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2005 White House Conference on Aging: The Top Ten Resolutions

The White House Conference on Aging meets once every ten years to make policy recommendations to the President and Congress. The final report from the conference will be presented to the President and Congress by June 2006. The top ten resolutions, as decided by the delegates of the conference were:

1. Reauthorize the Older Americans Act Within the First Six Months Following the 2005 White House Conference on Aging
2. Develop a Coordinated, Comprehensive Long-Term Care Strategy by Supporting Public and Private Sector Initiatives that Address Financing, Choice, Quality, Service Delivery, and the Paid and Unpaid Workforce
3. Ensure that Older Americans Have Transportation Options to Retain Their Mobility and Independence
4. Strengthen and Improve the Medicaid Program for Seniors
5. Strengthen and Improve the Medicare Program
6. Support Geriatric Education and Training for All Health care Professionals, Paraprofessionals, Health Profession Students, and Direct Care Workers
7. Promote Innovative Models of Non-Institutional Long-Term Care
8. Improve Recognition, Assessment, and Treatment of Mental Illness and Depression Among Older Americans
9. Attain Adequate Numbers of Health care Personnel in All Professions Who are Skilled, Culturally Competent, and Specialized Geriatrics
10. Improve State and Local Based Integrated Delivery Systems to Meet 21st Century Needs of Seniors



The White House Conference on Aging convened December 11–14 in Washington, DC was the fifth in the WHCoA history

Question: How many doctors does it take to change a light bulb?

Answer: Three. One to find a bulb specialist. One to find a bulb installation specialist. And one to bill it all to Medicare.

For more information about the White House Conference on Aging

The Deficit Reduction Act of 2005: Working to Eliminate Medicaid Fraud, Waste and Abuse

With Medicare, Medicaid and Social Security spending growing faster than the economy, faster than the population and nearly three times the rate of inflation, President Bush signed into law the Deficit Reduction Act of 2005 (DRA) on February 8, 2006. The goal of the DRA is to slow the pace of spending growth in both Medicare and Medicaid. According to The Kaiser Commission on Medicaid and the Uninsured, "the Act is expected to generate \$39 billion in federal entitlement reductions over the 2006 to 2010 period and \$99 billion over the 2006 to 2015 period. The DRA also includes net reduction of \$4.8 billion over the next five years and \$26.1 billion over the next ten years from Medicaid." One way these reductions will be met in Medicaid is through programs and provisions to eliminate fraud, waste and abuse in Medicaid.

Eliminating Fraud, Waste and Abuse in Medicaid

The Deficit Reduction Act includes millions of dollars in funding and mandates to combat Medicaid fraud, waste and abuse. Included in the Act is a provision that establishes compliance programs by Medicaid providers, which the Centers for Medicare and Medicaid Services will provide oversight through its Medicaid Integrity Program (Section 6035 of the DRA).

Through the DRA, every entity that receives at least \$5 million in Medicaid payments per year is required to establish a fraud and abuse training program by January 1, 2007 for all its employees, agents and contractors.

The training program must include:

- detailed information concerning the Federal False Claims Act;
- federal administrative remedies for false claim statements;
- state laws pertaining to civil and criminal penalties for false claims and statements; and
- whistleblower protections under these laws.

Additional Efforts

There are also sections of the Act that were enacted in an effort to assist in the reduction of fraud, waste and abuse that will have a direct affect on Medicaid beneficiaries. Provisions related to premiums and cost sharing and benefits and asset transfers make up about half of the savings in the DRA and have the most significant implications for beneficiaries.

Premiums and Cost Sharing

The DRA allows for flexibility in cost sharing and benefits. Section 6041 of the Act authorizes a state to impose varied alternative Medicaid premiums and cost-sharing for different income groups of individuals, subject to specified limitations. According to a recent study by the Kaiser Family Foundation, for beneficiaries with family incomes over 150 percent of the federal poverty level, or \$24,900 for a family of three in 2006, states may charge unlimited premiums and may

Cost sharing includes co-payments, coinsurance, deductibles, and any other charge to enrollees on a per-receipt of benefit basis, regardless of who collects. (Premiums are enrollee charges not on a per-receipt of benefit basis and thus are not technically cost sharing.)

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charge co-payments up to 20 percent of the cost of medical services. Co-payment limits are set at 10 percent of the cost of the service for beneficiaries with incomes between 100 percent and 150 percent of the FPL.

Possible Implication of Cost Sharing

- The Congressional Budget Office predicts that 13 million low-income people, about a fifth of Medicaid beneficiaries would be affected by the cost sharing provisions by 2015 and would face new or higher co-payments for medical services like doctor's visits and hospital care.
- It is said that by 2010 about 13 million low-income people would have to pay more for prescription drugs. This number will rise to 20 million by 2015 (New York Times)
- Nine million (4.5 million children) would be faced with cost sharing for the first time and three million would face increased cost sharing amounts (Kaiser Family Foundation)
- About 13 million individuals would be affected by the provisions related to cost sharing for prescription drugs. (Kaiser Family Foundation)
- About 80 percent of the savings would be attributable to decreased utilization of services or prescription drugs and the rest would reflect lower payments to providers. (Kaiser Family Foundation)

Reform of Asset Transfer Relating to Long-Term Care (Section 6011)

Before a Medicaid beneficiary can become eligible for long-term care services, a minimum asset level of \$2,000 must be divested. Under current law, countable assets include savings accounts and investments but exclude the home, one car, life insurance with a face value of less than \$1,500 and certain other items. Also, if applicants transfer assets for amounts below fair market value within three years of applying for Medicaid nursing home care, they are subject to a delay in eligibility. These provisions are changing under the DRA.

The Kaiser Commission on Medicaid and the Uninsured found that Federal savings over the 2006 to 2015 period is attributable to increasing penalties on individuals who transfer assets for less than fair market value to qualify for nursing home care. The Reform to Asset Transfer Rules changes the current law by:

- Counting as assets some previously exempt financial instruments (such as certain annuities, promissory notes and mortgages).
- Lengthening the look-back period from the usual 36 months to 60 months for counting for eligibility purposed all income and assets disposed of by individuals for less than fair Market value.

Possible Implications of Reform of Asset Transfer

- Moving the start of the penalty period from the date of the asset transfer to the date of application for Medicaid would result in an average delay of 3 months for Medicaid eligibility for 130,000 recipients by 2015 (or 15 percent of new Medicaid nursing home beneficiaries annually).

Documentation Requirements

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One of the most controversial provisions within the DRA is Section 6037, Citizenship Documentation which "prohibits Medicaid assistance to an individual who declares he or she is a U.S. citizen unless one example of specified kinds of documentary evidence of citizenship or nationality is presented."

Beginning July 1, 2006, the DRA would require new applicants, as well as most current beneficiaries at re-application, to verify their citizenship through extra documentation such as a U.S. passport, birth certificate or driver's license from a state that verifies social security numbers.

During the March 28th Senate hearing on Medicaid fraud, Sen. Daniel Akaka of Hawaii made a plea to Sen. Tom Coburn, chair of the Subcommittee on Federal Financial Management, Government Information and International Security, to change this provision in the budget reconciliation act. Akaka said, "An estimated 3.2 to 4.6 million U.S.-born citizens may have their Medicaid coverage threatened simply because they do not have a passport or birth certificate readily available." Akaka added, "Many others will also have difficulty in securing these documents -- such as Native Americans born in home settings, Hurricane Katrina survivors and homeless individuals." In response to Sen. Akaka, Coburn insisted that he would like to hold a hearing regarding the documentation requirements within the next three to four months.

The Deficit Reduction Act is seen as an important step forward in controlling mandatory spending and reducing Medicaid fraud, waste and abuse, but also presents a unique set of challenges. As significant efforts are being made to protect the integrity of the Medicaid program, efforts must be made to ensure

Medicare Part D in the News

After a very rocky start in January and February, enrollment is in full swing and some of the major Part D problems appear to be improving. Michael Leavitt, Secretary of Health and Human Services emphasized the success of the Part D benefit in his third Progress Report on April 4, 2006. Mr. Leavitt noted high enrollment rates, lower than expected program costs and beneficiary cost savings.

Two new Senate bills have been developed to protect pharmacists by requiring reimbursement for Part D claims within 14 to 30 days. This is a response to complaints that pharmacists are financially strapped due to slow payment mechanisms.

CMS deputy administrator, Leslie Norwalk, responded to concerns about the upcoming May 15th enrollment deadline for recipients who have already turned 65. The deadline will NOT be extended for most beneficiaries, with the exception of beneficiaries who qualify for a low income subsidy. Ms. Norwalk commented that pushing back the deadline would "undermin[e] what Congress put into place."

Kaiser Family Foundation surveyed the opinions of 517 seniors, age 65 and older, between April 6th and April 11th. The survey found that only 55% of seniors know the deadline is May 15th, while 38% do not know the correct deadline and 6% believe there is no deadline. 53% know that there is a penalty of a 1% premium increase per month that they delay their Part D enrollment past the May 15th deadline. 47% of seniors surveyed are unaware that there is a penalty for late enrollment. These numbers could be cause for alarm as the first enrollment season comes to an end.

[Please see the Kaiser Daily Health Policy Report for April 18, 2006 and April 26, 2006 (kff.org) and the Progress Report (available on cms.gov) for more information.]

PHYSICIAN OUTREACH: HELPING DOCTORS HELP THEMSELVES AND THEIR PATIENTS

Fraud investigations are increasingly turning-up fraudulently established medical fronts (e.g. medical clinics, physician groups, laboratories, and durable medical equipment companies) set up by professional criminals. In addition, legitimate providers are ever more the targets of identity thieves, who seek their credentials and billing information in order to bilk Medicare and Medicaid for services that were never provided.



The vast majority of the medical community is made up of honest doctors who have a great deal of compassion for their patient's well-being and strive to provide the best medical care possible. SMPs can assist health care providers in protecting their profession's good name through partnerships, education, and resources – and providers can assist SMPs by reminding their patients of the importance of reviewing their MSN, and distributing SMP materials.

Resources That Will Help Physicians Help Their Patients Navigate Part D.

A formulary finder that provides an easy way to access each of the Medicare Part D plan's formularies at: <http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp>

PDP formulary information on the Epocrates website. This familiar medical software company provides both tier and step therapy information, is updated constantly, and can be easily accessed by computer or downloaded to a PDA at: www.epocrates.com

Medicare Prescription Drug Coverage Provider Communication—Request for Prescription Information or Change form is a general fax form to expedite communications between pharmacists and physicians. www.cms.hhs.gov/center/provider.asp

Clarification about Part B versus Part D drug coverage information and chart found at: www.cms.hhs.gov/pharmacy/downloads/partsbdcovrageissues.pdf

If patients forget the plan they joined or still need to select a plan, go to www.medicare.gov and select the personal plan finder. Enter their Medicare information. If they have joined, it will display the name of the plan. They can also call 1-800-MEDICARE (1-800-633-4227) to get help joining.

Dedicated help for physicians is available. E-mail PRIT@cms.hhs.gov or join the regular conference call at 2 pm EST every Tuesday. Call 1-800-619-2457. Pass code: RBDML.

For personalized assistance for people with Medicare, call 1-800-MEDICARE. Phone lines are open 24/7. For help on enrollment information physician's can encourage their patients to call 1-800-MEDICARE, go to www.medicare.gov to access the plan finder, or go to www.eldercare.gov to get information about local organizations that can help with personalized counseling. If patients have low incomes or limited assets and need additional financial help, encourage them to call the Social Security Administration at

1-800-
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or go

The Center is hosting a two-part webinar series on Provider Fraud, scheduled for June 6th and June 13th. Information regarding time and registration will be made available through the AoA listserv. For more information contact, Scott Cooley at scooley@smprsource.org.

AOA UPDATE

AoA is planning a National Summit to be conducted in Washington, DC the first week of December 2006. Participants will learn about the Assistant Secretary's vision for AoA programs and services for seniors. The National Health Care Fraud Control conference for Senior Medical Patrol grantees will be conducted in conjunction with the AoA Summit. More details will be available in the next issue of the Sentinel.

Medicaid and Prescription Drug Fraud

In the last several years, the Centers for Medicare and Medicaid Services and state Medicaid officials settled several prescription drug fraud claims against major pharmaceutical companies alleging that 1) these companies inflated the cost of drugs sold to Medicaid beneficiaries, 2) paid kickbacks to Medicaid HMOs; or 3) fraudulently agreed to reduce the price of drugs to nursing homes to obtain additional nursing home business.



An issue common to each of these cases is how the state Medicaid programs determine what is the "appropriate" price to pay for drugs. Indeed, we know that drug pricing is a mystery—a drug sold by a drug manufacturer may have multiple prices depending on the discounts or rebates given to both public and private purchasers.¹ The new Medicare Part D program has illustrated these price variations very well.

Indeed, Congress has weighed on this issue several times—most recently in the Medicare Prescription Drug Improvement and Modernization Act of 2003—to reform the payment system for drugs paid for under Medicare, Part B. This reform is intended to save Medicare dollars and to reduce the incidence of fraud in this area. Yet, most state Medicaid programs continue to pay for Medicaid-covered drugs based upon the "average wholesale price."

This article attempts to summarize the Medicaid drug pricing system and identify ways in which beneficiaries might identify fraud and abuse in this area.

Inside the "Black Box" of Drug Pricing: The AWP

Medicare and Medicaid have traditionally paid reimbursements to drug manufacturers based on a percentage of the "average wholesale price" (AWP).² The AWP is supposed to represent the average price at which wholesalers and drug manufacturers sell drugs to pharmacies, physicians, pharmacy benefit managers, and other purchasers. The AWP has been compared to the "sticker price" for an automobile.³ The AWP of brand and generic drugs is published by private companies, including First DataBank, (publishing the "Blue Book AWP"), and Thomson Medical Economics, (the "Red book").

¹"Average Wholesale Price for Prescription Drugs: Is there a More Appropriate Pricing Mechanism?" National Health Policy Forum Issue Brief, No. 775, June 7, 2002 at 2.

²42 U.S.C. §1395u(o)(1)(A) for drugs paid for by Part B;

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³Id. at 3.

Data about these published prices come directly from drug manufacturers and is not independently verified for accuracy. These prices also do not reflect “prompt payment” discounts, rebates or other price reductions, and do not represent the “real” price paid by most purchasers.

Over the past five years, the HHS Office of Inspector General has published numerous studies criticizing the use of AWP to pay for drugs under Medicare Part B and in state Medicaid programs.⁴ In 2003, Congress required CMS to use a different pricing structure for Part B drugs, based on actual “average sales price” data submitted directly by the manufacturer and must include volume discounts, prompt pay discounts, cash discounts, rebates, and other incentives to purchase prescription drugs.⁵ These changes, however, have not yet been applied to change the method of Medicaid payment for these drugs.

Medicaid Use of the AWP

All state Medicaid programs pay for prescription drugs for eligible beneficiaries, which is actually an optional benefit under federal law. CMS estimates that state Medicaid payments for drugs will top \$40 billion in 2005 and Medicaid will be the largest single purchaser for prescription drugs in the nation.⁶

Federal regulations requires state Medicaid programs to reimburse drug manufacturers the lower of (1) estimated acquisition cost plus a dispensing fee, or (2) the provider’s usual and customary charge to the public for the drug.⁷ Most states calculate the estimated acquisition cost by using a percentage of the AWP—from 50% to 95%.⁸ But because the AWP is comprised of manufacturer-reported prices, and does not include discounts, rebates or other price reductions, these prices often exceed those prices available to local retail pharmacists and are generally understood to be well-above prices paid by private large drug purchasers.

State Medicaid programs could save \$5.2 billion per year, according to Congressional Budget Office estimates by changing reimbursement formulas.⁹ The House Ways and Means Committee reports that, according to OIG estimates, Medicare beneficiaries paid more than \$177 million in inflated Part B co-payments due to excessive drug prices in 2000.¹⁰

Drug Manufacturers Paid Large Settlements for Fraud

Several drug manufacturers have settled charges that they inflated the AWP and/or encouraged managed care organizations to change the labeling of the drugs in order to charge a higher rate to state Medicaid programs.¹¹

⁴TAP Pharmaceuticals paid CMS \$875 million to resolve claims that the company illegally inflated the price of Lupron, a cancer drug covered by Medicare, to encourage doctors and pharmacists to submit false claims.

⁵Medicare Drug Modernization and Improvement Act, Section 303(Pub. L.108-173), 42 U.S.C. 1395w-3a.

⁶“*Drug Spending and the Average Wholesale Price: Removing the AWP Albatross from Medicaid’s Neck*,” Bureau of National Affairs (BNA), Health Care Policy Report, Vol. 13, No. 36 at 1. See: <http://healthcenter.bna.com>.

⁷42 CFR §447.331

⁸DHHS, Office of the Inspector General, “*Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price*,” June 2005, OEI-03-05-00200 at 2. Testimony of Dennis G. Smith, Director of the CMS Center for Medicaid and State Operations, Before the Senate Finance Committee, June 28, 2005. U.S. House of Representatives, Ways and Means Committee Report, February 26, 2004, at 1.

⁹*U.S. ex rel Ven-A-Care v. Bayer* (2001) \$14 million settlement for Bayer marketing of the “spread” to physicians and home health agencies and giving deep discounts to providers and billing higher price to Medicaid. *U.S. v. Schering Sales Corporation*, (E.D. Pa) August, 2004.

¹⁰*U.S. ex rel Couto v. Bayer* (2003) settlement of \$257 million to settle federal and state claims for private labeling of Cipro to avoid Medicaid best price obligations in sale to Kaiser Permanente; *U.S. ex rel Couto v GlaxoSmithKline*(2003) settlement of \$88 million for privately labeling of Paxil and Flonase to

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avoid Medicaid best price obligation in sale to Kaiser Permanente.

¹⁰U.S. House of Representatives, Ways and Means Committee Report, February 26, 2004, at 1.

¹¹U.S. ex rel Ven-A-Care v. Bayer (2001) \$14 million settlement for Bayer marketing of the “spread” to physicians and home health agencies and giving deep discounts to providers and billing higher price to Medicaid. U.S. v. Schering Sales Corporation, (E.D. Pa) August, 2004.

Some drug manufacturers advertised to doctors that if they administered drugs within their offices and took advantage of offered discounts that the doctors could “pocket” the difference between the actual price of the drugs sold to the provider and amount of Medicaid reimbursement for the drug. Still other drug manufacturers paid kickbacks to HMOs to encourage the HMO to continue to keep their drug on the formulary.¹²

Currently, state attorney generals in Alabama, California, Connecticut, Florida, Illinois, Kentucky, Massachusetts, Missouri, New York, Ohio, Pennsylvania and Wisconsin are pursuing claims against 19 drug companies to recoup Medicaid overpayments.¹³

Beneficiary Identification of Medicaid Rx Fraud

Would SMPs or beneficiaries ever be able to identify whether his/her drugs are overpriced or know if their doctors have an incentive to prescribe certain medications over others? Here are several thoughts about how a beneficiary might protect themselves and the Medicaid and Medicare programs from this kind of drug fraud:

- A beneficiary might overhear a discussion about a financial advantage to the doctor in using one drug over another.
- A physician might suddenly switch the patient to another drug without explanation.
- A beneficiary might be told by a managed care plan that they are being given another medication that is the “same as” the medication that they were taking but now has a different name.
- A doctor, or doctor’s staff member might tell a patient that the doctor gets a “better deal” by providing a particular drug to Medicaid beneficiaries.

Beneficiaries may be reluctant to talk to their doctor or health plan directly about these issues, but they may approach the SMP staff about their concerns.

Understanding the Medicaid fraud regarding the AWP and the prices of Medicaid drugs may assist you in raising this issue with your state Medicaid fraud control unit.

Survey Says:

According to a Washington Post – ABC News poll, among those who have enrolled in Medicare’s new prescription drug benefit, three-quarters said the paperwork was easy to complete and nearly two-thirds said the program saved them money.

Innovative Partnership Ideas: Reverse Boiler Room Interview with Scott Adkins...

A New Spin on an Old Idea

Scott Adkins, Director of the West Virginia SMP, has found a way to educate several thousand older adults in just a couple days. Mr. Adkins first learned about reverse boiler rooms while working as an attorney at the West Virginia Attorney General's Office. That office used the notorious telemarketing scam technique to educate West Virginians on general consumer protection issues.

The "boiler room," as recognized by law enforcement, is typically a rented space with rows of desks, telephones and experienced salespeople who cold-call potential fraud victims. Investment firms that operate these fraudulent operations hold mandatory sales meeting to demonstrate high pressure sales techniques and distribute mandatory scripts. The salespeople, who may be registered brokers, are strongly discouraged from doing any outside research on the investment opportunity. They often have very high quotas to fulfill and may be randomly taped to ensure that the salespeople are not withholding investment funds. The reverse boiler room turns this scheme on its head. It reverses the deceptive mission of the boiler room, with volunteer callers providing fraud prevention tips to senior citizens.

When Mr. Adkins came to the West Virginia SMP several years ago, he brought this idea with him, along with a partnership plan to make the reverse boiler room concept work. They have now done a few of these events, and have found them to be incredibly successful. One was on telemarketing fraud and another taught Medicare recipients how reading their summary notices can save them money.

Partnering Up

Verizon donated the phone lines for these events. Along with the phone lines, at least 100 volunteers were necessary manpower to make the calls. Mr.

Adkins was able to find most of these volunteers through his SMP project and through the local AARP chapter, which sponsors his SMP project. He noted that other projects without these volunteer resources might still find related aging network organizations with similar volunteer manpower to assist in the event.



The "boiler room," is typically a rented space with rows of desks, telephones and experienced salespeople who cold-call potential fraud victims.

The Fine-Tuned Machine: Organizational Details

The event was set up in several two hour sessions, with thirty minutes of volunteer training preceding each call session. During training, staff taught volunteers general event protocols, use of the script, and emphasized confidentiality issues inherent with calling Medicare recipients about their use of summary notices.

Callers announced that they were calling on behalf of the SMP and then asked the Medicare recipients if they read their notices. Volunteers were trained to explain how the person on the line could benefit from reading their notices. For example, callers explained that the summary notice included information on how much providers were permitted to charge for services that went over the amount covered by Medicare. When armed with this information, Medicare recipients can dispute provider bills that overcharge them for services rendered. Volunteers also were trained to ask permission to send the Medicare recipients more information on the SMP, including a refrigerator magnet with

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their phone number.

The West Virginia SHIP was another instrumental partner in this education effort. A few SHIP counselors were on hand for each call session. This resource allowed more complicated calls to be transferred directly to an experienced Medicare counselor or to that counselor's callback list for follow-up.

Reaping Rewards of Successful Partnerships

Mr. Adkins noted that the long lasting benefits of reverse boiler rooms are well worth the effort to set them up. It provides a rich publicity opportunity for the SMP and for all of the partners involved in the reverse boiler room project. The West Virginia SMP experienced a dramatic increase in calls after each event. He found that the media draw alone made the whole thing worth the effort. With effective partnering, costs can remain quite low for the SMP. Through partners, he brought together a sufficient number of volunteers, acquired necessary telephone services and even received free refreshments for the event. The major cost for this project was the hotel rate for reserving the conference room where Verizon set up the phone bank.

Information tracking is something that Mr. Adkins suggested would add something to this event. He emphasized that there are many confidentiality boundaries that SMP projects must respect, but through the use of partnerships, it is possible collect data on calls. For example, this idea has tremendous potential for reaching homebound adults. Under normal circumstances, it might not be appropriate to acquire information on the homebound status of Medicare recipients called. However, if one of the partners is the local meal delivery service, they might call their clients themselves and permit the project to code those calls as a hard to reach population that has been reached.

While planning partnerships for these large events, Mr. Adkins noted that it is particularly crucial to understand how relationships can be mutually beneficial. He found that the reverse boiler room is an easy idea to sell. There is great potential for publicity, both in the media and during the phone calls. Mr. Adkins said that any state or federal agency that deals with consumers are a

Understanding Language and Literacy

Unlike their predecessors, many who have immigrated to the United States within the last 25 years have settled in communities far from the traditional destinations of California, Florida and New York. Though, something that all immigrants share is the difficulty of learning to speak and read English.

English is more difficult than many languages to learn and takes most people many years to become fully proficient. Seniors of ethnic minority populations within the US may have difficulty with written English for many reasons:

- They use a different alphabet (e.g. Arabic, Hebrew, Russian)
- Their native language may be written with characters or pictures (Mandarin, Cantonese)
- Their language may be written from right to left (Arabic, Hebrew, Persian) or vertically (Chinese, Japanese) instead of left to right horizontally.

It's important to remember that many elder immigrants have not had the opportunity to complete formal schooling in their native language, which makes learning to read and write a second language, such as English, even more of a challenge. In an attempt to reach these underserved populations, SMPs may want to consider using alternate forms of communications, such as ethnic radio stations or community access television stations.

If your SMP program has had success with reaching ethnic and cultural minority or you would like to learn what other SMPs are doing to reach out to underserved populations visit the

NATIONAL VOLUNTEER WEEK

SMPs Mark Your Calendars! It is National Volunteer Week. This week is a great opportunity to reflect on and praise the people who are the lifeblood of the Senior Medicare Patrol Program...our volunteers!!! SMP volunteers give their time and expertise without expecting monetary compensation to implement the SMP message. Recognize and thank these wonderful people for their efforts. The following are some fun ideas on how to recognize your volunteers throughout the year. Have fun!

January: Distribute a list of celebrity alumni of your program. Scramble the names or develop an activity to place the names in fill-in-the-blanks, so members can learn more about these individuals. This activity could be included your program's newsletter.

February: Send a valentine to every volunteer who has helped you grow or had an impact on you or the organization. Send volunteers a package of hot cocoa mix to "warm them up" during the coldest month of the year.

March: Take a jar of jellybeans to each meeting. Let participants guess how many jellybeans are in the jar. (Plan the number of jellybeans to equal the number of volunteers in your program last year.) After the guessing contest, talk about the significance and value of that number of volunteers working in this program.

Have a drawing that includes all the volunteers who have attended training sessions this month (or during the past 3 months). Present a mug, gift certificate, or pen.

April: Deliver a packet of vegetable or flower seeds to a volunteer who has "Helped us grow." During National Volunteer Week, write a press release thanking volunteers (If possible, list names of all volunteers) for their service to this organization.

May: Deliver a May Basket filled with flowers and/or treats to volunteers. Send a virtual (no cost) greeting card and bouquet of flowers through the Internet.

June: Sponsor a potluck picnic for volunteers.

July: Send 4th of July "sparklers" to volunteers with a message: "You Light Up My Life!"

August: Develop a "Tip Your Hat to a Top Volunteer" recognition poster that is posted in a public place (ex. County fair, grocery store, local cafe or post it on your web site). This is similar to an Employee of the Month award. Rather than requiring a selection committee to review qualifications, draw a name from the list of all volunteers in the program. Talk to several people (co-volunteers) who work with that individual to list 5 reasons we should tip-our-hat-to-this-top-volunteer.

September: Print LOTS of volunteer accomplishments in the monthly newsletter.

October: Deliver a bag of peanuts to each volunteer, with a label: "We would be NUTS without you!"

November: For northern climates, make a winter survival kit for your volunteers. (Include candles, matches, a metal cup, snacks, hot packs, etc.)

Mentor Program Spotlight: New Jersey Healthcare Advocate Volunteer Effort

The Center's Mentor Program was developed in response to needs articulated by SMPs. It is designed to be an interactive method of learning to foster a system for individual SMP support, specifically through sharing program strategies, skills and successful practices while actively involving volunteers in the education of beneficiaries to combat fraud, waste and abuse in their communities.

Read what Charles Clarkson, has to say about his participation in the program!

"It was tailored learning. My time is precious and the mentors focused on what I needed to know."

Charles Clarkson, NJ HAVE Program Coordinator.

According to Charles, participation in the Mentor Program enabled him to:

- *Bounce ideas off other SMP project Directors so I would be ahead of the learning curve;*
- *Develop confidence and efficiency in my SMP project by emulating what other programs were doing;*
- *Identify the characteristics and skills of effective advisory committee members;*
- *Implement tips, ideas and best practices of successful SMP programs including: recruiting great volunteers, and selecting the best system for providing training and orientation for volunteers;*
- *Develop methods of evaluating the success and effectiveness of the volunteers;*
- *Determine skills and methods of forming community partnerships and identifying partners that I would not have thought of myself; and*
- *Design culturally appropriate training, materials and activities.*

Everyone benefits from sharing ideas through the mentor program.

While participation is voluntary, commitment is expected of all parties. The frequency of contacts is determined by the participants, but at least monthly contact is strongly suggested. Contact includes, but is not limited to, phone calls, email correspondence, meetings at conferences where mentor/protégé are attending, et cetera.

Everyone needs a colleague to lean on and that's what the Senior Medicare Patrol Mentor program is all about. For more information on the Senior Medicare Patrol Mentor Program, email Shirley Merner at smerner@smpresource.org.

Visit us on the web at 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.

All newsletter submissions and inquires should be directed to Candice Griffin at cgriffin@smpresource.org.

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HOW MAY WE HELP YOU!

Responding to technical assistance inquiries is one of the primary services provided by The Center. We receive dozens of inquiries monthly via our toll free technical assistance line and email-- from the simple: *How can I access material in The Center's resource library?*; to the complex: *Can you explain the Part D benefit?* Below you will find highlights from one of our inquiries.

Question:

"Is there a MEDIC in my region that I should be sending my Part D complaints to?"

Response:

The Centers for Medicare and Medicaid Services has contracted with private organizations, called Medicare Drug Integrity Contractors (MEDICs), to assist in the management of audit, oversight, and anti-fraud and abuse efforts in the Part D benefit. Some of the main functions include identifying and investigating potential Part D fraud and abuse, developing potential Part D fraud or abuse cases for referral to law enforcement agencies, and acting as a liaison to law enforcement agencies.

In the fall of 2005, CMS hired Health Integrity, LLC, formerly Delmarva Foundation, to act as the national contractor to investigate Part D benefit scams. Although CMS will announce other MEDICs, Health Integrity currently receive all reports of potential fraud, waste and abuse in the Part D program from SMPs.

All complaints submitted by SMPs should be submitted on the standard Harking Grantee Complaint Form (copies are on The Center's website in the Outcomes/Tracking section). Your form should clearly identify you as an SMP project. You MUST include specific beneficiary contact information or Health Integrity is not able to process nor investigate your complaint. Generic complaints or descriptions of issues occurring your area that can't be attributed to a specific complainant are not actionable from a law enforcement perspective-- there has to be a "witness" to the potential crime.

When communicating with staff from Health Integrity (or any of the future MEDICs), project staff should always clearly identify themselves as affiliated with the SMP program. This is to ensure that your project and the SMP program receive acknowledgement for complaints submitted.

For more information about Health Integrity visit them on the web at: www.healthintegrity.org.