

INSIDE THIS ISSUE:

AOA UPDATE	3
PART D UPDATE	4
HEALTH CARE FRAUD STATUTES	5
MEDIA OUTREACH	5
VOLUNTEER RECOGNITION	7
CMS'S PREVENTIVE HEALTH SCREENING	8
MY.MEDICARE.GOV	9
THE \$299 SCAM	10
PRODUCTS AND PRACTICES DISTINCTION	11
LIS ENROLLMENT INTERVENTIONS	12
JURY DUTY SCAM	13
NHCAA TRAINING CONFERENCE	13
GLAD YOU ASKED!	14

Mark you calendar!

The Choices for Independence: A National Leadership Summit, hosted by the US Administration on Aging, will be held in Washington, DC from December 5—6.

For information on registration, agenda and other helpful materials visit www.aoa.gov.

GEORGIA CARES CONNECTS

Developing a broad base of partners with a common mission can be an ephemeral concept, but Jennie Deese has pared it down to a science as the director of GeorgiaCares. The project, which houses a SHIP and a SMP, generally seeks to fund production of additional materials with outside grants.

During a recent conversation, Jennie volunteered many great partnership ideas that could inspire other SMP projects. Overall, GeorgiaCares maintains relationships with approximately 75 partners. Jennie takes a very practical approach to her philosophy about finding and maintaining partnerships. Here is how she does it!

Making Contact

Organization partners should be non-profits or for-profits who will benefit from a relationship with a SMP. It is the win-win relationship that can lead to lasting partnerships. While brainstorming potential partners, rely on the basics. Where do older adults play, pray, work? Grocery stores, pharmacies and Wal-Mart-type stores are other potential partners with excellent access to our target population. In big sports states like Georgia, university sports programs are yet another way to reach retired persons with an advertisement while they're enjoying a game.

Get in touch with state and federal legislators. Remember where your funding originates! The SMP program is



Meddi Carrie, GeorgiaCares's "talking peach", is one of the creative ways by which this SMP spreads the word about Medicare fraud, waste and abuse.

quite relevant for legislators as older adults make up a significant portion of their constituency.

Internet Searches

Look up particular companies through an internet search engine. Large company websites will often have an "About Us" section, which may include information about foundations and specific causes that they support. Website information could lead you to a contact person or to a small grant announcement.

Elevator Speech

The elevator speech, or palm speech, is the standard guideline for holding

GEORGIA CARES CONTINUED FROM PAGE 1

someone's attention before that person has concluded that he is interested. Create a one to two minute speech that includes basic points about the SMP mission and how a partnership might be mutually beneficial. This can be useful for cold calling potential partners or spontaneous meetings at community events.

Visibility and Follow Up

Visibility is important, both with regards to staying in potential partners' minds and maximizing product placement when developing partnerships. Any community based partner might be able to keep your brochures on a countertop. Some partners will also have access to discounted printing services.

Immediate follow up with contacts after meeting them could include a handwritten thank you note. Projects might also include new contacts in the next newsletter mailing. Handwritten notes are more effective than form letters. Ms. Deese also has plans to record the GeorgiaCares volunteer web training and make it available to all partners through their website.

Partnership Pitfalls

SMP projects should make their mission and intent for the partnership clear. Openness will allow for an honest analysis of a particular partner's "fit" and prevent misunderstandings down the road. For example, car dealerships may not have a common mission. Any SMP rules should be clear to the partner from the beginning. GeorgiaCares often uses a Memorandum of Understanding that was developed with legal advice. It makes it clear that the program is not open to putting outside logos on their products. Outside product endorsements, like specific health plans, are also not an option. Ms. Deese noted that her program is careful to list partners in alphabetical order rather than to give certain organizations top billing based on contributions. The Memorandum of Understanding also further assures both parties that either partner can end the relationship at will.

Dynamic Partnerships

Georgia Pharmacy Association: GeorgiaCares has a strong and multi-faceted relationship with this group. GeorgiaCares obtained small (unrelated) pharmaceutical grants to create large brown canvas medication bags for seniors. These are distributed at Pharmacy Association "Brown Bag" senior events where older adults are encouraged to bring their set of personal medications to talk over potential contraindications with pharmacists. The presence of the pharmacists is organized at no charge to GeorgiaCares. The association has also coordinated with pharmacy schools and GeorgiaCares so that pharmacy students can fulfill volunteer service hours by answering hotline questions about medications for the SMP/SHIP. This was particularly helpful during the Medicare Part D open enrollment.

Kroger Grocery: This local grocery store paid for brochure printing costs and currently displays the GeorgiaCares brochure. They also do announcements over their PA system which explain that shoppers should "Call GeorgiaCares if you have questions about Medicare" and include the program's 1-800 number.

WSB-TV Channel 2: This television channel included GeorgiaCares in their Family2Family partnership, which also included members such as a large local furniture chain and AirTran. Some of the fruits of this relationship were apparent when the furniture chain began displaying GeorgiaCares brochures. The channel covered printing costs for these additional brochures.

GEORGIA CARES CONTINUED FROM PAGE 2

Rural Health Association: This group invited GeorgiaCares to the Georgia Capitol Building on Valentine's Day, when the SMP/SHIP handed out cards with candies and contact information. They were contacted by state congressmen following the event.

Meals on Wheels and Association of Home Health Care: These organizations distributed GeorgiaCares brochures to homebound older adults.

Parent Teacher Association: After considering the situations of many grandparents raising grandchildren, GeorgiaCares has connected with the PTA, as well as several small pharmaceutical company/association grants. Together, they have developed and started to produce a coloring book for young school children with information for their grandparents on the bottoms of the pages. Information includes: preventative health care, eating healthy, eye care, and health care scams.

AOA UPDATE: SMART FACTS IS COMING!

“How can we capture and report the activities of our SMP project more effectively?” “Is it possible for the semi-annual performance reporting process to be streamlined and automated?” “How can we improve the consistency and quality of SMP complaint management and referrals?” These are good questions, which have been discussed at regional SMP conferences, Stakeholder meetings and SMP program conference calls. The answer to all is a resounding “Yes—SMART FACTS is coming!”



Since March 2006, AoA and the Center have been working closely with the SMART FACTS contractor, Bearing Point, Inc. and the subcontractor, Social Solutions, Inc., in the development of a new web-based SMP complaint management, tracking and reporting system, dubbed “SMART FACTS”. A subcommittee of the SMP Stakeholders Committee has played an important role in providing feedback and inputs into the system's development and testing at key points. SMART FACTS' core function is capturing information on consumer inquiries and complaints received and actions taken by the project. In addition, the system is being designed to allow SMP's to capture project activities, including outreach, education and volunteer management. The system will be designed to provide guidance to users to enable greater consistency in decisions made on investigations or referrals of issues received. The system will allow automation of data collection for semiannual performance reporting and other purposes.

System development work is progressing very well, and an initial roll-out of the system is planned for fall of this year. SMP training on SMART FACTS—via webinars, conference calls, and on-site sessions at the December SMP meeting--will be an integral part of the implementation process. We are excited about the potential the system holds for strengthening the SMP program and for enabling us to capture and share all the great work of the projects! Stay tuned!

Barbara Dieker
Director, Office of Consumer Choice and Protection

MEDICARE PART D SUMMER UPDATE

The six month mark for the Medicare Part D Prescription Plans has come and gone. During the lull before the next open enrollment period, journalists, legislators, and researchers are taking stock of the program's performance. There are some continuing systems issues, perspectives on program complaints, and analysis of a potential windfall to pharmaceutical companies.

Part D plan customer service has been in the spotlight lately. Cynthia Tudor, a senior Medicare official, sent a memorandum to insurers last month that noted the 1-800-MEDICARE line "has been receiving a large number of urgent requests from beneficiaries who are enrolled" in Part D plans. Robert Pear of the New York Times reported Ms. Tudor had explained that "[t]hese urgent requests generally mean that the beneficiary is in immediate need of a medication refill." Mr. Pear noted that Ms. Tudor felt it necessary to remind insurers several times of their "obligation to resolve [member] complaints," as well as to avoid referring beneficiaries to 1-800 MEDICARE for questions about their specific plans or for plan-related complaints. Mr. Pear also pointed out that by not subscribing to these Federal standards, plans might risk up to \$100,000 fines from CMS. (Pear, NY TIMES 6/25/06)



The Government Accountability Office announced findings from a recent Part D customer service investigation. They found "that Medicare prescription drug plans generally provided incomplete and inaccurate information to callers who asked questions about the new benefit." This was a large scale investigation, with 900 calls placed to ten of the largest Part D plans. 864 of the 900 went through to a customer service representative. 22% of the 864 responses were inaccurate, 29% were incomplete and no answers were provided to the other questions. Two of these ten large companies provided incomplete or inaccurate information 75% of the time. These incorrect answers included important information such as premiums and the total cost of the plan. (Pear, NY TIMES 7/11/06)

At the same time, Dr. Mark McClellan, Administrator of the Centers for Medicare and Medicaid Services (CMS), announced "We have a pretty low rate of complaints, 2.2 per 1,000 beneficiaries in prescription drug plans, and inaccurate information has not been a major reason for complaints." (Pear 7/11/06) In a follow up press release on Jul 19th, CMS announced that they had received an average of 2.3 complaints per 1,000 beneficiaries enrolled in Part D plans. The average was a little higher at 2.6/1,000 for stand-alone prescription drug plans and lower for Medicare Advantage beneficiaries at 1.4/1,000. It is interesting to note that these data are based on a reporting mechanism that eliminates any plan with fewer than 1,200 enrollees. The highest complaint rates for stand alone plans were 6.2/1,000 at CIGNA and 6.3/1,000 at Sterling Insurance Group.

Milt Freudenheim of the New York Times reported that analysts are calling the inclusion of automatically enrolled dual eligibles a windfall for the pharmaceutical industry. The windfall is a result of the decision Congress made to bar "the government from having a negotiating role" in drug prices for the Part D plans. "Instead, prices are worked out between drug makers and the dozens of large and small Part D drug plans run by commercial insurers." The taxpayer will foot the bill for dual eligibles whether their drugs are funded through Medicare or Medicaid. However, in switching from Medicaid to Medicare Part D, the "best price" requirement is lost. This could generate up to a \$2 billion windfall. Mr. Freudenheim notes that "Congress may eventually impose spending ceilings" for these plans, but for now, covering the low income older adults is looking "rather lucrative". (Freudenheim NY TIMES 7/18/06)

PRIMER ON HEALTH CARE FRAUD STATUTES—PART I

Several important statutes form the basis for many health care fraud prosecutions: the False Claims Act, 31 USCA §3729-33, the Anti-Kickback Statute, 42 USCA §1320a-7b and the Stark Amendments. It is important to understand these laws and how they are applied in a wide variety of health care cases, including Medicare and Medicaid. This article will provide some background on the False Claims Act; future articles will cover the Anti-Kickback statute, the Stark amendments and other fraud laws.

Medicare/Medicaid False Claims Statute—Criminal Penalties

The Medicare/Medicaid False Claims statute, 1128B of the Social Security Act, 42 USCA 1320a-7b, imposes criminal penalties against anyone who “knowingly or willfully makes or causes to be made any false statement or representation of a material fact in an application for any benefit or payment” or has any “knowledge of the occurrence of any event affecting... the right to any such benefit or payment... with the intent fraudulently to secure a benefit...” under the Medicare, Medicaid, the Maternal and Child Health Services Block Grant or Title 20, the Social Services Block Grant Act. 42 USCA 2001 *et seq.*

The Civil Monetary Penalties section of the statute may impose penalties of up to \$10,000 for each false claim, award triple damages and exclude an individual from the Medicare and Medicaid programs. 42 USCA 1320a-7a.

Original False Claims Act—Civil Penalties

A second tool to prosecute false healthcare claims is the “original” False Claims Act, 31 USCA §3729-33, passed in March, 1863 to address Congress’ outrage following a delivery of boxes of ammunition and rifles to Union troops that contained only sawdust. In a nutshell, this False Claims Act creates civil penalties against any person who knowingly presents a false or fraudulent claim for payment or approval; uses a false record or statement to get a false or fraudulent claim paid or approved by the Government; or conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

Civil penalties must be at least \$5,500 and not more than \$11,000 plus triple damages that the Government sustains because of the act of that person. Because courts have allowed penalties to be assessed for *each* claim that is filed fraudulently, it is not uncommon for False Claim Act penalties to accrue into thousands, even millions, of dollars. Additionally, the False Claims defines, “knowingly” broadly to include a person with

Continued on page 6

Media Outreach

Need help in your media outreach efforts? Visit The Center’s website. There you will find a series of articles that contain helpful information to help your program increase visibility through successful media outreach efforts. Topics include:

- * An Introduction to Media Outreach
- * Interview Tips
- * Media Advisories and Press Releases
- * Letters to the Editor and Op-Ed Pieces

To view these helpful resources visit The Center’s website at www.smpresource.org.

HEALTH CARE FRAUD STATUTES CONTINUED FROM PAGE 5

actual knowledge of the fraud, who acts in deliberate ignorance or the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. *No proof of specific intent to defraud is required.*

In addition to the imposition of monetary penalties, the Office of the Inspector General (OIG) is authorized to exclude providers that violate the False Claims Act from participation in Medicare and other Federal health care programs, as was the case when several California providers were excluded from billing Medicare following a complaint submitted by the state's SMP. Criminal convictions trigger a mandatory exclusion. According to the OIG, they may elect not to exclude a health care provider in the event only civil convictions occur. This is often the case when the best interest of the program or beneficiaries are served by allowing continued participation in the program. Though, the OIG generally requires that providers adopt specific measures to better ensure their integrity. These measures are set forth in a corporate, institutional or individual integrity agreement (collectively referred to as a CIA).



Several important statutes form the basis for many health care fraud prosecutions.

Consistent with the United States Sentencing Commission's "Federal Sentencing Guidelines Manual," the CIA contains the seven core elements of an effective compliance program. In addition, the OIG generally requires the submission of periodic reports concerning the provider's compliance efforts and reserves the right to impose sanctions for a material breach of the CIA. While CIAs almost always include these basic elements, the specific terms of a provider's CIA are subject to extensive negotiations. Among the relevant factors considered in crafting a specific CIA are the severity and extent of the underlying misconduct, the provider's existing compliance infrastructure and the resources available for such efforts. To learn more about CIAs or view a list of health care providers and entities currently subject to CIAs with the OIG, visit: <http://oig.hhs.gov/fraud/cias.html>¹

The statute also allows any individual, called a "relator," to assert a claim on behalf of the Government against anyone who the individual believes has filed a false claim. This individual action, known as a "qui tam" lawsuit, allows the relator to recover up to 25% of the proceeds of the action or settlement of the claim in which the government has chosen to intervene; 30% of any recovery if the government chooses not to intervene.

In addition to these specific laws regarding false claims, the Department of Justice often utilizes other criminal statutes including "wire fraud" (for sending fraudulent claims through the mail), racketeering, conspiracy charges, as well as a myriad of other laws regarding the Medicare and Medicaid programs.²

Recent examples of False Claims Act convictions include:

Tenet Hospital Corp. agreed to pay more than \$900 million to settle charges that it "upcoded" hospital billing claims to increase reimbursements, paying kickbacks to physicians for referral of patients and for claiming additional patient days as "outliers" to increase Medicare hospital reimbursement.³

NY Ophthalmologist agreed to pay \$1,015,817 to settle false claim charges that he billed Medicare for

HEALTH CARE FRAUD STATUES CONTINUED FROM PAGE 6

ophthalmologist services that were never provided to residents of adult care homes in New York and Long Island.⁴

Health South Corp agreed, or was ordered to pay \$327 million to settle false claim allegations for outpatient physical therapy services that were not properly supported by certified plans of care, overbilling Medicare on hospital cost reports and home office cost statements.⁵

Gambro Healthcare agreed to pay \$310 million to settle charges of false claims for providing home dialysis patients with equipment and supplies through a sham durable medical equipment company to increase Medicare reimbursement, billing for phantom supplies, billing for ancillary medications and services that were not medically necessary—a requirement for Medicare reimbursement.⁶

For more information about the Federal False Claims Act and its *qui tam* provisions, including a list of recent settlements, visit: <http://www.taf.org>.

¹Health and Human Services Office of the Inspector General, See: <http://oig.hhs.gov/fraud/cias.html>

²Title 18 of the United State Code entitled “Crimes and Criminal Procedure” contains numerous provisions that are used to impose criminal penalties, including Conspiracy to Defraud the United States Government, 18 USCA §286, imposes criminal penalties for conspiracy to file false claims; False and Fictitious or Fraudulent Claims, 18 USCA §287; Conspiracy to Commit Offense or Defraud, 18 USCA §371; Contractors, Bonds, Bids and Public Records, 18 USCA §494; Contracts, Deeds, and Powers of Attorney, 18 USCA 495; Statements or Entries Generally, 18 USCA 1001; Possession of False Papers to Defraud the United States, 18 USCA 1002; Mail Fraud, 18 USCA 1341; Racketeer Influenced and Corrupt Organizations (RICO), 18 USCA 1018, Obstruction of Proceedings Before Departments, Agencies and Committee, 18 USCA 1505.

³Department of Justice press release, June 29, 2006, see: http://www.usdoj.gov/opa/pr/2006/June/06_civ_406.html

⁴Department of Justice press release, March 1, 22006, See: http://newyork.fbi.gov/dojpressrel/pressrel06/medicare_fraud030106.htm

⁵Department of Justice press release, November 7, 2005. See: http://www.usdoj.gov/opa/pr/2005/November/05_civ_595.html

⁶*Id.*

“AND I QUOTE...”

Volunteer recruitment and management is an important function within the SMP program. Without the hard work of volunteers it would be difficult to spread the message of the program. There are a number of ways SMPs can acknowledge the work of volunteers: newsletters, award ceremonies, and so on. If you dedicate a section of your newsletter to your volunteers or even have a newsletter just for your volunteers here are just a few quotes you can include to show your support and appreciation for the work they do on behalf of you and your staff.

The purpose of human life is to serve and to show compassion and the will to help others.

--Albert Schweitzer

This is our special duty, that if anyone specially needs our help, we should give him such help to the utmost of our power.

--Cicero

Just as the wave cannot exist for itself, but is ever a part of the heaving surface of the ocean, so must I never live my life for itself, but always in the experience which is going on around me. It is an uncomfortable doctrine which the true ethics whisper into my ear: You are happy, they say therefore you are called upon to give much.

--Albert Schweitzer

QUOTES CONTINUED FROM PAGE 7

You have not done enough, you have never done enough, so long as it is still possible that you have something to contribute.
--Dag Hammarskjöld

Life is mostly froth and bubble, Two things stand like stone, kindness in another's trouble, courage in your own.
--Adam Lindsay Gordon, "Ye Wearie Wayfarer" 1833-1870

To keep a lamp burning we have to keep putting oil in it.
--Mother Teresa

Wisdom is the power that enables us to use knowledge for the benefit of ourselves and others.
--Thomas J. Watson

We are rich only through what we give, and poor only through what we refuse.
--Anne-Sophie Swetchine 1869

A volunteer is a person who can see what others cannot see; who can feel what most do not feel. Often, such gifted persons do not think of themselves as volunteers, but as citizens - citizens in the fullest sense: partners in civilization.
--George Herbert Walker Bush

I've come to believe that each of us has a personal calling that's as unique as a fingerprint - and that the best way to succeed is to discover what you love and then find a way to offer it to others in the form of service, working hard, and also allowing the energy of the universe to lead you.
--Oprah Winfrey



Remember, using quotes is just one of the quick, easy and meaningful ways you can express your appreciation for your volunteers. And you can quote me on this...

THE CENTERS FOR MEDICARE & MEDICAID SERVICES'S NEW FOCUS: PREVENTIVE HEALTH SCREENINGS

The Centers for Medicare & Medicaid Services is shifting its focus from enrolling Medicare beneficiaries in the new Part D prescription drug benefit to ensuring that the 41 million people with Medicare take advantage of preventive services, CMS Administrator Mark B. McClellan said during a meeting earlier this year.

During a meeting with CMS's Advisory Panel on Medicare Education, McClellan went on to say that CMS and its partners have worked to close the "benefit gap" but have yet to close the "prevention gap" in health care. To close this gap, CMS wants to use the partnerships it develops with advocacy, volunteer and other groups nationwide for enrollment outreach. "What we are looking to do now is turn some of that same extensive network and cooperation into an effort to help people use the new benefits in Medicare," he said.

PREVENTIVE HEALTH CONTINUED FROM PAGE 8

Thanks to the passage of the MMA, millions of people with Medicare will be able to live longer, healthier lives through the utilization of new preventive services that became effective January 1, 2005. CMS hopes that by putting resources into prevention, early diagnosis, complication reduction and savings in Medicare funds will be the end result.

With SMPs being a vital point of contact for a number of Medicare beneficiaries, it is possible that you might receive a question about this new benefit. For more specific information about these benefits and other Medicare preventive services, get a free copy of the Guide to Medicare's Preventive Services (CMS Pub. No. 10110) at www.medicare.gov on the web when you select "Publications." For more information, beneficiaries can call 1-800-MEDICARE to receive a rundown of benefits along with recommendations based on their personal characteristics.

MY.MEDICARE.GOV

The Centers for Medicare & Medicaid Service now offers beneficiaries and their caregivers a free, secure online service that allows them to access Medicare information. Registered users will have access to personalized information regarding Medicare benefits and services. My.Medicare.gov can be used to:

- * View claim status (excluding Part D claims),
- * Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card,
- * View eligibility, entitlement and preventive services information,
- * View enrollment information including prescription drug plans,
- * View or modify your drug list and pharmacy information,
- * View address of record with Medicare and Part B deductible status, and
- * Access online forms, publications and messages sent to you by CMS.

In light of the decision made by CMS this summer to transition to quarterly Medicare Summary Notices (MSNs), My.Medicare.Gov holds promise as a tool to help seniors better track their claims in real time. Sallie Richardson with the Utah SMP has created a simple new flyer that she distributes to consumers describing the sign up process for online access (visit The Center's online resource center for a copy). "I hope that everyone is encouraging beneficiaries and caregivers to join My.Medicare.Gov. This will eliminate [some of] the frustration of not receiving the MSN monthly by mail. Agencies can encourage their beneficiaries to join so that they can access information without having to [gather] all their MSNs when we are investigating billings. They will also be able to watch their deductibles info and other Medicare info that will be very valuable. I am encouraged."

Beneficiaries can register by visiting <http://my.Medicare.gov>.

OUTREACH TO UNDERSERVED POPULATIONS: THE \$299 SCAM

It's called the "\$299 Scam," named for the amount of money high-pressure scammers talk seniors, the disabled and immigrants into withdrawing from their checking accounts to pay for a non-existent prescription drug plan. It's the latest scam to take advantage of the confusion surrounding the Medicare Part D drug benefit that took effect January 1.

The "M-O" is usually the same: scammers try to talk Medicare beneficiaries into revealing their Medicare number and other sensitive information. They are then charged \$299 as a "one time fee" to maintain the phony coverage. In some variations of the scheme, victims are offered advice on making drug plan decisions for an additional fee. Reports have come in from across the country about the original \$299 scam, as well as newer variations. According to Janay Haas in Oregon, the effects of "inflation" have increased the asking price for these offerings, up to as much as \$389. In the latest variations of the scam, seniors are being told that the Iraq war has depleted the Medicare trust fund and in order to maintain their coverage they need to pay for an additional plan.



In some variations of the \$299 scam, seniors are being told that the Iraq war has depleted the Medicare trust fund.

Authorities have cautioned consumers to be alert when dealing with any company offering Medicare drug coverage, and say there are some red flags that usually signal the pitch is a scam:

- Legitimate Medicare drug plans will not ask for payment over the telephone or the Internet;
- No Medicare drug plan can ask a person with Medicare for bank account or other personal information over the telephone;
- Legitimate drug plans won't offer "free" physical exams or try to sell you medical appliances or equipment. Callers generally ask for bank account or credit card information, and in one instance were bold enough as to call back when a beneficiary closed their bank account to prevent the withdrawal. The callers generally provide a toll free number, that goes unanswered or has extremely long hold times.

The Center has completed translation of one of the \$299 scam flyers produced earlier this year into several languages (Russian, Korean, Vietnamese, Simplified Chinese and Spanish). Please log onto the resource library and download copies or contact us at info@smpresource.org for assistance in locating resources.

Survey Says

More than eight in ten seniors who are enrolled in a Medicare Part D drug plan are satisfied with their plan, although almost two in ten say they encountered a major problem in using it, according to the latest Kaiser Foundation [tracking survey](#) of seniors' experience under the new Medicare drug benefit.

The 2006 Products and Practices of Distinction

The Center's third annual call for Products and Practices of Distinction produced a collection of outstanding submissions that SMPs are using to empower healthcare beneficiaries. With this round, eighteen proposals were submitted making this year's selection process more difficult than ever. The submissions have been reviewed and now The Center is pleased to announce this year's recipients of the Products and Practices of Distinction. To learn more about these products and practices and to view the Honorable Mentions visit www.smpresource.org!



Oregon Seniors and People with Disabilities (Aileen Kaye and Janay Haas)

Submission: Caregivers Training

For this practice, the Oregon SMP partnered local organizations to provide 36 training sessions in 18 Oregon cities. The training, called, "Helping Caregivers Fight Fraud and Abuse" included an audience of paid home care workers, home health agency staff, adult foster home staff, family caregivers, respite caregivers, SHIBA volunteers, and law enforcement officers. Trainees receive a manual and a "goodie bag" full of consumer protection information to take back to the Medicare/Medicaid beneficiaries for whom they provide care and a training certificate. Incentives to attract trainees included day and evening sessions, local training locations, a simple toll-free registration process, refreshments, and training credits where appropriate.



Operation Restore Trust of Iowa (Sherry Jaeger)

Submission: Wall and Desk Calendar

For this product, the Iowa SMP designed a wall and desk calendar. The desktop calendar was disseminated to healthcare professionals, policy makers, law enforcement and the media to act as a reminder of the SMP message. In a coordinated effort with the Iowa Housing Authority, the wall calendar was given to Medicare and Medicaid beneficiaries living in low-income housing.



Minnesota Board on Aging/Senior LinkAge Line (Jacqueline Bruno Peichel)

Submission: Senior LinkAge Line Playing Cards

For this product, the Minnesota SMP created an innovative product to provide 52 tips to prevent health care fraud, abuse and errors. Printing a fraud message on the face of each card exposes players to several messages every hand played. Each card contains the Senior LinkAge Line 800 telephone number for anyone looking to respond to a message on a card.

NCOA FUNDED TO TEST LOW-INCOME SUBSIDY ENROLLMENT INTERVENTIONS

In testimony June 14th before the House Ways and Means Committee concerning Medicare prescription drug implementation, the National Council on Aging (NCOA) called for a targeted national strategy to reach out and enroll the over 3 million beneficiaries in greatest need who are eligible for the low-income subsidy (LIS), and comprise up to 75 percent of those who still do not have drug coverage. According to an NCOA press release, NCOA estimates that at least 150,000 people who applied for the LIS and were denied coverage would actually qualify for LIS if they applied instead for a Medicare Savings Program. This is because eight states (AL, AZ, DE, ME, MS, and VT) do not have any asset test for one or more categories of the Medicare Savings Program and MSP-eligible beneficiaries are deemed eligible for LIS.

NCOA also called on Congress to eliminate the asset test as a condition of LIS eligibility, saying that more than half of the applications rejected were ineligible because they failed to meet that test. NCOA received a grant earlier this year from CMS and other public and private entities to study the use of list-driven interventions to identify and enroll eligible beneficiaries in the Medicare Prescription Drug Benefit. The CMS grant, entitled “Cost-Effective and Scalable Strategies for Enrolling Medicare Beneficiaries in Medicare Prescription Drug Extra Help,” is part of a private-public partnerships to support a five-year strategy of identifying and enrolling eligible beneficiaries through a series of tailored, list-driven intervention approaches already known to be effective in Low Income Subsidy (LIS) enrollment. NCOA is partnering with Benefits Data Trust (BDT) to lead this list-driven intervention research project. NCOA has already received private funds which they plan to award through grants to support test interventions for the proposed study. NCOA expects to test 24-30 intervention approaches over the five-year period.

The NCOA team is coordinating with CMS to accomplish two objectives critical to the success of the interventions. First, the project will facilitate an ongoing partnership between NCOA and CMS to refine marketing lists by identifying beneficiaries already enrolled in the Medicare Part D LIS or Medicaid. This will allow BDT to create the “cleanest” list possible of potential LIS-eligibles. BDT reported that use of similarly refined lists for outreach efforts to low-income populations has increased the enrollment success rate, and decreased the cost of enrollment.

Second, NCOA will use CMS funding to evaluate alternative, list-based outreach strategies. NCOA intends to partner with L&M Policy Research for the evaluation of intervention approaches. In addition, NCOA will rely on Bridgespan to be an advisor for cost-effectiveness studies. Evaluation of these approaches could supplement existing market research knowledge, and be useful for quality improvement of ongoing and future beneficiary outreach efforts for LIS.

In related news, the Social Security Administration mailed a notice in June to 500,000 beneficiaries whom they determined may be eligible for the Low Income Subsidy (LIS) but have not yet applied. In the letter SSA urges the beneficiaries to act now to find out if they qualify for extra help with their prescription drug costs.

For further information about the CMS grant to NCOA contact: Susie Butler, CMS, at (410) 786-7211.

WARNING ISSUED ON JURY DUTY SCAM

The Georgia Department of Human Resources Division of Aging Services is warning the public about a scam involving jury duty.

Callers pretending to be court officials such as court clerks, jury coordinators or judges' secretaries claim an arrest warrant has been issued because the person called didn't show up for jury duty.

When the person denies getting a summons, the caller asks for the person's Social Security number and date of birth to "verify" the information and cancel the arrest warrant. Sometimes callers ask for credit card numbers.

The scam has been reported in 11 states, including Georgia. The FBI and federal court system have issued nationwide alerts on their Web sites, warning consumers about the fraud.

If someone calls about missing a jury summons, follow up with the court directly. Anyone who has given out personal data should contact the three credit bureaus to put a fraud alert on their accounts and file a complaint with the Federal Trade Commission, www.ftc.gov. Also notify the court about the call.

For an educational presentation on consumer fraud, contact your local Area Agency on Aging. For assistance, call 404-657-5319.

(As reported in the Atlanta Journal-Constitution on 7/20/2006)



The NHCAA Institute for Health Care Fraud Prevention is holding its 2006 Annual Training Conference November 14—17 in Marco Island, Florida.

Featured speakers include:

- * Daniel R. Levinson
Inspector General, Office of Inspector General, U.S. Department of Health and Human Services
- * Brian Flood
Inspector General, Texas Health and human Services Commission
- * Commander Scott Waddle
U.S. Navy (Ret.)

The conference also includes five educational tracks intended to assist the participant in selecting workshops that addresses your specific area of interest. For more information about the training conference or to register visit them on the web at www.nhcaa.org. Please note that early registration ends October 6th!

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THE NATIONAL CONSUMER
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For more information about the National Consumer Protection Technical Resource Center, please visit us at www.smpresource.org.

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GLAD YOU ASKED!

Question: If a beneficiary is unhappy about having their Social Security number appear on their Medicare card [or insurance care], what can they do?

At the present, Congress is pursuing appropriations to implement a plan that would require The Centers for Medicare & Medicaid Services to remove Social Security numbers from Medicare cards in order to reduce the risk of identity theft. This effort, headed by Senator Dick Durbin, has resulted in CMS preparing a report outlining their plan for expeditiously changing the numerical identifier used to identify Medicare beneficiaries.

Until CMS removes Social Security numbers from Medicare cards, beneficiaries can make a photocopy of their Medicare card and take a black marker and cross out the last 4 numbers of their Social Security number. That way, if their wallet is ever lost or stolen, no one would be able to obtain the full SSN thereby reducing the risk of new-account fraud.

Another option for both beneficiaries and SMPs is to contact your Senators and Congressional representatives and tell them that you oppose the use of Social Security numbers on the Medicare cards. At the state level, you can contact your state legislative representative and tell them that you favor a law similar to that in California that restricts the display and posting of Social Security numbers. For more information about this Social Security Confidentiality law, visit www.privacy.ca.gov/recommendations/ssnrecommendations.pdf.

Have question or concern, contact The Center for help at info@smpresource.org