's Cost of Living Adjustment

- Doug Goggin-Callahan: Last year, many MSP recipients had their eligibility for the program reconsidered after Social Security's Cost of Living Adjustment (COLA) was released. This rebudgeting occurred prior to the release of the new income limits for MSPs (which are based on the Federal Poverty Levels). As a result, many individuals lost their MSP, though they were actually still eligible once the new income limits were released. We had been told earlier this year that DOH would be taking steps to prevent this from occurring again. What does the Department of Health plan to do to avoid similar problems this year?

- In 2012, MSP recipients will not be rebudgeted until the new Federal Poverty Levels (FPLs) are received. This will allow the state to avoid disenrolling those who may continue to qualify for an MSP in the following year.

    - Doug Goggin-Callahan: If any of those on the call encounter clients who are disenrolled because of the COLA, who should they contact?

    - Rita Zink: They should contact their local Department of Social Services Office. If there is a problem that cannot be resolved at the local office, these issues can be addressed by the Department of Health.

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    - Dan Reedy: Will people who receive *both* Medicaid and an MSP be rebudgeted for both programs this year, before the FPL is released? Or would they be rebudgeted for Medicaid before the end of the year, and rebudgeted for the MSP once the new FPLs are released?

    - Rita Zink: I believe that DSS offices will wait until the FPL is released to rebudget individuals with both Medicaid and an MSP.

    - Dan Reedy: Will those who are due to recertify after they receive their COLA but before the FPLs are released be disenrolled from the MSP? Will their recertification be delayed until the FPLs are released? If they are disenrolled, and subsequently found eligible once the new FPLs are released, will they get retroactive benefits?

    - Rita Zink: This is something we could look into further.

Application and Recertification for Medicaid and MSPs in the wake of Hurricane Sandy

Mary Lou Festa:

- DOH has been working with downstate districts affected by Hurricane Sandy, which include Nassau, Suffolk, Putnam, Rockland, Westchester, Orange, and Sullivan counties, and the counties of NYC. DOH has met with the Office of Temporary and Disability Assistance (OTDA) and Office of Children and Family Services (OCFS), as well as FEMA and IT groups to best determine how to assist counties through the aftermath of the disaster.

- Renewals for all Medicaid programs (including Medicare Savings Programs and Family Health Plus) which were due as of November 30 were automatically granted an extension:

- All Medicaid and MSP recipients in counties affected will have one additional month to recertify
- About half of these recipients were granted an additional two months to recertify so that DSS offices are not overwhelmed by recertifications due on December 31.
- All MSP and Medicaid recipients located in New York City who were required to recertify in November were granted an additional two months to recertify.

Mary Harper:

- The state suspended closing actions for all Medicaid cases from the date that the Hurricane hit NYC.
    - Mailings did go out on schedule, as they were mailed prior to the date the hurricane hit New York.
    - Timeframes have been extended, but recertification is still required for all Medicaid and MSP recipients. Those who receive notices from their local DSS should still respond in a timely manner.
- All Medicaid offices are currently open, except the Bellevue office.
- Medicaid renewals have been relocated to 34th street.

Linda Hacker:

- HRA has been providing an unusually high number of updates in response to the disaster.
- Advocates can stay appraised of any changes by signing up to receive updates from HRA through the MARC system.

To sign up for updates from HRA, you can register on the following website: http://a069-marc.nyc.gov/marc/default.aspx

- There has been a temporary interruption in HRA's helpline service
- If there are any issues that advocates encounter that are not being addressed, they should inform HRA about these issues.

    - Helen Ruan: should renewals for Medicaid programs still be sent to the P.O. Box in Brooklyn?

    - HRA: Yes, the mail vender is running, so they should go to the same place. This system records electronic copies of all renewals, which is substantially more secure than previous systems.

    - Heather Bates: We have heard from several agencies that they lost copies of files for their clients. If they need new copies of these documents, should they contact HRA?

    - HRA: Applicants should contact HRA in these situations. They can request new copies of renewal forms on the HRA helpline as well.

- There is a fax number that can be used by agencies to get new copies of renewal notices. This number is the recommended method of getting renewals at this time, due to service interruptions on the HRA helpline. This number is available here: http://wnylc.com/health/download/366/
- Renewals for Medicaid (for those who are ***not*** Disabled, Aged, and Blind) and other public benefits are available online at the HRA website. (Note: you cannot renew MSP applications online.)

EPIC Update:

EPIC Premium Payments

- Medicare Part D premium payments were delayed by the transition to a new payment system.
    - Payments for June and July were not released until last week.
    - Plans have received August invoices, and payments for August should be sent out this week.
    - EPIC hopes to catch up on all premium payments for its members' Part D plans by the end of the year.

    - Doug Goggin-Callahan: Has EPIC encountered members who were told that they would be disenrolled if they did not pay their Part D premium?

    - Rhonda Cooper: If any EPIC members do receive these letters, they should contact the EPIC helpline and EPIC will resolve the problem. It is rare for members to receive termination notices, though some plans may have systems set up that send these notices automatically to members who have premiums that are overdue. Part D plans have generally been very cooperative through the changes to EPIC's payment systems.

EPIC Application

- The new EPIC application has been approved and will be printed shortly.
    - The application itself has not changed, and anyone who wishes to apply for EPIC can continue to use the same application in 2013 as was available in 2012.
    - There is a new brochure and rate card reflecting EPIC premiums and deductibles that will be included with the application in 2013.
    - This application is available online in Spanish and seven other languages.
    - A person can apply for EPIC without any documentation, as EPIC verifies income and residency information through matches with the Social Security Administration and the IRS.
- EPIC's new enrollment system is currently being finalized. This system needed to be changed to reflect the deductibles and fees of EPIC members in 2013.

Renewal

- EPIC sent out renewal forms to all members,
    - Many members returned these forms.
    - Those who did not return these forms will not be disenrolled.
        - EPIC will use their income information on file, as well as SSA and IRS matches to determine what their fee or deductible will be.

Notification of EPIC Fees and Deductibles

- Fee members will be notified around the beginning of December about how to use their EPIC coverage, what their EPIC fee will be, and that they will be required to return payment in order for coverage to begin in January.
    - If EPIC fee plan members do not pay their fee by the beginning of January, they will receive another notice during January informing them that they must pay their fee within 30 days or they will lose EPIC coverage.
- Notification letters will be staggered, so that the EPIC helpline will not be overwhelmed by calls.
- People who receive full Extra Help will have their EPIC fees waived. EPIC will pay Part D premiums for individuals with incomes up to $23,000 and couples with incomes up to $29,000.

- After notifying the fee plan members, EPIC will notify deductible plan members what their EPIC deductible will be.
    - Notices will also inform EPIC deductible plan members that they must pay their Part D premiums in order to continue to receive coverage.
- Any members who disagree with the decision about their fee or deductible will be able to call the EPIC helpline and request that their income be reconsidered.

Information about the EPIC changes that will take effect in January, 2013 is available here: http://www.health.ny.gov/health_care/epic/2012-13_key_points_and_faq.htm

CMS Update

Gary Wirth and Michelle Ketchum: Medication Therapy Management (MTM) Programs

Overview of the MTM Program

- MTM program is designed to:
    - Ensure that Part D drugs are optimally used
    - Reduce the chances of adverse events
    - Improve therapeutic outcomes.

Changes to the MTM Program

- When Part D began in 2006, there were few requirements for MTM programs
- These programs were changed in 2010
    - New criteria to qualify
    - More standardization
- MTM requirements were expanded further as a result of the Affordable Care Act (ACA)
    - The ACA mandated a standardized format for the Comprehensive Medication Review which is provided to MTM members.
        - A standardized form associated with this review must be used beginning January, 2013
    - Required that all targeted beneficiaries be offered a Comprehensive Medication Review
        - In the past, beneficiaries receiving long term care were exempt from this requirement

Qualifying for MTM

- Three requirements to qualify for MTM
    1. Beneficiary must have multiple chronic diseases
        i. Plans cannot require more than three diseases to qualify for MTM
        ii. Plans can set their minimum at either two or three chronic diseases
        iii. Can target beneficiaries with any chronic diseases, or specify specific diseases

    2. Beneficiary must take multiple Part D drugs
        i. Plans cannot require more than eight prescription drugs
        ii. They have the flexibility to set this minimum at between two and eight prescription drugs

    3. Likely to meet or exceed an annual cost threshold for covered Part D drugs
        i. In 2006, this was initially set to $4000
        ii. In 2010, it was reduced to $3000.

iii. This amount will increase slightly each year
iv. In 2014, the cost threshold to qualify for MTM is $3144

Plan Requirements

- Each year, Part D sponsor must submit MTM program description to CMS for approval
    - This is part of each Part D plan's annual bid
    - CMS will review description to ensure that programs meet minimum requirements
    - During the year, sponsors can only make positive changes to their MTM program, and these must be approved by CMS.
- Many plans offer MTM to an expanded population beyond that required by CMS. In some cases, MTM services are offered to all plan members.
- Minimum MTM services
    - Offer interventions for prescriber and beneficiary
    - Offer an annual Comprehensive Medication Review
    - Provide quarterly Targeted Medication Reviews with follow-up interventions when necessary.

Enrolling in MTM

- Plans should enroll members quarterly. This enrollment in the MTM program should occur automatically, and the plan member will have the option to opt out of the MTM program.
    - MTM programs are not mandatory.
    - Each individual MTM service is voluntary. A member can be enrolled in an MTM program, but choose not to receive any of the MTM service that are offered.

Comprehensive Medication Review

- Interactive person-to-person or tele-health consultation performed by a pharmacist or other qualified provider
- Results of the review are delivered in an individualized written summary in a standardized format
- This should be offered to beneficiaries as soon as possible after they are enrolled in the MTM program.
    - Within 60 days
- If a beneficiary is cognitively impaired
    - Pharmacist or other provider will reach out to prescriber to ask them to participate in the medication review.

Targeted Medication Review

- Must be performed at least quarterly
- Follow-up interventions if necessary, delivered to beneficiary or prescriber.

Standardized format for summary of Comprehensive Medication Review

- Goes into effect January 1, 2013
- Requires a certain level of service within Comprehensive Medication Review
    - Discussion of beneficiary concerns with drug therapy
    - Provider must collect purpose for each medication and consider drug interactions
    - Engage beneficiaries in managing their own drug therapy
- Standardized format developed by CMS with beneficiary and provider input
    - Easy-to-understand content and wording

    - Larger font
- Composed of three elements
    - Cover letter
    - Medication action plan
        - Helps beneficiary to resolve current issues and meet goals of treatment
        - Specific action items discussed during Medication Review
            - For example, be sure to take medication at certain times
    - Personal Medication list
        - Helps beneficiary understand medications and they how relate to treatment plans
        - Improves communication about tracking meds with healthcare providers
        - Beneficiary can add new medications and start dates
        - They can also cross out other medications, and list stop dates and reasons for stopping.

Beneficiary awareness

- Many beneficiaries are unaware of their options with respect to MTM programs
- CMS has been working to increase awareness
- A page in the 2013 Medicare & You handbook is about MTM programs
- Part D plans must include more information on their websites about their MTM programs
- MTM programs will be included as a plan ratings measure in 2014
- Information about MTM programs is available on the www.medicare.gov planfinder
    - On the plan results page, MTM programs are listed
    - MTM information is listed on the "drug costs and coverage" tab for each plan
    - Beneficiary can also click on the MTM eligibility information link to find out more about the plan's eligibility criteria for its MTM program.
        - This will list the minimum requirements to qualify for MTM services
        - If the beneficiary appears to qualify, they should speak to the plan to find out more about their eligibility and the services that they would be offered.
- There have been numerous presentations to providers, Medicare beneficiaries and advocates about MTM programs.

- Heather Bates: There certainly seems to be a lot of potential in this program. We would be happy to help get the word about MTM. A question: on the outset of a person's involvement in the MTM program, will they get the full Personal Medication List for all of their drugs, and is this list segmented in any way?

- Gary Wirth: When a beneficiary has a Comprehensive Medication Review, the MTM provider will discuss the beneficiary's current medications with them. The provider will then provide the beneficiary with a list of these medications along with instructions about how to understand and use this list. The only time a list of medications is sent to the beneficiary is following this Comprehensive Medication Review.

- Michelle Ketchum: While there are specific criteria to qualify for a MTM program, once a person is enrolled all of their conditions and medications are considered as part of the program. All of their medications will be reviewed for all of their health conditions.

- Heather Bates: These programs could help beneficiaries better understand why they are taking specific medications. How could a Comprehensive Medication Review affect a person's likelihood of receiving denials for Part D drugs?

- Gary Wirth: There should be no relation between a person's involvement in MTM programs and their likelihood of pursuing an appeal. To be eligible for MTM, a person ordinarily needs to be taking a certain number of covered Part D drugs. However, during the Comprehensive Medication Review, all of a person's drugs, including non-covered and excluded drugs, will be reviewed so that the beneficiary fully understands how the drugs they are taking will work together.

- Dan Reedy: Would a Comprehensive Medication Review ever be used to urge plan members to change from non-formulary drugs (which may be covered as a result of a successful appeal) to drugs that are on the formulary? And could it be used to convince plan members to change to lower cost generic options?

- Michelle Ketchum: Providers may work with the beneficiaries to overcome barriers to access needed medications. For example, if a beneficiary is unable to access a drug because it is not being covered, the provider could make suggestions to the prescriber to switch to a lower cost or formulary alternative. However, the purpose of this review is to help the beneficiary meet their goals, regardless of whether or not their drugs are covered.

- Bethene Trexel: Would bad drug interactions be noted during a medication review?

- Gary Wirth: The Comprehensive Medication Review involves checking for concerns such as adverse drug interactions. Also, this is an opportunity for the beneficiary to share their concerns about their drug therapy.

- Michelle Ketchum: In addition to the Comprehensive Medication Review, plans must also perform Targeted Medication Reviews quarterly. During the Targeted Medication Reviews, plans may identify adverse drug interactions, and may reach out to the prescriber to recommend changes to the beneficiary's drug therapy.

- Heather Bates: Do plans share the results of the medication reviews with prescribers on a regular basis?

- Michelle Ketchum: Plans must perform the Targeted Medication Review quarterly, and if needed, they will follow up with the prescriber. The Comprehensive Medication Review summary is provided to the beneficiary, though beneficiaries are encouraged to share this review with their prescribers.

- Heather Bates: Beneficiaries could bring this review to the Annual Wellness Visit, which is an annual preventive visit that is covered by Medicare as a result of the Affordable Care Act.

The CMS website about Medication Therapy Management Programs is available here:
http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html

A Medicare Learning Network article about MTM programs is available here:
http://www.ngsmedicare.com/wps/wcm/connect/4b4d66004d198e15a2d9a7798be655ff/SE1229.pdf?MOD=AJPERES&CACHEID=4b4d66004d198e15a2d9a7798be655ff

If you have any questions about the Part D MTM program, please send them by email to the Part D MTM mailbox at PartD_MTM@cms.hhs.gov

CMS Initiatives Encouraging Beneficiaries to Join Higher Quality Plans

- CMS is working to increase awareness about the CMS 'star ratings' quality ratings system. This is a factor that beneficiaries may want to consider before joining a Medicare Advantage or Part D Plan.
- To encourage beneficiaries to join a higher quality plan, CMS sent a notice to those in consistently low performing plans informing them that their plan has been rated poorly and that they may want to consider their other plan options
    - This was notice was sent to 525,000 beneficiaries nationwide.
    - Consistently low performing plans are those plans that have received under three stars to at least three consecutive years
- Low performing plans are identified on the CMS planfinder by an icon.
- Beneficiaries who wish to enroll in a low performing plan must do so by contacting the plan directly
    - They cannot enroll through 1-800-Medicare or on the www.medicare.gov planfinder
- Anyone in a consistently low performing plan has been granted a one-time Special Enrollment Period to enroll in a higher-rated plan (or a new plan that has not yet been rated) during the benefit year.
    - This SEP cannot be used to pick a different one or two star plan
    - People should not use this SEP if they can avoid it. If a person can change plans during Fall Open Enrollment, they should enroll before the end of the enrollment period so that they will have the new coverage in place for January 1.
    - This SEP is only available by calling 1-800-Medicare or contacting the CMS regional office.
    - It is *not* available on the www.medicare.gov website and cannot be accessed by enrolling through a plan itself
- There is also an SEP allowing beneficiaries to enroll in plans that receive CMS's highest quality rating (5 stars) during the plan year.
    - This SEP *can* be accessed through the plans themselves, as well as through 1-800-Medicare

    - Maurice Jones: Are there any 5 star plans in New York?

    - Dan Reedy: There is one 5 star Part D Plan, which is the Blue Cross and Blue Shield PDP.

    - Maurice Jones: Can anyone in a plan that received fewer than three stars use the Special Enrollment Period to sign up for a higher quality plan?

    - Paul Collura: To qualify for the SEP, the plan must be a *consistently* low performing plan, which means that it must have received fewer than three stars for three consecutive years.

    - If a person is in a three star or lower plan, how will people know that their plan has been received a low quality rating?

    - Paul Collura: Anyone in a plan that has received a low star rating for three years in a row has received a letter from CMS notifying them about this low rating and encouraging them to choose a plan that received a higher rating.

    - What about people in the plans that have not received a rating yet? How will they know if their plan is going to receive a low quality rating?

- Paul Collura: There is simply not enough data to assess very new plans, which is why they cannot have a star rating yet. These plans will receive a rating once CMS has enough data to judge the quality of care provided by the plan. To qualify for the SEP to join a plan with a higher quality rating, a person must be in a plan that has received a low quality rating for three consecutive years, so this will not affect those who are enrolled in plans that are too new to have received a quality rating.

- Maurice Jones: Is there a list at www.medicare.gov that outlines the plans that are available in each area based on their star rating?

- Paul Collura: A list of low performing plans can be provided in the minutes. (See below)

- Does CMS do anything to incentivize low performing plans to improve the quality of care that they provide?

- Paul Collura: Absolutely. Every plan that was identified as a consistently low performing plan was required to submit corrective action plans for CMS approval. CMS has provided these plans with feedback about their performance to encourage them to do better in the future. CMS considers past performance to determine whether to approve plan expansions into new areas. In 2015, CMS will begin terminating plans for consistently poor quality performance.

- What does low performing mean, exactly?

- Paul Collura: Many factors are taken into account with the star ratings. These measures include measures related to the health outcomes for members as well as the beneficiary experience. In particular, specific measures that are taken into consideration include customer service, measures related to preventive care, management of chronic conditions, responsiveness to appeals and grievances, drug pricing, patient safety measures, complaint volume, and performance in audits.

- Brenda LaMere: The Medicare planfinder indicates the star ratings for each plan that shows up in a beneficiary's search results, and this is a helpful way to compare plan options. Plan results can also be sorted according to their star ratings.

- Allison Cook: Early in 2013, there will be a mailing to those who have enrolled in low performing plans to inform them about the low quality rating of this plan. Will this also be sent to people who were already enrolled in this plan prior to 2013?

- Paul Collura: This mailing will only be sent to those who have newly joined the low performing plans. Anyone who was already enrolled in these plans was already notified of the plans low rating by CMS in October.

A list of the low performing plans is available here:
www.medicarerights.org/pdf/Low-Performing-Plans-2013.pdf

A CMS notice for SHIP counselors explaining the SEP for those in low performing plans is available here:
www.medicarerights.org/pdf/Low-Performing-Plans-SHIP-notice.pdf

The Medicare Interactive page about the CMS Star-Ratings System is available here:
http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=1742

Plan Terminations in NYS

Senior Whole Health SNP and the Empire Blue Cross and Blue Shield PPO that were terminating in many New York counties were among the largest plan terminations in NY in 2013. These plans must have sent non-renewal notices to their members by October 1, and CMS has also sent notices to members of these plans notifying of the plan termination and urging them to choose a new plan for 2013.

- Doug Goggin-Callahan: There were some concerns from beneficiaries in Westchester about the termination of the Blue Cross and Blue Shield termination and the availability of other plan options in the area. Are there concerns that there may be certain areas of the state where beneficiaries might have trouble finding an alternative health plan?

- Paul Collura: I believe that there were other PPO plan options in the areas affected by this plan termination. Overall, plan offerings remain robust in NY State.

- Dan Reedy: In some counties, the only other PPO option is the UnitedHealthCare PPO. In a few of these counties, there were concerns that this plan did not have the major hospital in the county in its network.

- Paul Collura: Any plan that has its contract approved by CMS must meet requirements that it has an adequate provider network in the areas in which it operates. Plans contract with different provider organizations, and these contracts can change during the year.

CMS's 2013 Plan Landscape Documents are available at the links below:

Medicare Advantage Plans: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2013-MA-Landscape-Source-Files-v101212-.zip

Special Needs Plans: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2013-SNP-Landscape-Source-Files-v101212.zip

PDPs: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2013-PDP-Landscape-Source-Files-v102212-.zip

Planfinder Problems

The Medicare Rights Center will be sharing feedback about the www.medicare.gov planfinder tool with CMS periodically throughout this enrollment period.

Any Coalition Partners can feel free to share problems that they encounter with the planfinder, or ideas for improving this tool, with Dan Reedy (Medicare Rights Center) at: dreedy@medicarerights.org

CMS Action Following Hurricane Sandy

CMS has provided an Exceptional Circumstance SEP to those who were unable to choose a plan during the Fall Open Enrollment Period as a result of Hurricane Sandy. This is not intended to be an extension of the Fall Open

Enrollment Period. Anyone who is able to enroll during the Fall Open Enrollment is encouraged to do so, as this will ensure that they have coverage in place on January 1, 2013. If an individual's circumstances prevent an enrollment from occurring prior to the end of the Fall Open Enrollment, this SEP is available.

If necessary, beneficiaries can access this SEP by contacting 1-800-Medicare. Plans cannot enroll beneficiaries through this SEP. If anyone experiences difficulty accessing this SEP, they should notify the CMS Regional Office to resolve the problem.

The Medicare Rights Center released a press release about the Exception Circumstance SEP for individuals affected by the hurricane, which is available at the link below:
http://www.medicarerights.org/newsroom/pressreleases/2012_29.html

CMS has also worked with plans located in the New York area to help them address any hurricane-related issues that they encounter. Some plans have been operationally damaged during the storm. CMS issued a memo to Medicare Advantage and Part D plans informing them about their responsibilities to allow greater leniency with respect to prior authorization and network requirements for members located in disaster areas. If beneficiaries are unable to get in touch with plans, or if their plan is not complying with the requirements for beneficiaries in a disaster area, then they should notify CMS about these problems.

Medicare Rights Center

Every year, this coalition advocates for Congress to extend several benefits that are very important for Medicare beneficiaries, particularly those with limited incomes. We will send a letter to Congress urging the inclusion of the following in the Health Extenders Bill:

- Extension of the QI Medicare Savings Program.
    - QI is the highest income Medicare Savings Program, with income limits set at 135% of the Federal Poverty Level.
    - The program is a block grant, and must be reauthorized every year.

- Extension of an exceptions process for Medicare's therapy caps
    - There is an $1880 annual limit for Medicare coverage of Physical and Speech Therapy, and a separate $1880 limit for Medicare coverage of Occupational Therapy.
    - Beneficiaries who qualify for an exception may continue to receive coverage of therapy beyond these limits.
    - Exceptions to these caps must be extended every year.

- Funding for Outreach, Education, and Enrollment in Low Income Programs
    - This funding began through the Medicare Improvement for Patients and Providers Act of 2008.
    - Funding ended in September
    - The Medicare Rights Center would like this funding to be extended for at least another year.

A draft of the letter urging Congress to extend the QI program, extend Medicare's therapy cap exceptions, and continue funding for outreach, education, and enrollment in low income programs is available here:

www.medicarerights.org/pdf/medicare-savings-coalition-extenders-letter-2012.pdf

Please review this letter carefully. All organizations that participate in this call (with the exception of government agencies) will be signed on to this letter. If your organization does not wish to be signed on to

this letter, please inform us by emailing Dan at dreedy@medicarerights.org.

The Medicare Rights Center has released several fact sheets about proposals intended to contain Medicare costs. These fact sheets investigate whether the proposals currently under consideration will reduce healthcare expenses, or if they will shift costs from the government to consumers. Most Medicare beneficiaries live on limited fixed incomes, and simply cannot afford to pay more for their healthcare. The Medicare Rights Center will discuss these proposals and their implications for Medicare beneficiaries during December's call.

The Medicare Rights Center's fact sheets are available here:
http://www.medicarerights.org/pdf/Medicare-Strong-Built-to-Last-2012.pdf
http://www.medicarerights.org/newsroom/pressreleases/2012_30.html

The Medicare Rights Center submitted a letter to Congressional leaders urging Congress to move away from the Sustainable Growth Rate payment formula, which every year relies on Congressional action to avoid drastic payment cuts to Medicare providers.

This letter can be viewed here:
www.medicarerights.org/pdf/Letter-to-Congress-11-2012.pdf

****The preceding minutes are Medicare Rights Center's account of the New York State Medicare Savings Coalition meeting held November 14th, 2012****