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## Center Staff Update

We bid farewell to Emily Neagle, who left The Center to pursue opportunities in Florida. We ask that you join us in welcoming our newest staff addition, Michelle Becker. Michelle joined The Center last month as Project Assistant.

## MEDICARE PART D PRESCRIPTION DRUG PLANS: FIRST MONTH IN REVIEW

All eyes are on the Medicare Part D Prescription Drug Plans as the program's first month comes to a close. Many sources report mixed reviews of Medicare beneficiaries' experiences with Part D enrollment and implementation.

In a one month progress report on the Medicare Prescription Drug Benefit, Mike Leavitt, Secretary of Health and Human Services, reports that more than 24 million Medicare beneficiaries are already enrolled in a Part D plan. It is notable, that of that 24 million, only 3.6 million are receiving coverage for the first time. According to the CMS website, enrollment figures as of mid January are as follows:

- Stand-alone Prescription Drug Plans: about 3.6 million (2.6 million since Dec. 13)
- Medicare/Medicaid: 6.2 million, including 600,000 in Medicare Advantage plans.
- Medicare Advantage: 4.5 million plus the 600,000 Medicare/Medicaid beneficiaries.
- Retiree coverage: About 6.4 million retirees are enrolled in the Medicare retiree subsidy. Also, as stated last month, about 1 million retirees are in employer coverage that incorporates or supplements Medicare's coverage. Another estimated 500,000 retirees



The Secretary of HHS reports that more than 24 million Medicare beneficiaries are already enrolled in a Part D Plan.

are continuing in coverage that is as good as Medicare's.

- TRICARE/ FEHB retirees: 3.1 million.

About 42 million seniors and disabled are eligible for the Part D Prescription Drug Plans, by enrolling in a private insurance plan. Participation in these plans should lower drug costs for enrollees because the "government is subsidizing their drug costs." (Washington Post 2/3/2006)

### Choices

According to The New York Times, although competition between plans has lowered costs, "the multiplicity of drug plans has caused confusion

**MONTH IN REVIEW** CONTINUED FROM PAGE 1

among beneficiaries and pharmacists.” The newspaper reports that although Senator Thomas Carper (D-DE) voted for the drug benefit, he was concerned that “The Centers for Medicare and Medicaid Services approved too many plans.” (The NY Times, 2/3/2006)

The Senate rejected an amendment to extend the enrollment period and allow beneficiaries to change plans without penalty from May 15<sup>th</sup> to December 31<sup>st</sup>. Eligible seniors will be able to enroll after May 15<sup>th</sup>, but will receive penalty increases in premium rates for each month past that deadline. (Washington Post, 2/3/06)

**Savings**

Mr. Leavitt reports that although “independent experts had projected premiums of over \$37 a month,” now new estimates are pointing to a much lower average of \$25 per month. He credits competition between the plans. The New York Times reports that federal Medicare drug coverage costs are “expected to be \$30.5 billion, down from a prior estimate of \$38.1 billion.”

**Obtaining Prescriptions**

Originally, CMS was encouraging eligible Medicare recipients to remain in the pharmacy until they received their prescriptions. In his latest report, Mr. Leavitt notes that processing delays for new enrollments exist. He recommends “allowing more time between when [Part D beneficiaries] enroll and when they use their coverage.” For optimal results, he suggests “enrolling early in the month, ideally before the 15<sup>th</sup> to allow more processing time.” Mr. Leavitt found that the pharmacists’ billing system has not worked perfectly, data translation problems, enrollment processing delays, and drug plans’ failure to anticipate call volumes were primarily responsible for the beneficiaries’ difficulties.

**Transitional Supply Extended**

Mr. Leavitt reports that “Medicare will notify plans

that the 30-day transitional coverage period in effect will now continue for 60 more days.” This extension is aimed at allowing beneficiaries additional time to find plans that cover their prescription drug needs or return to their physicians to change to drugs covered by their chosen plans.

**Reimbursing States**

The Washington Post reported that dozens of states set up temporary coverage for prescription drugs that Medicare eligible seniors have been unable to obtain through their Part D plans. Although the Miami Herald reported on January 18<sup>th</sup> that the federal government refused to reimburse states, Mr. Leavitt has announced in his more recent one month review that states will be reimbursed between now and February 15<sup>th</sup>. State reimbursement plans will be temporary extended past that date if necessary.

**Dual Eligibles**

A study issued January 26<sup>th</sup> by the Department of Health and Human Services Office of Inspector General found that about 82 percent of dual eligible beneficiaries in the Part D benefit will not be able to get all of the most commonly prescribed drugs because of exclusions in their new drug plans. Only 18 percent of dual eligible beneficiaries are assigned to drug plans that include all of the most commonly used 178 Part D eligible drugs. (<http://www.oig.hhs.gov/oei/reports/oei-05-06-00090.pdf>)

The Los Angeles Times asked in mid-January, “With so much riding on the new program, and with the government’s best health care experts having had two years to get ready, how could the launch have stumbled so badly?” It is apparent that Part D’s first month of implementation has been a bumpy ride for beneficiaries, pharmacists, CMS, and private drug plans. Mr. Leavitt acknowledges these challenges and emphasizes that CMS intends to continue “the process of problem-solving and improvement—guided by lessons learned.”

## AOA UPDATE

The Assistant Secretary for Aging, Josefin G. Carbonell, invites the Aging Services network to join the AoA Medicare Partnership Campaign by registering at <http://www.aoa.gov/medicare/index.asp>. Your participation will provide you with access to information on the implementation of Medicare Part D benefits as you assist beneficiaries in making informed health care decisions and avoiding costly errors. The Senior Medicare Patrol's knowledge and past work with "dual eligibles" bring valuable knowledge to the campaign.

### ELECTRONIC GRANT SUBMISSION:

AoA is now requesting that all applications for funding opportunities be submitted electronically through [www.grants.gov](http://www.grants.gov). In 2005, teleconferences were held to assist prospective applicants to understand the credentials and passwords necessary to apply online. AoA is planning to conduct a teleconference in the Spring of 2006 to provide additional information about completing the application process. In addition, you may email [support@grants.gov](mailto:support@grants.gov) for assistance with any part of the process. For AoA assistance with Grants.gov, contact Arthur Miller at 202-357-3438

### CALL FOR SMP GRANT REVIEWERS:

Regulations require that each application be ranked by three independent reviewers that will comprise a diverse panel to develop a consensus of the merits of each application. SMP applicants only compete within their state hence Project Directors may review applications outside of their state barring no other conflict of interest exists. Interested professionals with knowledge of the Aging network, the SMP program and who are skilled at written analyses/oral communications may email your resume to [Barbara.Lewis@aoa.hhs.gov](mailto:Barbara.Lewis@aoa.hhs.gov) by February 28, 2005. We anticipate that reviews will take place the spring. Non-Federal reviewers are paid \$50 per applications reviewed and \$150 for participation in the panel discussion which is primarily conducted via conference call.

### PROJECT ABSTRACTS/EXECUTIVE SUMMARY:

Applications for new or continuation funding must include the project's; duration, goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, and products. Grantees are requested to also email the one page summary for inclusion in the 2006 National Health Care Fraud Control conference program. [A sample abstract will be forwarded by your AoA project officer]

### PERSONNEL NOTE:

Margaret A. Tolson AoA Grants Management Officer retired December 2005 after thirty seven years of federal service. The Senior Medicare Patrols began under her guidance and have grown into the largest discretionary grant program in AoA. We will miss her wise counsel regarding match funding requirements, grantee's budget negotiations, carryover requests and a host of other issues. Dan Berger in the Center for Management is currently the Acting Grants officer.

### UPCOMING EVENTS:

Spring	Summer	Fall
Continuation Applications Due	SMP Grant Awards Announced	2006 National Health Care Fraud Control Conference (Tentative)
Program Announcement Published	Semi-Annual Reports Due	Final (FY 03—06) Reports
Project One Page Abstract/Executive Summary	OIG Performance Measures Input	

## MINORITY AND ETHNIC COMMUNITIES HARDEST HIT BY FRAUD

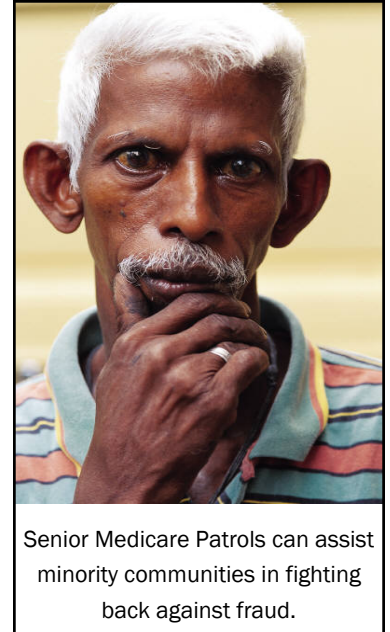
A recent Federal Trade Commission study found that minority groups are considerably more likely to fall victim to fraud. The study cited Hispanics twice as likely as non-Hispanic whites to be victims; blacks are three times as likely; and a stunning 34 percent of American Indians report being hit by fraud – a rate 6 times greater than non-Hispanic whites!

Many minority seniors utilize a variety of traditional health practices as their primary form of care and they consider “modern” or conventional Western medicine to be a secondary, though powerful, alternative. This situation is not surprising. The World Health Organization estimates that up to 80 percent of the world uses herbal medicines and other forms of traditional healing as their primary form of health care. Most of these traditional practices have been utilized effectively for hundreds and even thousands of years among many cultures. It is important to remember when working with seniors of different cultures that they may have a different set of health beliefs, practices, and attitudes that those of providers in the dominant culture.

Scam artists have certainly realized these differences and see it as an opportunity to make a quick buck. The FDA reports, claims for “miracle” medicines, therapies, and services are often made in languages other than English, making it difficult for regulators to stop new schemes. Hucksters prey on immigrants and those of limited English abilities who are typically unfamiliar with the US marketplace and who may believe that any health-related product they see for sale has been proven safe and effective.

*The Center* staff had the opportunity to attend this year’s annual National Health Care Anti-fraud Association (NHCAA) conference, held in San Diego last November. At the conference, FBI officials informed the audience that one approach being utilized by criminals involves taking out ads in ethnic community newspapers for bogus health care products, including phony Medicare Part D plans. In the ads, criminals pass themselves off as Prescription Drug Providers in order to steal people’s personal information and defraud the health care system.

Senior Medicare Patrol projects can assist minority communities in fighting back against fraud. SMPs have reported success partnering with worship, community and cultural resource centers. Ethnic media outlets have been another key to spreading the SMP message and posting scam alerts. Ask bi-lingual volunteers to assist you by scanning the ethnic newspapers for unscrupulous ads. The Center has a growing library of cultural resources. If your program has materials to share, please submit them to the online resource center, or email Center staff. Working together to fight health care fraud, we can all make a difference.



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<sup>1</sup> Federal Trade Commission. “Consumer Fraud in the United States: An FTC Survey Staff Report of the Business of Economics and Consumer Protection.” Keith B. Anderson, August, 2004.

<sup>2</sup> Yehieli, M. Grey, M. and Vander Werff, A. “Reaching out to elderly minorities, immigrants and refugees: A Senior Medicare Patrol Guide.” 2004

## PHYSICIAN BILLING FOR EVALUATION AND MANAGEMENT (E & M) SERVICES

In November, 2005, the OIG published two reports on physicians' use of "Modifier 25" and "Modifier 59." Physicians use these two modifiers to obtain payment for additional services billed on the same day as other professional services for which the physician also billed Medicare. What are Modifier 25 and Modifier 59, and why are they important to a SMP?

A short lesson in Medicare's arcane world of physician billing and payment may provide greater understanding about physician services fraud, errors or abuse and the use of these "modifiers" in Medicare payment to physicians. Two concepts are important in understanding these OIG reports.

### Bundled Services and Supplies

As generally understood, Medicare requires physicians to provide a "code," usually a five or six-digit number (called a "CPT code"), for each claim for service that a physician or non-physical practitioner provides for a Medicare beneficiary. A physician may bill under more than one CPT code on the date of service but Medicare rules strictly interpret when and how a physician may submit these claims. For each code, the physician must submit medical documentation regarding the diagnosis and treatment performed.

In 1996, Medicare developed the Correct Coding Initiative (CCI) to establish standardized coding systems and reduce inappropriate Part B payments. As part of this initiative, Medicare requires that payment for all services that are considered integral in the performance of a medical procedure be "bundled." Bundling requires that payment for incidental procedures, in effect, be included with payment for the primary service. If a physician bills Medicare for services that should be bundled under Medicare payment rules, Medicare will deny payment for that service. (Internet Only Manual, *Medicare Claims Processing Manual*, Chapter 12, Physicians/Non-physical Practitioners, Section 20.3.)

A physician (or physician's office) is expected to know when services are to be bundled. If the physician chronically fails to bill correctly the carrier conducts training for the physician and/or his/her staff, may conduct "prepayment claims review" before payment is made to the physician and may recover erroneous payments made to the physician.

Medicare provides several exceptions to this bundling rule if the physician performs an additional service that is not integral to the primary procedure. To indicate that a second claim is a separate procedure, the physician adds a "modifier," or a two-digit number or an alpha-numeric combination onto the code listed on the claim. The OIG reports detail two of these modifiers--Modifier 25 and Modifier 59, although there are many more modifiers as well.

The OIG's report, entitled "Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits," (OEI-03-02-00771) examines 350 randomly-selected claims to determine the appropriateness of the use of Modifier 59. Modifier 59 may be used to request payment for two distinct services with codes that are not, generally, both paid under Medicare's rules. The study found that 40 percent of these paid claims were paid improperly because the services were not distinct from each other, or that the services were not documented.

**EVALUATION AND MANAGEMENT (E & M) SERVICES** CONTINUED FROM PAGE 5**Evaluation and Management Codes**

The second OIG report examines the bundling of specific codes called “evaluation and management” codes (“E&M codes”). These codes, generally, indicate physician services to evaluate a person’s medical condition, provide counseling on treatment alternatives or to consult with another physician regarding a medical diagnosis or treatment and cannot be billed under any other medical procedure code. Medicare’s E&M coding has been one of the most controversial areas of Medicare claims for physicians.

An E&M service may be billed separately, using “Modifier 25” to report a “significant, separately identifiable evaluation and management service that is above and beyond the pre- and postoperative work of the procedure.” (Internet Only Manual, *Medicare Claims Processing Manual*, Chapter 12, Physicians/Non-physical Practitioners, Section 30.6.6B) Medical documentation may be requested by the carrier to justify the primary service performed as well as the evaluation and management service.

The OIG’s report, entitled “Use of Modifier 25” (OEI-07-03-00470) randomly selected 450 claims from all of the 2002 Part B Medicare claims using a Modifier 25. From this sample the OIG found that Medicare erroneously paid 35% of the E&M services using Modifier 25, either because the services did not meet the requirements for use of the modifier (1%) or they lacked sufficient medical documentation to justify payment (34%).

**Why Are These Reports Important?**

The OIG reports estimates that improper use of Modifier 25 may results in \$538 million in improper payments by Medicare or the beneficiary. The OIG also found that Medicare made payments of approximately \$59 million due to the use of the Modifier 59.

Although the details of Medicare claims are difficult to figure out, these codes are listed on Medicare Summary Notices and may be important in helping a beneficiary understand why a claim is denied, and whether the beneficiary is responsible to pay for the service.

**Before you sign up for that tax refund online.....**

IRS is warning consumers against a phishing e-mail scam that directs them to a website to enter personal identifying and financial information in order to receive a tax refund. The bogus e-mail, which claims to come from [taxrefunds@irs.gov](mailto:taxrefunds@irs.gov) tells the recipient that he or she is eligible to receive a tax refund for a given amount. It provides a link that recipients are supposed to

follow to submit a form online. Recipients are also asked to provide personal identifying and financial information—the kind of information used by ID thieves to defraud consumers of their funds and credit. Call the IRS at 1-800-829-1040 to verify if you are legitimately being contacted by e-mail about a tax refund.



## SO YOU WANNA BE A RADIO SUPER STAR!?

Maybe you don't aspire to be the likes of Rush Limbaugh, but getting connected with a local radio station can be a good gig. Not only do you get to do something different, but you have a great opportunity to get your message out to hundreds or even thousands of people. From Vermont to Texas, Senior Medicare Patrol projects across the country have tried their hand at radio talk shows, and have met with some interesting successes.

### How did you get started?

It can be as easy as making a phone call and pitching a good program idea. Sometimes your neatly packaged press release might even get picked up and generate a call. In Alaska, they are lucky enough to have a public information officer to help coordinate interviews. And, according to Essien Ukoidemabia, SMP and SHIP program director, she is "always setting me up with crazy interviews with media who deal in controversial subjects." All jokes aside, these "crazy" interviews are making a difference in Alaska. Essien reports that many people tell her that hearing her on the radio resulted in their phone call to her office.

#### *Additional tips for getting started:*

- Send out news releases to get coverage of outreach events. Smaller towns have higher visibility and result in more coverage.
- Make yourself approachable. According to Essien, "that goes a long way with getting someone to write a story about our pet projects when the editor thinks it is a boring subject."
- In Vermont, Anita Hoy met with some success by sending out a mailing requesting time on local radio stations.
- In Atlanta, Vicki Shanahan was lucky enough to have a volunteer who was invited to participate on a gospel station, and got Vicki invited to participate as well.
- Anne Fredrickson in Ohio turned a guest appearance on a couple shows into a regular hosting job for a Medicare talk show on a senior oriented

radio station.

### What barriers did you encounter?

"As with all press, print or electronic media, we tend to think our story is of GREAT interest and they

don't. To get your story on, you have to think like them-- think about what will sell," says Barbara McGinity of the Texas Better Bureau Foundation SMP project. Anita ran in to problems because initially her SMP program wasn't familiar to most people in Vermont, either listeners or radio station personnel. Ann Burch, with the Michigan SMP, said her biggest challenge is "paring down the info for the time allotted—hitting and knowing the hot points...You can't walk in and wing it. That is not fair to your listeners or your radio host." Essien said her biggest challenge tends to be short lead times—shows want immediate interviews, when they ask. Anne's biggest challenge has been her unsuccessful attempt at securing a state Congressman as a guest for her regular radio show. Undaunted, Anne says she usually has little problem attracting guests for her show, which is aired on a station that has 30,000 senior listeners per week, and another 60,000 per month on the internet.

### What sort of outcomes has the radio outreach produced?

Increased call volumes are the most tangible outcomes reported by most respondents. Sometimes these calls are complaints, but most tend to be requests for presentations, and oftentimes new volunteers. For the Ohio SMP, the radio station outreach effort was their "number one" recruiting effort used to attract their initial group of volunteers. Karen Bolin, previous Florida SMP project staffer, suggested that the air



"...getting connected with a local radio station can be a good gig."

**RADIO SUPER STAR** CONTINUED FROM PAGE 7

time can be used as an in-kind third party contribution for the matching requirement for the grant. In addition, when she arranged radio shows and invited outside guests to participate, she was able to request a letter noting the guests in kind contribution for their time. Outside guests were they key to keeping her show interesting at the same time allowing her partners in the aging network to gain exposure for their work. And the only real costs are the investment of staff time for most- arranging guests, script development, drive and on air time. In Ohio, Anne is looking to capitalize on the free airtime by securing additional outside funding to produce a series of “Medicare Mini-Moments” to promote the regular show.

**What are the keys to success and anything else you’d need to know to get started?**

**Essien (AK):** I [think] it’s the subject matter, my aggressive Publicity Agent and the interpersonal relationships our office has developed with the seniors. The Medicare/Medicaid population knows us as the hands on agency. We provide one-on-one counseling and the seniors love that.

**Anita (VT):** I think open-lines of communication and sharing information helps foster successful relationships. Radio interviews/talk shows are an easy way to broadcast important messages. I believe that folks do not need any more paperwork/ flyers/ advertisement/ outreach materials and that an audio-message delivered is direct, time-saving and more interesting.

**Ann B (MI):** Seek out a station that your beneficiaries are likely to listen to, not rock etc. Contact the radio station and describe to them how the information would be beneficial to their listeners. Have info already prepared so the station can see what the topics are. You have to sell the station on the idea. Also information that you provide has to be short and sweet. Not dull and boring. Sometimes this is a challenge with some of the topics we deal with, but it is possible. With info such as waste, fraud and abuse, paring down the info into a scenario that describes a real life case or situation is very powerful and will likely win you a return performance. Be prepared and share this info with the radio host. That way everyone is on the same page during the interview. Sometimes the topic is chosen by the host and other times I decide what to talk about, but I always give the host the info in advance to the airing or taping of the show.

**Barbara (TX):** To be a credible source, they have to feel you are honest and reliable. Never tell any media anything that you know to be false...and if you are not sure and are speculating...make sure they understand that. Respond to phone calls from media as soon as you can. If you do, they will call you first next time. Know your topic, follow through with promises, be on time and reliable. Be available when they have questions. Establish a personal relationship-- where you are the “go to” person for them.

**Vicki (GA):** Many non-mainstream stations seek out guests...be proactive, let the stations know of your organization and ask to be invited to participate.

**Anne (OH):** Pro Seniors relationship with the station and the Director in the past, as well as the continued funding from our AAA to the station to provide our fraud project the opportunity to produce PSA’s about Medicare fraud are [key to our success]. Persist, persist and persist!! You need to sell yourself and your project to radio. It is way more effective and cheaper than live TV. It’s generally repeated and tends to be more available to folks than live television. I am VERY fortunate that I have a “senior” based station that happens to be VERY interested in more than music for seniors but issues and concerns about growing older!! I guess I am spoiled but I believe others can make it happen even if it’s not a dedicated senior station!!

## MENTOR PROGRAM SPOTLIGHT—THE INTER TRIBAL COUNCIL OF ARIZONA

The SMP Mentor program was established to provide support and develop program strategies, skills and successful practices through monthly conference calls. Within the Mentor Program exists mentor teams who focus on furthering the purpose of the program as it related to their target populations. With outreach to American Indian groups posing a unique challenge to SMPs, a mentor team was developed to determine the most beneficial methods for reaching this group. The mentor team includes:

- Dennis Dudley, AoA Project Officer
- Shirley Merner, The Center
- Ada Leach, Arizona SMP
- Susan Mount, Oklahoma SMP
- Wendell Holt, GLITC SMP
- Julie Galstad, Montana SMP
- Buffie Saavedra, New Mexico SMP
- Colleen Black, Oklahoma SMP
- Cindy Brown, Oklahoma SMP

This group was selected because of their experience and expertise in working with Native American populations.

One of the members of this team comes from a newly funded Senior Medicare Patrol Project. Last year, the Administration on Aging awarded funds to 38 new Senior Medicare Patrol Projects, including the Inter Tribal Council of Arizona, Inc (ITCA). As an SMP, the Inter Tribal Council of Arizona has a unique perspective when it comes to dealing with its target population.

Outreach to American Indian groups poses exceptional challenges to SMPs. In order to effectively face these challenges, you must first increase your cultural competency. In this mentor program spotlight, the Inter Tribal Council of Arizona and their mentor team provide great information to get you started on successful outreach to the American Indian population.

Due to the significance of the entire tribal community, reaching out to groups should be considered in outreach efforts – from elders, to families, to tribal leaders, to social service providers and others within each tribal group.

In addition to including the entire community in your outreach efforts, there are other factors that should be considered, which include:

- lack of transportation,
- limited English proficiency,
- fear and mistrust,
- limited resources and infrastructure, and
- Tribal mores and folkways.

Taking into account that these limitations and differences exist will make for better planning when reaching out to the American Indian population.

## MENTOR PROGRAM SPOTLIGHT CONTINUED FROM PAGE 9

In addition to developing cultural competency, another method that has made the SMP's of the mentor team successful in reaching the American Indian population has been the development of community based partnerships. This approach to developing education and outreach includes tribal community members, organizational representatives, volunteers, health and social service providers and tribal leadership in all aspects of the planning process. The partners lend their expertise, but focus on enhancing and supporting the self-empowerment to the tribal communities.

### Educational Outreach for American Indian Communities: Lessons Learned

When conducting education outreach to American Indian Communities there are three key components that should always be considered.

1. **Engaging the tribal community and its people.** Among factors known to be important to American Indian elders is face to face presentations in a highly visible way, using meaningful symbols and in some cases, in the native language of the recipients. The message and the materials should use simple language.
2. **Establishing relationships and respect for culture.** Preparing the community for an SMP presentation takes a long time. Establishing a trusting relationship among tribal members may take months. There is no "turn-key" approach. Seek advice from community elders and leaders, and break bread with them. Each tribal community needs to be visited, with a respected leader identified, consulted and found to be supportive of the project.

Scheduling is very labor intensive and extremely important. The community calendar must be previewed; and dates for ceremonials must be taken into consideration. The project staff must have back-up plans when cancellations come on short notice. For example, a death among the tribe.

Spirituality is strongly connected to overall views of health care.

The presentation needs to be adapted to the community's mores and preferences. Even in communities where a Benefits Coordinator is present, considerable hands-on assistance is needed. The complexity of the program, the complications in producing documents and even transportation issues point to the need for the SMP program to be visible and active in the community.

3. **Engaging American Indians.** Education is valued highly. Information should be presented in ways that honor and respect the community and self-empower the tribal members.

It is important to establish a friendly, trusting relationship with the elders. Formal presentations won't get results. The SMP introduction should give an overview of what they can learn in the follow up sessions. American Indian elders need to have an opportunity to consider the project's worth before they accept it.

Use simple language and highly visible presentations and speak slowly. Presentations should include the very basic key points. Presentations must be concise, this audience does not need to know all of the details, nor will they tolerate complicated language. For example, SMP trainers have found that elder American Indians responded well to a very short introduction and two or three key points. Presenters need to explain



The Inter Tribal Council of Arizona believes that the entire tribal community should be considered in outreach efforts

**MENTOR PROGRAM SPOTLIGHT** CONTINUED FROM PAGE 10

beneficiary information in a way that is relevant to the listener's life. It is important to use pertinent examples and story telling to get a point across.

If someone from the tribal community can be present to translate key concepts into the elder's language, there seems to be increased understanding and acceptance of the SMP program.

It is important to listen and take time to hear the elders concern. Most elders hesitate to speak up in group presentations. However, as the elders became more familiar with the presenters, they became more open and interactive.

The presenters need to have enough background to answer basic questions, and self-confidence to say they don't know all of the answers and will have to do some research. A critical part of maintaining credibility is to follow through and to come back with answers. They are very skeptical of programs where presenters do not return for follow up.

Although sometimes challenging, educating consumers from different cultures is possible. With the right tools and resources, providing valuable information to help beneficiaries identify unintended Medicare and Medicaid billing errors as well as potentially fraudulent activity can be a success. If you would like to learn more about the successful strategies put into practice by this or any other Mentor Team, you should considering joining The Center's Mentor Program. As a participant, you will benefit from:

- numerous networking opportunities;
- a panel with expertise in a special population;
- sharing best practices among the SMP community; and
- seasoned directors and projects

For more information about The Center's SMP Mentor Program, contact Shirley Merner at [smerner@smpresource.org](mailto:smerner@smpresource.org).

### **Civic Ventures Accepting Nominations for Purpose Prize**

As the first of 77 million baby boomers turn 60 in 2006, Civic Ventures, a nonprofit organization working to help America achieve the greatest return on experience, announces The Purpose Prize - five \$100,000 investments in Americans over 60 whose creativity, talent and experience is transforming the way our nation addresses critical social problems. Sixty semi-finalists ("60 at 60+") will also receive national recognition for their work. To nominate someone or apply yourself, visit [www.leadwithexperience.org](http://www.leadwithexperience.org). Application deadline is February 28, 2006. The first awards will be made in June, 2006.

## ADVISORY PANEL ON MEDICARE EDUCATION MEETING FOCUSES ON DUAL ELIGIBLES

The much publicized issue of dual eligible Medicare beneficiaries (those who have both Medicare and Medicaid) transition to the new Medicare drug program, was the burning topic of the day at the recent Advisory Panel on Medicare Education (APME) meeting. Convened January 27<sup>th</sup> in Washington DC, the panel heard from a host of Centers for Medicare and Medicaid Service's (CMS) staff, including Administrator Dr. Mark McClellan. CMS speakers were quick to point to the early successes of the program, but several acknowledged that critical implementation issues had arisen, and discussed steps being taken to remedy problems.



"...the top priority of CMS officials is the dual eligible transition."

According to McClellan, the top priority for CMS officials is the dual eligible transition. He described two specific issues being faced by this group, considered to be the most vulnerable population. The first is the large number of individuals who switched plans near the end of December, but enrollment data wasn't properly transmitted. So, when these people presented themselves to the pharmacy, there was no record of their enrollment, or in some instances, it wasn't clear which plan they were actually enrolled in. Long telephone hold times at both CMS and the drug plans resulted in people either being asked to pay out of pocket for their medications, pay incorrect co-payments, or turned away altogether to resolve the issue on their own. The second large group of problems with the dual eligible transition was the result of snafus in the complex hand off of data from the state to Medicare and from Medicare to the prescription drug plans. According to McClellan, in some cases it just didn't happen. The result is that these people were never enrolled in a plan. McClellan reviewed the measures implemented prior to January 1<sup>st</sup>, including the pharmacy look-up system, point of service coverage plan and also discussed a number of steps taken since January 1<sup>st</sup> to resolve the problems. A complete set of dual eligible records and their plan assignments have been shared with all the plans, who were asked to cross-check their enrollment records, and CMS has worked closely with several plans who had encountered special problems. Problems reported with dual eligible beneficiaries have significantly declined since the second week in January.

McClellan noted that in addition to the dual eligible transition issues, for the longer term CMS will focus their efforts on creating a smoother process for month to month changes in plan enrollment for all beneficiaries. He urged seniors to sign up or make changes earlier in the month, so that the information has time to work its way through the system. He also noted that customer service, at both CMS and the plan level is an issue they are addressing. They have worked quickly to add new Customer Service Representatives to decrease call times, and increase the consistency of information provided by these individuals.

Clayton Fong, President and CEO of the National Asian Pacific Center on Aging, expressed concern to Dr. McClellan regarding formulary issues that are now arising with dual eligible beneficiaries. According to Fong, as many as 60% of the dual eligible individuals they have counseled have at least one drug not included on the formulary for the plan they were assigned to by CMS. While CMS required plans cover a 30 day supply of current medications, and some plans have instituted a process that will allow beneficiaries to obtain non-formulary prescription for as much as 3 months, few beneficiaries understand that at the end of that time frame those medications won't continue to be covered. Rebecca Snead, with the National Council of State Pharmacy Association Executives, acknowledged that pharmacists have no way of identifying and thus informing

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beneficiaries that a particular medication is only being covered by the plan temporarily. Fong predicts that the next wave of issues will arise in February, as the 30 day supply of prescriptions begin to run out, and patients are left with drugs still not covered by their plans. In that instance, individuals then have the option of contacting their doctor to discuss a change in their medication, switching to a plan that covers all of their medications, or filing an exception with the plan.

CMS reported that as of mid January 785,000 dual eligible beneficiaries had switched plans. Dr. McClellan stated that CMS is working to share with plans several approaches they might take to resolving these issues, including a “pay and educate” approach or a gradual transition for this population, moving people onto plan formularies by major categories of drugs. Ultimately, the decision is left up to the plan about how to handle the process. Fong suggested CMS consider encouraging plans to allow the state pre-authorization process that many beneficiaries have gone through previously to replace whatever process they may have, when an individual needs to request an exception for a specific medication. He also noted that his organization has recently distributed a press release through major Asian news outlets urging people with both Medicare and Medicaid to themselves confirm that their medications are on the formulary for their plan (using 1-800 Medicare of the online plan finder), or contact his organization for help in making sure they are enrolled in a plan that meets their needs.

**Long Term Care Rx Implementation**

Dr. Jeffrey Kelman, Chief Medical Officer for the Center for Beneficiary Choices at CMS, provided an overview for meeting participants about implementation of the new benefit in the long term care setting. Dr. Kelman estimated that they’ve achieved approximately 70% “penetration” in the nursing home setting, and predict by year’s end they will have achieved a 90% penetration rate. He estimated that only about 20% of individuals in long term care settings that were auto-enrolled actually received (or their guardian received) the enrollment letter sent by CMS and another 20% contacted 1-800-Medicare to obtain the information. CMS responded to 500,000 fax requests in the last six weeks of the year by nursing homes requesting information about plan assignments. He did note that plans were required to implement 90-120 day transition supplies for those in long term care, to provide a longer window of opportunity reconcile formulary changes. Responding to a panel members’ question about the controversial non-coverage of benzodiazepines under the new benefit, Dr. Kelman stated that 49 out of 50 states are providing coverage for these medications. The only state not providing coverage is Tennessee, and he indicated they are considering individual requests for coverage of these medications. Kelman attributes the early implementation successes seen in the long term care setting to a number of last minute systems changes implemented by CMS, as well as a comprehensive outreach strategy that included distribution of information to the more than 15,000 nursing homes using the MDS system. A system required in each facility. He acknowledged that CMS is continuing to address the “B versus D” issue, clarifying when medications are covered under which benefit.

**Strategic Focus**

During the meeting, several members encouraged CMS to consider how the committee could be more proactive and strategic in their deliberations at future meetings. Topics for consideration including outreach with health prevention and promotion messages and consumer use of quality of care data to drive decision

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making. The APME was established in 1999 to develop and implement a national program that describes options for selecting Medicare health plans and enhance CMS' effectiveness at educating and reaching out to Medicare consumers, including underserved communities. The next meeting will be convened in the second quarter of 2006.

**CMS MEDIC Convenes Consumer Protection Panel**

In late fall, CMS awarded Health Integrity, LLC (a subsidiary of Delmarva Foundation) the first of eight contracts to entities for the management and reporting of complaints related to the Medicare Prescription Drug Benefit.

The MEDIC's primary responsibilities are to analyze data to find problems that indicate fraud or abuse could be occurring; investigate potential fraudulent activities surrounding enrollment, eligibility determination or distribution of the prescription drug benefit; investigate unusual activities that could be considered fraudulent as reported by CMS, contractors, or beneficiaries; conduct fraud complaint investigations; and develop and refer cases to the appropriate law enforcement agency as needed.

As part of its work, the MEDIC team has formed a Consumer Protection Panel. The panel has representation from various groups including the SMP network, AARP, the National Association of State Units on Aging, CMS and others. The purpose of the panel, in part, is to provide the MEDIC with expert input from the grassroots level as to possible fraud related to Part D.

The first teleconference was held January 18<sup>th</sup>. Jo Ann Lamphere, DrPh from the Lewin Group moderated the call. The agenda included introductions of panel members, and provided an overview MEDIC activities. On the first call, many examples of problems with Part D implementation were shared. Notably, most of the problems discussed were identified as implementation issues rather than actual fraud.

The panel will be meeting monthly by teleconference.

For further information  
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## SPOTLIGHT ON PARTNERSHIPS: TRIADS

### Who they are:

Triad was first conceived in the 1980s and formalized in 1988 by representatives from AARP, the International Association of Chiefs of Police and the National Sheriffs' Association. Triad is not an acronym; it simply represents a group of three- law enforcement, seniors and community groups. Triad is actually the concept of partnering for the safety of seniors.

Once a Triad is formed, a SALT Council is created. SALT is an acronym, which stands for Seniors and Law Enforcement Together. The SALT Council is the working arm of the Triad, much like a PTA. Usually, the Triad is formed at the county level and a SALT Council is established. Then individual communities within the county (cities, towns, municipalities, or villages) appoint representatives to the SALT Council so that every community in the county is represented. The SALT council usually consists of community representative as well as representatives from local law enforcement, including the police or sheriff's department.



### What they do:

Triad's goal is to reduce crime against the elderly, and to reduce the unwarranted fear of crime that seniors often experience. A local Triad, through its SALT Council, and based on NATI programs, conducts organized programs and activities to meet its objectives. Some examples are: Files of Life, wherein magnetic refrigerator cards are distributed to the elderly that capture information for use in case of emergencies; educational talks given to senior groups on crime prevention, scams and schemes, or personal safety; senior visitations or adopt-a-senior; and inter-generational programs, to name a few.

Forming a Triad in a community has many benefits, among them, it:

- Opens communication between public safety personnel and the elderly
- Allows seniors to voice their concerns about crime and safety
- Provides an avenue for active senior volunteers to help others
- Reduces senior isolation, a contributing factor to senior victimization
- Strengthens the ties amongst community groups,
- Builds a sense of community, and
- Expands law enforcement personnel capabilities within the community.

### How SMPs work with Triads:

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According to a survey completed last year, about 40% of Senior Medicare Patrol staff currently have some type of relationship with a Triad in their state.

- In Connecticut, staff from the SMP serve on the state advisory board for the Triad;
- In Maine they have set up booths at local Triad events and presented on Medicare fraud issues at local and statewide meetings;
- In Oklahoma, Triads have served as a source of complaint referral for health care fraud and abuse allegations.
- The West Virginia SMP partnered with the state Triad to conduct grassroots education and outreach for the prescription drug card program;
- In Wisconsin, a Deputy from the County Sheriff's office, who also happens to be one of their most active volunteers, has taken a lead role with Triads in their state; and
- The Center and AoA participated in the 2005 National Triad Conference in December by exhibiting and distributing information about the SMP program, presented at three sessions. (We couldn't keep enough materials on the table!)

### Challenges:

SMPs report that Triads don't exist in every area, and don't always have well established state boards. Because they are a volunteer based organization, and often have difficulty finding funding to support their activities, leadership and membership can fluctuate. At a minimum, most report that they at least are provided an opportunity to participate in annual or local senior outreach events.

### Where to learn more:

Visit the national triad association's website: [www.nationaltriad.org](http://www.nationaltriad.org)

#### NATI

1450 Duke Street  
Alexandria, VA 22314

## BACK TO BASICS: SENIOR VOLUNTEERS

### What is the True Value of a Volunteer?

Last March, *Independent Sector* announced that the 2004 estimate for the value of one hour of volunteer time reached \$17.55, up from \$17.19 in 2003. This is a tool that can be used to help organizations quantify the enormous value volunteers provide. The hourly value of volunteer time is based on the average hourly wage for all non-manager, non-agriculture workers as determined by the Bureau of Labor Statistics, with a 12 percent increase to account for fringe benefits.

We can estimate the dollar value of a volunteer hour. However, the true value extends beyond money. Volunteers bring added value to the organizations who "hire" them. Consider the following thoughts about volunteers:

- They become organizational/mission advocates.
- They give a human touch.
- They build community spirit and support.
- They increase diversity.
- They bring unique/local knowledge and skills.

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- They are outsiders and bring a fresh or broader point of view.
- They have an increased credibility because they are not paid employees.
- They make contacts and expand the sphere of influence.
- They are pioneers.
- They are more free to criticize and speak up for improvements or new approaches.
- They are more free to take a risk and experiment with new ideas/ approaches.

Volunteers do not save money for organizations but they *do* help to use resources in the most effective and efficient way. Volunteers can provide excellent value for money, but organizations must be willing to invest in this valuable resource in order to get the best value.



*The true value of a volunteer is difficult to determine and goes beyond a per hour estimate.*

## PART D PROGRAM INTEGRITY UPDATE

The National Consumer Protection Technical Resource Center held a teleconference on February 2, 2006 on Medicare Part D Program Integrity. The presenters included **John Bettac**, of Health & Human Services Office of the Inspector General, Office of Investigations, **Sandra Love**, MS, RHIA, Health Integrity, LLC, **Laura Minassian-Kiefel**, MPH, CHC, MMA Integrity Specialist, Division of MMA Integrity, Centers for Medicare and Medicaid Services Program Integrity Group, and **Mary Beth Senkewicz**, National Association of Insurance Commissioners.

The presenters provided an overview of the roles and jurisdiction of various entities related to Medicare Prescription Drug program fraud and abuse issues. They were also able to illustrate some examples of recent complaints alleging fraud or abuse in the Medicare Prescription Drug program, as well as identify potential scams that consumers are likely to be most vulnerable to now that the program is underway.

The Health and Human Services Office of the Inspector General (OIG), CMS and the new enrollment and eligibility MEDIC report receiving a number of complaints of fraud, waste and abuse related to the Part D program since the program kicked off in November. According to John Bettac with the OIG, they are continuing to investigate complaints about “\$299” plans that attempt to pass themselves off as Medicare plans; overly aggressive Medicare Advantage plans trying to persuade consumers to join these HMO like plans that also offer prescription drug coverage; and complaints of fraud being perpetrated against non-English speaking people with Medicare.

Sandy Love, Project Director for Health Integrity’s MEDIC program (funded by CMS to work on fraud, waste and abuse issues), noted they continue to receive complaints that are blatant program integrity issues, as well as concerns regarding specific marketing violations.

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Major categories of complaints received include:

- Deceptive marketing practices
- Individuals or organizations posing as Medicare or Social Security officials with the to steal personal information or money
- Sales reps who came to the home uninvited
- Sales reps that asked for credit card or banking info
- False advertisement of drug prices
- Sales reps asking for payment over the telephone
- Beneficiary asked to sell prescription drugs
- Kickback money offered

Examples of deceptive marketing practices include: consumers being enrolled in a Medicare Advantage plan instead of a regular Part D Prescription Drug plan; being told drugs are on the plan's formulary that were not, or pharmacists encouraging enrollment in plans without regard to the needs of the consumer.

Health Integrity reported on a complaint about an individual who was approached by an insurance salesman on the street while walking her dog. Licensed and unlicensed insurance agents selling plans continues to be an issue. And, according to Mary Beth Senkewicz with the National Association of Insurance Commissioners, your state Department of Insurance wants to know about it.

To report complaints of potential fraud, waste or abuse, Senior Medicare Patrol project staff should continue to contact the CMS MEDIC, Health Integrity:

1-877-7SafeRx (1-877-772-3379)  
[MEDICinfo@healthintegrity.org](mailto:MEDICinfo@healthintegrity.org)

SMP staff should **also** contact the state Department of Insurance with concerns about licensed and unlicensed insurances sales representatives. To locate your state agency, visit: [http://www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm)

For copies of the audio teleconference on Part D program integrity issues, contact Michelle Becker at [mbecker@smpresource.org](mailto:mbecker@smpresource.org).

Visit us on the web at [www.smpresource.org](http://www.smpresource.org)

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For more information about the National Consumer Protection Technical Resource Center, please visit us at [www.smpresource.org](http://www.smpresource.org).

All newsletter submissions and inquiries should be directed to Candice Griffin at [cgriffin@smpresource.org](mailto:cgriffin@smpresource.org).

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## GLAD YOU ASKED!

*Question: Can a Medicare beneficiaries change their Part D plan before May 15, 2006?*

Yes, Medicare beneficiaries who are dissatisfied with the Part D plan may change their enrollment one time before May 15, 2006. For 2006 the "Annual Enrollment Period" (AEP) and the "Initial Enrollment Period" (IEP) are the same—November 15, 2005 to May 15, 2006. When an individual first signs up for a Medicare drug plan, he/she is exercising his IEP. If a person wants to make a change in that enrollment he/she may disenroll from the first plan by simply enrolling in another Medicare prescription drug plan or Medicare Advantage plan with, or without, drug benefits. With this change in enrollment the individual is exercising his/her AEP.

This rule can be found in the Medicare Manual entitled, "*PDP Guidance, Eligibility, Enrollment and Disenrollment.*" Section 20, and can be found at [www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDP\\_EnrollmentGuidance\\_08.29.05.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDP_EnrollmentGuidance_08.29.05.pdf).

The guidance further says that once he makes each of these elections he has used his election period and has no other election period unless, for some reason, he is eligible for a Special Enrollment Period (SEP). Reasons for having a SEP include--the loss of other creditable prescription drug coverage, a move to another region of the country, plan misrepresentation, Medicaid eligibility, or being admitted to, or discharged from, a skilled nursing facility.

Finally, beneficiaries who are dissatisfied with their Medicare Advantage plan may disenroll from that plan and enroll in a stand-alone Medicare drug plan or another Medicare Advantage plan with prescription drug benefits until June 30, 2006. If an individual first enrolls in a Medicare Advantage plan with a Medicare drug benefit, he/she must enroll in another Medicare Advantage plan with a drug benefit or may enroll in a stand-alone drug benefit. Medicare Advantage regulations allow beneficiaries who enroll in these plans to change enrollment once between January 1-June 30, 2006 and in 2007, between January 1-March 31.

*Confused or have questions about consumer's ability to switch plans? Contact The Center for help at [info@smpresource.org](mailto:info@smpresource.org)*