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## AoA Regional Meetings

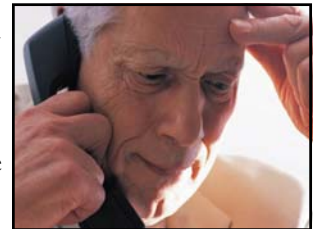
The 2005 Senior Medicare Patrol (SMP) Regional Conferences are fast approaching. For more information, or to register online please visit the conference website at [www.wciconferences.com/aoa\\_2005/index.htm](http://www.wciconferences.com/aoa_2005/index.htm)

## MEDICARE PRESCRIPTION DRUG PROGRAM MARKETING

A number of Senior Medicare Patrol programs have reported that telemarketers purporting to be related to the Medicare prescription drug program have called consumers to encourage enrollment in other non-Medicare drug discount programs, or to obtain the beneficiary's Medicare information. While we know that the Centers for Medicare & Medicaid Services (CMS) have not yet approved any drug plans, and any approved plans cannot begin marketing to consumers until October 1, 2005 these facts do not stop unscrupulous telemarketers from trying to obtain Medicare numbers or other personal information from beneficiaries or as a marketing technique to persuade anxious beneficiaries to join an unapproved prescription drug plan.

**Misuse of the Medicare name or emblem.** Such telemarketing may violate a federal law, 42 U.S.C. 1320b-10, which prohibits the unauthorized use of the Medicare name and emblem. Indeed, telemarketers calling beneficiaries alluding that their drug card is related to the Medicare-approved drug discount card or the soon-to-be-introduced Medicare prescription drug program may itself be interpreted as a misuse of the Medicare name, if indeed, their product has nothing to do with either the Medicare-approved discount drug card or the new prescription drug program. In addition, telemarketers that prey on consumers' anxiety about the new Medicare prescription drug program by encouraging them to sign up for their plan may also be violating this law. This federal law authorizes significant monetary penalties for these violations.

Obviously, any drug plan marketing itself as a "Medicare-approved" drug plan now is likely fraudulent and a violation of 42 U.S.C. 1320b-10. These scams should be reported immediately to CMS (see below).



Unscrupulous telemarketers are working to obtain Medicare numbers or other personal information from beneficiaries

Although Medicare approved drug discount cards are still available, CMS staff report that they do not believe that any card sponsors are actively recruiting new members at this time.

**CMS Medicare Prescription Drug Program Marketing Guidelines.** Drug plans that have applied to be a Medicare approved plan in 2006 are eager to talk to individuals with Medicare about their plan. To ensure that drug plan sponsors market these plans in a responsible fashion, CMS has prepared Marketing Guidelines for the Medicare Prescription Drug Plans and Medicare Advantage programs. Highlights of these guidelines include:

- No Medicare prescription drug program may begin marketing to individuals with Medicare until October 1, 2005.
- Existing Medicare Advantage plans, Medigap plans and prescription discount drug card sponsors may use member enrollment data to

(continued on page 2)

market their new drug program.

- Plans cannot distribute any marketing material until after the plans have contracted with CMS, expected to be on September 15, 2005.
- Plans cannot say that they are “Medicare-endorsed,” that they are calling “from Medicare,” or that they are calling “on behalf of Medicare.” They may say that they are “Medicare-approved,” that they are “contracted with Medicare to provide prescription drug benefits” or that they are a “Medicare-approved Medicare Advantage Plan or Prescription Drug Program”.
- Plans may “cold call” individuals with Medicare, but only existing Medicare Advantage plans that offer an approved prescription drug program may enroll individuals over the phone. All other plans must enroll individuals by setting up an in-person meeting, or by mailing enrollment information.
- Telemarketers must comply with the Do-Not-Call Registry, and must comply with the federal and state laws regarding calling hours. Telemarketers must abide by consumers’ requests not to call again.
- Telemarketers cannot request beneficiary identification numbers—Social Security or Medicare numbers.
- Plan sponsors must include a pre-enrollment formulary drug list (which includes at least a subset of the complete formulary) with application materials.

What should you do if you receive phone calls about these possible scams? First, advise the consumer to get as much information as possible—a name, a callback number and any other information about the telemarketer. CMS requests you report any consumer complaints about the misuse of the Medicare name or fraud or abuse in the Medicare prescription drug program via email to Jolie Crowder at [info@smpresource.org](mailto:info@smpresource.org), who will forward your complaints to the CMS program integrity office and AoA (see related story below)

## AOA MEETS CMS PROGRAM INTEGRITY OFFICIALS

AoA and Center staff recently participated in a meeting with several staff from a relatively new Program Integrity Division at CMS serves as primary agency focal point for fraud, waste and abuse oversight of the Medicare Prescription Drug, Improvement, and Modernization Act of

2003 (MMA) provisions related to the drug card, drug benefit, and the Medicare Advantage program.. The meeting was facilitated by Bill Gould, Senior Technical Advisor, Division of MMA Integrity and Brigid Davison, Acting Director, Division of MMA Integrity, and included several analysts as well as the division’s law enforcement liaison. Topics discussed during the meeting included development and dissemination of consumer outreach materials, an upcoming press release announcing CMS’ program integrity “messages” for the prescription drug benefit, reporting procedures for complaints involving the new prescription drug plans, as well as potential training and education outreach opportunities with the SMP community for CMS staff.

Another topic of discussion included the new Marketing Guidelines issued this month for the prescription drug plans, including the Medicare Advantage prescription drug plans. According to CMS, prescription drug plan applicants are not restricted from contacting consumers now for the purposes of “educating” them about the new benefit. However, as no plans have been formally approved, no entity should be formally marketing their plan as “Medicare approved” until October, and plans will never be able to enroll individuals over the phone. Also, plans can not refer to themselves as “Medicare endorsed” or “recommended by Medicare.” For more details, refer to the Marketing Guidelines for the plans, available on the CMS web site . A second release of the Marketing Guidelines is expected out later this summer.

CMS has requested that until the new MEDICs (see related article) are selected later this summer, any complaints received by SMPs related to the prescription drug benefit be forwarded to their division. The Center will assist with facilitating this process, by serving as the intermediary between the SMP projects and CMS. Should you receive a consumer complaint, please document as much detailed information as possible, including:

- City and state of complainant
- Complainants name and contact information
- Name of company
- City and state of company
- Description of complaint

The standard SMP complaint tracking forms provide the appropriate format for submitting information. Please submit your complaint form via email to [jcrowder@smpresource.org](mailto:jcrowder@smpresource.org). For questions, call: 202.261.7561.

## Provider Education

The Center is currently working on developing Provider Education that will help SMPs build effective partnerships with providers, educate providers on the SMP message, and inform providers and their staff on ways to prevent fraud, waste, and abuse.



There are several fraud, errors, and abuse related resources available to SMPs via the Internet. CMS offers a web-based training course: Medicare Fraud and Abuse. In this course, you will learn what safeguards to use to protect yourself against fraud, waste, and abuse and what liability and penalties you could face if you commit fraud and abuse. To complete this training, visit [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=1](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1).

CIGNA's Benefit Integrity (Anti-Fraud) Unit has an article with basic information that is useful to educate providers on how they can protect themselves from fraud. (The full text of this article contains basic information about what fraud is and how providers can be protected from becoming victims of fraud.)

Excerpts from "Protecting Your Practice" - CIGNA's Benefit Integrity (Anti-Fraud) Unit:

**"If a procedure is not documented, it is as if it never happened."**

Documentation is one of the most critical aspects of your practice. Your documentation is the only proof of the services you provide. If a procedure is not documented, it is as if it has never happened. One day you may be called upon to prove the services that you have rendered. Without proper documentation, you have no recourse. Document the services that you perform legibly and completely. The extra time that it takes may seem crippling. However, the value of this time is marginal compared to the consequences that could be incurred.

**"Your pin is similar to a credit card number...protect it."**

In order to bill Medicare directly, you must first obtain a provider identification number (PIN). Your PIN is the number that you use to bill Medicare for services that you perform, or services rendered by your employees "incident to" your services. Your PIN is similar to a credit card number in that it could be used by someone else to bill Medicare inappropriately. Protect it.

## Kaiser Family Foundation National Survey: Public's Views about Medicaid

Perhaps surprising, given years of debate about Medicaid, frequent references to the program as the "Pac Man" of state budgets, and periodic calls for reform, public attitudes toward Medicaid are remarkably positive, and opposition to cuts is reasonably strong, according to a new public opinion survey released today by the Kaiser Family Foundation <http://www.kff.org/medicaid/pomr062905pkg.cfm>.

While two-thirds of the public think their state has major budget problems, a substantial majority are reluctant to cut Medicaid to balance state budgets. A majority think the federal government should maintain or increase federal spending on Medicaid; only 12 percent of the public prefer seeing federal funding of Medicaid cut.

### Attitudes Towards Medicaid

Nearly three-quarters of adults say Medicaid is a "very important" government program, ranking it close to Social Security and Medicare in the public's mind, equal to federal aid to public schools, and above defense and military spending. About 8 in 10 Democrats and Independents view Medicaid as an important government program; while fewer, still 6 in 10 Republicans express that view.

A majority of Americans report having some interaction with Medicaid, either having been enrolled themselves at some point or knowing a friend or family member who has received health coverage or long-term care assistance through that program. Additionally, if they needed health care and were eligible, nearly 8 in 10 Americans say they would be willing to enroll in Medicaid. This view is consistent across different party identifications.

"We expected Medicaid to be relatively unpopular with the public, much like welfare was. But we found that Medicaid ranks closer to popular programs like Medicare and Social Security in the public's mind. The fact that so many Americans have had some kind of contact with Medicaid themselves or through family and friends is one factor that could help explain this result," said Mollyann Brodie, Ph.D., Vice President and Director of Public Opinion and Media Research for the Foundation.

(Continued on page 4)

## Kaiser National Survey *(continued)*

### Budgets and Medicaid

"This poll shows that Americans across the political spectrum value the role Medicaid plays in our health care system," said Diane Rowland, Executive Vice President of the Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. "As with the rest of the health-care system, much of the political debate surrounding Medicaid these days focuses on controlling costs, but proposals to cut funding for the program or scale back the coverage it offers do not appear to be popular with the public."

While the public seems reluctant to see state Medicaid funding cut, they are divided on the best way to grapple with their state's budget problems. Nearly a quarter say their state should cut funding for programs other than Medicaid (like education, prison systems, and transportation); 21 percent say that their state should raise taxes and the same number say that the state should cut Medicaid funding to address the budget problems. Twenty-three percent of the public volunteered that the budget problems should be addressed in some other way.

Half of the public feels the federal government should put more money into the Medicaid program to help states with budget problems, but 43 percent think the federal government cannot afford to do this right now given its own budget problems.

### Perceptions About A Medicaid "Crisis"

About 6 in 10 believe that the Medicaid program is either in financial crisis or has major problems but is not in a financial crisis, while three in ten say it has minor problems or no problems. The public believes rising prescription drug costs, growing long-term care and nursing home expenses, and higher payments to doctors and hospitals are major reasons why Medicaid spending has recently increased. Many also believe that fraud and abuse in the program, greater enrollment and poor management are major reasons for Medicaid spending growth.

Despite concerns about Medicaid's financial problems, none of the proposals to address the program's problems that the public was asked about garnered support from a majority of the public. For example, about 4 in 10 say they favor reducing the number of people who qualify for the program, lowering payments by Medicaid for prescription drugs, lowering payments to doctors and hospitals, increasing co-payments and deductibles that enrollees pay, or eliminating the ability of middle-class seniors to transfer their assets to children in order to qualify for Medicaid.

One Medicaid restructuring proposal being discussed by policymakers is increased state flexibility in determining which benefits are offered in a particular state. Nearly 6 in 10 people believe that all states should be required to offer the same set of core health-care benefits to receive federal funding, while nearly 4 in 10 say states should be able to decide their own benefits. More than 8 in 10 people think that the following benefits (some of which are optional under current law) are essential to Medicaid coverage: hospital stays, prescription drugs, medical equipment like wheelchairs and artificial limbs, mental health services, emergency room visits, nursing home care, physical therapy, and doctor visits. Less than half of the American public views coverage for chiropractor visits and travel to and from doctor visits as essential.

### Public Knowledge About Medicaid

While most Americans point to the importance of Medicaid, and many have a basic understanding of this complex program, about half are less familiar with the program's specific details. More than half do not know that Medicaid is the insurance program for many low-income families regardless of their age, and more than 6 in 10 do not understand its role for people with low incomes who need nursing home care or home health care. Nearly half the public does not know that Medicaid is funded by both the federal and state government, and more than half don't realize that it covers more people than Medicare. While low-income children and their parents account for three-quarters of Medicaid's total enrollees, 54 percent of the public does not know that low-income families make up most of Medicaid's enrollees. Further, although 70 percent of program spending is for the elderly and individuals with disabilities, 46 percent do not recognize that most of program spending is for those groups.

A chartpack, topline, and related material are available at [www.kff.org/medicaid/pomr062905pkg.cfm](http://www.kff.org/medicaid/pomr062905pkg.cfm).

## AOA UPDATE

For years, partnerships have been developed on the local level to provide information and assistance to people with Medicare. Senior Medicare Patrol programs have been diligent in their efforts to collaborate with their state's Attorneys General Office, Area Agencies on Aging, and other local aging partners. With the current expansion of the Medicare program, developing partnerships is more important than ever.



The Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) announced on a national conference call to Aging and SHIP community providers an enhanced partnership to learn more about the new benefits provided under the Medicare Modernization and Improvement Act of 2003. CMS Administrator, Dr. Mark McClellan, joined AoA's Assistant Secretary for Aging, Josefina Carbonell, and other partners from the various aging agencies, to outline a strategy for developing both national and regional partnerships to reach out to people with Medicare and make sure they understand the choices and options that are available to them.

These partnerships are being developed at a critical time. These coming months will be the most important in the history of Medicare, as Medicare turns from a program that helps pay the bills when beneficiaries get sick and have complications from their chronic illnesses, into a program that now covers and helps beneficiaries take advantage of the best prevention-oriented treatments that modern medicine has to offer. That includes screening tests, and programs to help people with chronic diseases get better continuity of care and, of course, prescription drugs. These are the most important months in the history of Medicare, in terms of giving seniors real help with the costs of prescription drugs.

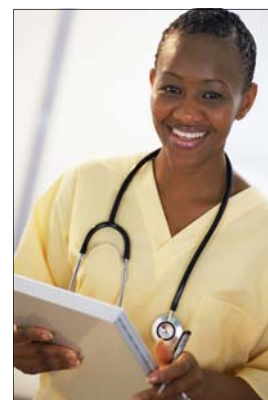
Through the AoA and CMS partnership, the Aging Services Network will play an integral role with us in reaching many people with Medicare to help them lower their medical costs, improve their financial security, and especially, stay healthier as a result of the new Medicare coverage.

For more information, visit the AoA website at [www.aoa.gov/medicare/news/default.asp#2](http://www.aoa.gov/medicare/news/default.asp#2). Or, to receive ongoing communications, including: new CMS information, training opportunities and links to online resources and tools, register at [www.aoa.gov/Medicare](http://www.aoa.gov/Medicare).

## NEW- TOOLKIT FOR HEALTHCARE PROFESSIONALS: MEDICARE PRESCRIPTION DRUG COVERAGE

CMS has released the Toolkit for Healthcare Professionals: Medicare Prescription Drug Coverage. To access the toolkit and other educational resources, visit the drug coverage information webpage (Medlearn) for physicians and other healthcare professionals, [www.cms.hhs.gov/medlearn/drugcoverage.asp](http://www.cms.hhs.gov/medlearn/drugcoverage.asp)

[The Toolkit for Healthcare Professionals: Medicare Prescription Drug Coverage](#) (adobe pdf 860Kb) includes downloadable educational materials specifically for physicians and other healthcare professionals and their staff to learn the basics about Medicare Prescription Drug Coverage. It also includes materials to distribute to their Medicare patients. The kit contains reproducible artwork, a letter from the CMS Administrator, a fact sheet (english and spanish), a brochure, an article, and a list of other resources.



Physicians and other healthcare professionals and their staff, partner organizations, social workers, financial counselors, and discharge planners will find this toolkit a valuable resource to get information to people with Medicare. You may add your logo and business information to these materials and copy freely, if you wish.

## TIPS FOR SUCCESSFUL MEDIA OUTREACH: THE INTERVIEW

*This is the third in a series of articles providing you with useful information to help you increase your program's visibility through successful media outreach efforts.*

Depending upon who you ask, press releases can be the best or worst tool in your media outreach toolbox. But press releases and media advisories are just one tool to consider when you begin to think about seeking publicity.

According to Bill Stoller, founder and publisher of *Free Publicity, The Newsletter For PR Hungry Businesses*, “publicity ‘gurus’ are springing up all over the Internet touting the press release as the answer to all marketing ills. Just knock out a release, mass e-mail it to journalists, sit back and wait for Oprah to call. If you don’t have a story to tell, your press release is utterly worthless.”

Stoller offers four “must-haves” when generating publicity-- absolute accompaniments to any really good (or bad) press release:

**1. A newsworthy story.** It's the very basis for your publicity efforts. Without it, your press release means nothing. Ask yourself- Who Cares? If it isn't important or new it's not newsworthy.

**2. Learning to think like an editor.** Oh, what an edge you'll have in scoring publicity over all those press release worshippers once you learn how to get inside the head of an editor. Give an editor what he wants in the way he wants it and you'll do great.

**3. Relevance.** Tie in with a news event, make yourself part of a trend, piggyback on a larger competitor's story, but, by all means, make your story part of a picture that's bigger than just your organization. Stories that exist in a vacuum quickly run out of oxygen.

**4. Persistence.** Sending out a press release and waiting for results is lazy and ineffective. If you really believe in your story, and you believe that it's right for a particular media outlet, you need to fight to make it happen. Call or e-mail the editor to pitch your story BEFORE sending the release. If one editor says no, try somebody else. If they all say no, come back at them with a different story angle.



“...press releases can be the best, or worst tool, in your media outreach toolbox.”

### DEVELOPING PRESS RELEASES

It's best to use a traditional press release format. It is important to use the news release to *concisely* answer the questions: Who? What? Where? When? Why? How?

Newswriting style is brief, simple, and to the point. Whenever appropriate, incorporate news from current publications and news releases of the US Administration on Aging, Centers for Medicare & Medicaid Services (CMS), or other related entities. Make sure you “cut the fat” out of your release, read, re-read, and have someone disinterested, read again. Every line should have meaning.

Email or fax your news release a couple of days before the event, with follow-up calls the day before. Be sure to discuss the advance lead time required with your newspaper page editor; smaller newspapers may require a longer lead time. Include a hard copy of the release in your press kit on the day of the event.

- Each paragraph should not exceed four to five lines.
- Double-space the text.
- The whole release should not exceed a page and a half.
- Do not split paragraphs between pages.

Every release should carry your name as the contact for further information, your telephone number, e-mail address, the date and, of course, the name of your organization. Provide reporters with 24-hour contact information. Your organization's media contact should be someone who will “bend over backwards to get the information reporters want.”

To draw attention before it happens, consider issuing a media advisory between 7 and 10 days in advance. The structure is the same as a press release and is sent to local news media. Emphasize date, time and locations of the event, and how to obtain more information.

**SUCCESSFUL MEDIA OUTREACH** (continued)**PRESS RELEASE TEMPLATE**

FOR IMMEDIATE RELEASE

(Date)

CONTACT

(Name), (Phone Number)

(HEADLINE: KEEP IT SHORT &amp; USE ALL CAPITAL LETTERS)

**1st paragraph:** Briefly explain what is happening, who is involved, and when and where it is taking place.**2nd paragraph:** Why is this event significant and newsworthy?**3rd paragraph:** Quote from an expert involved that emphasizes how significant the event is.**4th paragraph:** More details on where and when the event is happening, if necessary.**5th paragraph +:** Other pertinent details including, speakers' names and affiliations, as well as descriptions of any visual details of the event that will provide photo opportunities for reporters.

MORE (if release goes to a second page)

### (to indicate the end)

**TIL NEXT TIME!**

In our next segment, we'll be discussing Letters to the Editor and Op-Ed pieces. We'd love to hear your feedback—good, bad or ugly! Feel free to contact Jolie Crowder at [jcrowder@smpresource.org](mailto:jcrowder@smpresource.org).

**For more information**

- Stoller, B. Smashing the Myth of the Press Release. <http://aboutpublicrelations.net/ucstollera.htm>
- Taichert, PN. Practical Pointers for Powerful Press Releases. <http://aboutpublicrelations.net/uctaichertta.htm>
- Wallack, Larry and Lori Dorfman, Katie Woodruff, and Iris Diaz. *News for Change: An Advocate's Guide to Working with the Media*. (Thousand Oaks: Sage Publications, 1999.)

**What's New Online?**

*We've recently added a page to the Center's website that identifies new pages and materials that have been added to the website. You can access this section from the home page of the website, simply visit [www.smpresource.org](http://www.smpresource.org). An excerpt of new items:*

Wisconsin SMP Volunteer Training Handbook

Missouri SORT Volunteer Training Handbook

Variety of CMS Prescription Drug Benefit Resource Materials—English &amp; Spanish

HHS Office of Inspector General SMP Performance Report

Updated SMP Fact Sheet

Be sure to visit the website to upload and share your new or favorite project resource materials. For questions or assistance, contact Candice Griffin at [cgriffin@smpresource.org](mailto:cgriffin@smpresource.org).

## CMS TO SELECT NEW DRUG BENEFIT INTEGRITY CONTRACTORS

In order to ensure the protection of the Medicare Trust Fund, CMS will contract with other entities to support its anti-fraud and abuse efforts associated with the Prescription Drug Benefit. In April, CMS issued a Pre-Solicitation Notice regarding its intent to award multiple contracts for this effort. The new “Drug Benefit Program Integrity Contractors” or MEDICS will be selected later this summer, beginning with an “Enrollment and Eligibility Medicare Drug Integrity Contractor.”

Some of the functions that the MEDICS contractors will be expected to perform in order to detect fraud and abuse in the prescription drug program include the following:

- Review bids for participation in the drug program;
- Review fraud and abuse programs of organizations involved in the program;
- Assist CMS to develop a list of organizations that may need future monitoring based on past history;
- Proactively evaluate potentially inappropriate activity by Part D providers;
- Annually audit at least 1/3 of the Part D sponsors, including Medicare Advantage Plans and conduct audits of retiree drug sponsors;
- Conduct complaint investigations as well as preliminary investigations of fraudulent enrollment, eligibility determination and benefit issuance;

Refer appropriate cases to law enforcement and support investigations by law enforcement agencies.

The Enrollment and Eligibility Medicare Drug Integrity Contractor will be expected to monitor any fraud and/or abuse in enrollment, eligibility and marketing of legitimate and false Part D plans; make referrals to law enforcement, as appropriate; and, perform beneficiary protection audits.

## THE OPEN ROAD TO AGING

"The Open Road: America Looks at Aging," is a film that will air on public television stations across the nation next month. It will look at the personal and social impact of the baby boomers' retirement .

Through stories of seniors either in retirement or about to retire, the film probes the important social, economic, and cultural issues at stake, as well as the obstacles and opportunities the "third stage" of life presents. "The Open Road" is a film that will make people think, talk, and plan for the road that lies ahead.

Funded by The Atlantic Philanthropies and NCOA, "The Open Road: America Looks at Aging" was produced by Emmy Award-winning producer Nina Gilden Seavey of The Documentary Center at The George Washington University. Oregon Public Broadcasting is the presenting station for the film.

Check your local listings for airtime, or visit [www.theopenroadfilm.com](http://www.theopenroadfilm.com) and click “community outreach” for more information, as well as how to access the viewer’s guide and sign up for an e-newsletter. For a preview, visit [www.theopenroadfilm.com](http://www.theopenroadfilm.com).

## NEW MENTOR PROGRAM PARTICIPANTS

Derrick Ariyoshi, Program Director of the Hawaii SMP project is the newest addition to the Mentor Program. Derrick is joined by his volunteer mentors, Scott Adkins (WV), Cindy Brown (OK), Scott Cooley (IA), Ada Leach (AZ), Lisa Purcell (RI), Julie Schoen (CA), and Mary Soutwick (TX). Shirley Merner, Center Co-Director, serves as coordinator and mentor as well.

This mentor group was formed to help the Hawaii project gain a network of support and develop program strategies, skills, and successful practices through monthly conference calls with volunteer mentor participants.

If you are a new grantee or director and are interested in being mentored, or if you are a director who would like to serve as a mentor, check out the information below:

### ~MENTOR PROGRAM~

Reasons to participate as a mentee:

- New Grant
- New Director
- Networking
- New Directions
- Special Populations Focus
- Wanting more regular and focused assistance

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**Contact Shirley Merner, Co-Director**

**877.808.2468**

**[smerner@smpresource.org](mailto:smerner@smpresource.org)**

### ~MENTOR PROGRAM~

Reasons to participate as a mentor:

- Expertise in a special population
  - Networking
- Sharing Best Practices with the SMP community
  - Seasoned Director or Project

**Contact Shirley Merner, Co-Director**

**877.808.2468**

**[smerner@smpresource.org](mailto:smerner@smpresource.org)**

## FIRING HIGH MAINTENANCE VOLUNTEERS: HOW TO FIRE

**By Thomas W. McKee**

***Reprinted with permission***

In every workshop on volunteer management I am asked the question, "How do you fire a volunteer?" Volunteers don't get paid. Why would I want to fire them? Couldn't we just let them continue doing what they want to do when they want to?

Unfortunately, it isn't that simple. Volunteer roles are very important to the mission of the organization, and if the job isn't getting done or if the volunteer is lowering the morale of the other volunteers, we have a responsibility to correct the situation. It could be that the reason we want to get rid of a high maintenance volunteer is because they are not fulfilling their responsibilities, or it could be that they are just impossible to work with. However, before we make that decision, we need to make sure that we have taken every performance-coaching step to correct the situation. Performance coaching, the one-on-one meetings that happen between the manager and the volunteer, may provide an opportunity to resolve our concerns. Some organizations, like the California State Railroad Museum, have formal performance reviews for all volunteers and regular performance management meetings.

If the volunteer manager has developed very specific job descriptions and expectations, the manager can talk to the volunteer when those expectations are not being met. All of these alternatives are both easier to implement and managerially smarter than making a decision to terminate a volunteer. They recognize that there are many reasons why a person may be behaving inappropriately, and that some of these reasons have answers other than separating that person from the program. We strongly urge that you to consider each of these alternatives before deciding to fire any volunteer. The goals of performance-coaching are to get the project back on target. If the volunteer does not do the job, it is time to find a replacement.

Before you have the firing meeting, be sure to check out the legal ramifications of such a decision.

### **Legal Issues**

It is not outside the realm of possibility that a terminated volunteer could sue you and your organization. Even if no one sues, carefully following a clearly defined process will assure everyone in the organization that people were treated fairly. Emotional and unexpected dismissals could cause upheaval in your organization. Legal issues are never simple, and every nonprofit agency is unique. Always check with your organization's lawyer before making any legal decisions. Many liability concerns can be avoided by carefully screening volunteers before they get involved.

In addition to job descriptions you would be well advised to develop a volunteer manual that clearly outlines the duties and responsibilities of your volunteers. This is especially important if you do face the need to terminate someone. The more documentation you have, with conditions and policies for termination, the safer you will be. To be doubly safe, be sure to distribute the policies to new volunteers. Some organizations even have the volunteers sign a letter of agreement outlining the expectations on the part of the organization and the volunteer. Board members are handled a different way since their service (and termination of such) is covered by the bylaws of the organization. Terminating a board member is a matter for the board as a whole to act according to the bylaws.

***...Interested in reading more? Download the full article from the Center's online Resource Library at [www.smpresource.org](http://www.smpresource.org).***

- Legal Justification
- Developing a System for Making Firing Decisions
- Part I: Communication of Clear Expectations
- Part II: Investigation
- Part III: The Firing Meeting

## UNDERSTANDING THE DRUG BENEFIT TROOP COMPONENT

The following FAQ's from the CMS website may assist you in better understanding the True Out Of Pocket costs (TrOOP) associated with the Medicare Prescription Drug Coverage which begins January 1, 2006. It is important to note that almost 11 million low-income people with Medicare are expected to apply for the "extra help" (low-income subsidy) program which features comprehensive coverage with no gap. This "extra help" counts as True Out Of Pocket costs, so the information below may not apply to them.

- Q.** What is "TrOOP" and what is the difference between an out-of-pocket cost and a "true out-of-pocket cost"?
- A.** TrOOP stands for "true out-of-pocket" costs. The MMA and CMS regulations create a distinction between all beneficiary out-of-pocket expenditures and those that will be counted toward the annual Part D out-of-pocket threshold—the latter are known as "true" out-of-pocket (TrOOP) expenditures. These are costs actually paid by the beneficiary, another person on behalf of the beneficiary, or a qualified State Pharmaceutical Assistance Program (SPAP) and not reimbursed by a third-party (such as a supplemental insurance plan sponsored by a former employer) that will count toward the TrOOP threshold that determines the start of the catastrophic coverage. Most third-party assistance, such as that from employers and unions, does not count toward the TrOOP threshold.
- Q.** What counts toward my out-of-pocket limit? Does help from churches or charities count?
- A.** Out-of-pocket spending consists of costs related to the \$250 deductible, the 25 percent beneficiary co-insurance (or equivalent co-pays) up to the initial coverage limit, 100 percent co-insurance during the coverage gap, and the roughly 5 percent co-insurance paid in the catastrophic coverage. By law, only cost-sharing paid by certain sources counts toward the drug benefit's out-of-pocket limit, which defines the start of the catastrophic coverage. These sources include:
- The enrollee (or another person on behalf of the enrollee)
  - CMS (on behalf of a low-income enrollee who qualifies for low-income subsidies or "extra help"), and
  - A State Pharmaceutical Assistance Program (SPAP)

In the final rule, CMS defines "person" (first bullet, above) in the legal sense of the word, to include unrelated corporations, so charities that are not connected to insurers or the beneficiary's employer could have a role in helping beneficiaries with their out-of-pocket costs. Therefore, CMS' broad definition of the term "person" captures not only "bona fide" charities, but other charitable organizations as well. Thus, even if a charity is not a bona fide charity for purposes of Federal fraud and abuse law, any drug payments it makes on behalf of Part D enrollees would count toward True out-of-pocket costs (TrOOP) unless otherwise excluded as payments by a group health plan, insurance or otherwise, or similar third party payment arrangement. Charities that are established, maintained, or otherwise controlled by an employer or union will likely fall under the CMS definition of "group health plan" and will therefore be excluded from TrOOP on this basis.

The rule also outlines specific insurance and government programs that will not count toward the out-of-pocket limit. These include cost-sharing obligations subsidized in whole or in part by employers, other insurers, and government programs (for example, the Indian Health Service (IHS), Department of Veterans Affairs (VA), Department of Labor

(continued on page 12)

### "Survey Says"

According to Kaiser Family Foundation, older adults are mixed about the new Medicare drug benefit. Few older adults say they are planning to enroll in a new drug plan: less than 1 in 10 (9 percent) say they will enroll, while nearly 4 in 10 (37 percent) say they will not. Many are withholding judgment until they get more information.

For help in making this decision, most older adults say they would turn to their doctor (49 percent) or their pharmacist (33 percent) before going directly to a Medicare information source (23 percent).

**UNDERSTANDING THE DRUG BENEFIT TROOP COMPONENT** (continued)

Federal Workers' Compensation Program, Federally Qualified Health Centers (FQHCs); Medicaid; the State Children's Health Insurance Program (SCHIP); black lung benefits; Ryan White CARE Act funds; and State special funds that assist certain individuals with their medical costs). Congress chose to distinguish between payers of out-of-pocket costs in order to encourage current employers, other insurers, and government programs to continue offering prescription drug coverage when the Medicare drug benefit begins.

**Q.** Do all beneficiaries have to reach a TrOOP amount before their catastrophic coverage begins?

**A.** No, over 11 million low-income beneficiaries will have comprehensive coverage.

**Q.** Do beneficiaries have to track TrOOP? How will I know how close I am to the out-of-pocket limit?

**A.** No. Ultimately, tracking and calculating TrOOP is the responsibility of the Part D plan. From the beneficiary's perspective, most of this TrOOP tracking will occur automatically. However, beneficiaries have an obligation to inform their Part D plan of any supplemental coverage for prescription drug benefits they have, and of any reimbursement of out-of-pocket costs they receive (as, for instance, from a Health Reimbursement Account), so that TrOOP can be correctly calculated.

The new Medicare drug plans and Medicare Advantage plans are responsible for coordination of benefits with state pharmacy assistance programs (SPAPs) and other insurers (including Medicaid programs, group health plans, the Federal Employees Health Benefits Plan (FEHBP), military coverage (including TRICARE), and other coverage we may specify at a later date), including the tracking of out-of-pocket costs.

CMS will work with industry and may hire a facilitation contractor to share enrollment information about Part D beneficiaries. Through these mechanisms Medicare plans and third-party payers can share paid claims information regarding covered Part D drugs. The system will match the beneficiary on the paid claim to his or her Part D plan and then send the paid claim data to that plan for TrOOP calculation. CMS hopes to make this interaction as real time as possible.

In addition, Part D plans must request information on third party insurance from beneficiaries. CMS expects Part D plans to update Medicare records based on the information provided by beneficiaries to reflect changes in coverage, including the primary or secondary status of such coverage relative to Medicare. Any beneficiary who materially misrepresents information on third parties may be disenrolled from any Part D plan for a period specified by CMS and may also be subject to late enrollment penalties upon enrollment in another plan.

The Medicare drug plans and Medicare Advantage plans will furnish an 'Explanation of Benefits' form to enrollees who receive covered Part D drugs. The explanation of benefits will include:

- A listing of the item or service for which payment was made, as well as the amount of such payment for each item or service;
- Information regarding the cumulative, year-to-date amount of benefits provided relative to the deductible, the initial coverage limit, and the annual out-of-pocket threshold for that year;
- A beneficiary's cumulative, year- to-date total of incurred costs (to the extent practicable); and,
- Information about any applicable formulary changes.

CMS requires that an explanation of benefits (EOB) be provided at least monthly for those utilizing their prescription drug benefits in a given month. CMS believes it is most appropriate for enrollees to receive a written EOB, via U.S. mail. Plans may offer additional mechanisms for the provision of such information – for example, via a Web site or call center. Plans may provide the EOB through alternative means – electronically via email, for example – only to the extent that enrollees affirmatively elect to receive their EOBs in such a manner. In the preamble,

CMS suggested that plans might explore provision of EOBs at the point-of-sale, but that statement was in no way intended to impose a requirement on pharmacies to provide plan information in the absence of the technological capacity to do so.

**TROOP** (continued)

This requirement is consistent with CMS' policy regarding the Medicare Summary Notice, which is provided monthly for beneficiaries with Part A or Part B utilization. It is also consistent with the standards followed by banking and other financial organizations, which provide their clients with monthly statements provided there is activity on their accounts.

Additional FAQ's on Medicare Prescription Drug Coverage can be viewed at <http://www.cms.hhs.gov/medicarereform/drugcoveragefaqs.asp>

## NEW KCMU COMMISSION OF MEDICAID SPENDING AND ENROLLMENT OF LOW-INCOME MEDICARE BENEFICIARIES

A new Kaiser Commission on Medicaid and the Uninsured analysis finds that Medicaid spent roughly \$105 billion on the 7.5 million Medicare enrollees who were eligible for Medicaid in 2003. Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003 includes detailed charts and state-by-state data tables on enrollment and eligibility group and spending by service, which can also be viewed on State Health Facts Online. It also provides new state-by-state estimates of the impacts on federal and state Medicaid spending of shifting the full cost of selected Medicaid services for dual eligibles to the federal government. Additionally, the Commission has updated its fact sheet, Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries.

Findings from the new Commission analysis include:

- About two-thirds (5.9 million) of dual eligibles are individuals age 65 and over with the remaining one-third consisting of younger persons with disabilities;
- 58 percent of aged and disabled Medicaid enrollees are dual eligibles;
- States with the highest expenditures on dual eligibles are California, Florida, Illinois, Massachusetts, New York, North Carolina, Pennsylvania, and Texas;
- The average Medicaid spending per dual eligible in the nation is \$14,114 in 2003, ranging from \$7,793 in Nevada to \$27,920 in Connecticut;
- 66 percent of Medicaid spending on dual eligibles is for long-term care services;
- The \$15.2 billion Medicaid spent on prescription drugs for Medicare enrollees in 2003 accounted for 14 percent of all Medicaid spending on dual eligibles;
- Among all dual eligibles, 20 percent had more than

\$20,000 in health care spending and this group accounted for more than three-fourths (76 percent) of all dual eligible spending.

The dual eligible population has been a recent focus of Medicaid and Medicare policy debates. Dual eligible individuals comprise only 14 percent of the Medicaid population, but account for 40 percent (\$105 billion) of all Medicaid spending on health care services. As both the states and the federal government look to decrease Medicaid cost growth, there is renewed attention on dual eligibles, since they have a much higher per-capita cost than other Medicaid beneficiaries. Additionally, these 7.5 million older Americans and persons with disabilities will have their prescription drug coverage transition from Medicaid to Medicare's new drug benefit beginning in January 2006.

To inform discussions of financial responsibility for health coverage of dual eligibles should lie, the new Commission report also includes state-by-state estimates of the potential fiscal impacts of various proposals to shift some of the cost of dual eligible care from the states to the federal government. For example, if the federal government had accepted full financial responsibility for prescription drug coverage of the population in 2003, it would have amounted to \$6.5 billion in savings to the states. (While Medicare will take over drug coverage of dual eligibles in 2006, states will still be required to make a clawback [link to clawback report] payment based on 2003 spending.) If the cost of long-term care services for dual eligibles was shifted, it would have cost the federal government \$30.3 billion in 2003, providing states with a 27 percent reduction in their total state Medicaid spending.

We hope you find this new analysis useful. If you would like to explore this issue further, contact the Commission at 202-347-5270 or [kcmu@kff.org](mailto:kcmu@kff.org).

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Newsletter development is supported in part by grant No. 90AM2806, from the Administration on Aging, Department of Health and Human Services. Grantees undertaking technical resource centers under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official Administration on Aging policy.

## HOW MAY I HELP YOU?

Responding to technical assistance inquiries is one of the primary services provided by The Center. From the simple—do you have brochures in Spanish?—to the complex—what are the rules regarding reimbursement for home health services following hospitalization?—we’ve received hundreds of inquiries via our toll-free technical assistance line and email since we opened our doors. Below you will find highlights from one of our more frequent technical assistance inquiries.

**Question:**

“I would like to use The Center’s *10 Tips for Protecting Yourself* flyer, but want to put my own logo and contact information on it. Is that okay?”

**Response:**

As the saying goes, imitation is the sincerest form of flattery. The Center’s resource materials are not restricted by copyrights, so you are welcome to use them in any form. In fact, the *10 Tips for Protecting Yourself* document was the basis for an article that was printed in a local community newspaper this year.

While the original version of materials we develop have The Center’s logo and contact information, you are more than welcome to replace this with your organization’s own info, completely re-design, use only the text, or use only the parts you need. If for some reason we only have an Adobe pdf version of the document available on the website, be sure to ask and we will be happy to share the original file type to make your job a little bit easier. Many of our materials are designed in Microsoft Publisher, which is a relatively inexpensive and very easy to use graphic design suite—for novice users. It comes with a large number of design templates for pamphlets, brochures, flyers, newsletters and more. It’s well worth the investment if you don’t already have it.

We would request that you let us know if you do choose to use any of The Center’s materials and receive any feedback about the design or content—positive or negative. We are always striving to create better products for everyone’s use. In addition, if you substantially modify any materials you find online, we’d also ask that you return to the website and upload your newly revised material in the online resource library. If that’s too difficult, send it to a staff person, and we’ll be happy to take care of that for you.

Thanks for asking, and keep those questions coming!