



NEWSLETTER



DEPARTMENTS OF JUSTICE AND HEALTH AND HUMAN SERVICES ANNOUNCE RECORD-BREAKING RECOVERIES RESULTING FROM JOINT EFFORTS TO COMBAT HEALTH CARE FRAUD

FOR IMMEDIATE RELEASE
 Contact: HHS Press Office
 February 11, 2013

Government Teams Recovered \$4.2 Billion in FY 2012

WASHINGTON – Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius today released a new report showing that for every dollar spent on health care-related fraud and abuse investigations in the last three years, the government recovered \$7.90. This is the highest three-year average return on investment in the 16-year history of the Health Care Fraud and Abuse (HCFAC) Program.

The government’s health care fraud prevention and enforcement efforts recovered a record \$4.2 billion in taxpayer dollars in Fiscal Year (FY) 2012, up from nearly \$4.1 billion in FY 2011, from individuals and companies who attempted to defraud federal health programs serving seniors and taxpayers or who sought payments to which they were not entitled. Over the last four years, the administration’s enforcement efforts have recovered \$14.9 billion, up from \$6.7 billion over the prior four-year period. Since 1997, the HCFAC Program has returned more than \$23 billion to the Medicare Trust Funds.

These findings, released today in the annual HCFAC Program report, are a result of President Obama making the elimination of fraud, waste and abuse, particularly in health care, a top priority for the administration.

The success of this joint Department of Justice and HHS effort was made possible by the Health Care Fraud Prevention and Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste and abuse in the Medicare and Medicaid programs and to crack down on individuals and entities that are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with new tools and resources provided by the Affordable Care Act.

“This was a record-breaking year for the Departments of Justice and Health and Human Services in our collaborative effort to crack down on health care fraud and protect valuable taxpayer dollars,” said Attorney General Holder. “In the past fiscal year, our relentless pursuit of health care fraud resulted in the disruption of an array of sophisticated fraud schemes and the recovery of more taxpayer dollars than ever before. This report demonstrates our serious commitment to prosecuting health care fraud and safeguarding our world-class health care programs from abuse.”

“Our historic effort to take on the criminals who steal from Medicare and Medicaid is paying off: We are gaining the upper hand in our fight against health care fraud,” said Secretary Sebelius. “This fight against fraud strengthens the integrity of our health care programs and helps us fulfill our commitment to our seniors.”

About \$4.2 billion stolen or otherwise improperly obtained from federal health care programs was recovered and returned to the Medicare Trust Funds, the Treasury and others in FY 2012. This is an unprecedented achievement for the HCFAC Program, a joint Justice Department and HHS effort to coordinate federal, state and local law enforcement activities to fight health care fraud and abuse.

The administration is also using tools authorized by the Affordable Care Act to fight fraud, including enhanced screenings and enrollment requirements, increased data sharing across the government, expanded recovery efforts for overpayments and greater oversight of private insurance abuses.

Since 2009, the Justice Department and HHS have improved their coordination through HEAT and increased the number of Medicare Fraud Strike Force teams to nine. The Justice Department’s enforcement of the civil False Claims Act and the Federal Food, Drug and Cosmetic Act have produced similar record-breaking results. These combined efforts coordinated under HEAT have expanded local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud. In FY 2012, the two departments continued their series of regional fraud prevention summits, and the Justice Department hosted a training conference for federal prosecutors, FBI agents, HHS Office of Inspector General agents and others.

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New Medicare Dashboard Advances ACA Goals for Chronic Conditions

Data tool helps to identify opportunities to improve care for beneficiaries with multiple chronic conditions

Marilyn Tavenner, Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), announced a new Medicare Chronic Conditions Dashboard, which furthers the Affordable Care Act's goals for health promotion, prevention and management of multiple chronic conditions. The dashboard offers researchers, physicians, public health professionals, and policymakers an easy-to-use tool to get current data on where multiple chronic conditions occur, which services they require and how much Medicare spends helping beneficiaries with multiple chronic conditions.

The Dashboard helps users find, analyze and apply summarized data from CMS' Chronic Conditions Data Warehouse. The Dashboard will promote better understanding of overlapping medical conditions related to overall patient health, helping to identify common concurrent conditions and areas where prevention and treatment can improve care and lower costs. The dashboard is part of the Department of Health and Human Services' (HHS) Initiative on Multiple Chronic Conditions, established in 2009.

The *Multiple Chronic Conditions: A Strategic Framework* was developed to serve as a national roadmap for HHS as well as public and private stakeholders to use to coordinate and improve the health of beneficiaries with multiple chronic conditions.

<http://acl.gov/www.acl.gov/NewsRoom/eNewsletter/CurrentNewsLetter.pdf>



DON'T BE A VICTIM OF MEDICARE FRAUD!

Millions of dollars are stolen from seniors every year. Recognize and report instances or patterns of health care fraud, errors and abuse. **It's YOUR money!**

Be proactive by following three simple steps:

- **PROTECT** your personal information
- **DETECT** errors and fraud by reading your Medicare Summary Notice (MSN)
- **REPORT** any suspicious billing on your MSN and/or any suspicious activity to the Arkansas SMP

For questions regarding your MSN or to volunteer, **CALL 1-866-726-2916**



The Arkansas SMP is scheduling presentations for 2013!

If you would like for us to come to your area to speak about current scams and health care fraud prevention, call 1-866-726-2916.



To sign up to receive email consumer alerts from your Attorney General, please log on to:

gotyourbackarkansas.org/alerts/sign-up-for-alerts/



In 2013, the health care law increases the discounts and savings to 52.5 percent of the cost of most brand name drugs and 21 percent of the cost of covered generic drugs.



Be on the lookout for the newly designed Medicare Summary Notice (MSN)! Coming soon!



SETTLEMENT REACHED WITH PHARMACEUTICAL COMPANY

Arkansas Medicaid program to receive \$533,129

LITTLE ROCK – Attorney General Dustin McDaniel reached a settlement agreement with Healthpoint Ltd. resolving allegations that the Texas-based pharmaceutical manufacturer falsely represented to the government that its drug was eligible for reimbursement, but Healthpoint knew that its drug Xenaderm (topical ointment used to treat bed and pressure sores) was ineligible for reimbursement because the FDA had determined in the 1970s that the drug’s principal ingredient was “less than effective” for its intended use. Since 1981, Medicaid has not paid for “less than effective” drugs or those drugs that are identical, similar or related to them.

Arkansas’s Medicaid program, with federal matching funds added, will receive **\$533,192.49** as a result of the settlement.

FIGHTING HEALTH CARE FRAUD PAYS DIVIDENDS

In February 2013 a report from the U.S. Office of the Attorney General and the U.S. DHHS shows that efforts in going after criminals who steal from Medicare and Medicaid are paying off!

The report shows that last year (2012) a record \$4.2 billion was recovered and a total over the last four years of \$14.9 billion because fighting health care fraud has become a top priority:

Strengthened Coordination: Over the past four years there has been a strengthened coordination between the departments and law enforcement. Through a combination of a record number of ‘boots on the ground’ and tougher criminal sentences and record civil recoveries, taxpayers have been saved immeasurable losses by deterring those who seek to game the healthcare system for personal gain.

Technology: Cutting-edge technology has also been put into place which makes it possible to identify and respond to fraud faster.

Suspension of suspicious payments: There are now systems that can identify suspicious claims in real time, taking away the criminals' head start. Using technology to freeze accounts with suspicious purchases, suspending suspicious payments before they go out. In the first year alone, this has led to 536 new investigations.

Tougher Screening Processes: Tougher screening processes for providers in areas where fraud is most likely to occur (home health visits or medical equipment and supplies) have been established, keeping bad actors from ever getting into the system in the first place.

Over the last three years, the government recovered a record \$7.90 for every \$1 invested allowing for better care to beneficiaries and a strengthened health care programs for future generations.

<http://www.chron.com/opinion/article/Fighting-health-care-fraud-pays-dividends-4266939.php>

MANHATTAN DOCTOR PLEADS GUILTY TO \$8.5 MILLION MEDICARE FRAUD SCHEME

A medical doctor, along with three other participants, pled guilty in Manhattan federal court to participating in a scheme to defraud Medicare out of approximately \$8.5 million through the use of fraudulent HIV/AIDS clinics in New York. The defendants executed the fraudulent scheme by recruiting HIV/AIDS patients eligible for Medicare and paying them kickbacks in exchange for signing on as patients at the clinics. The defendants then submitted claims for reimbursement to Medicare for drugs that were never purchased and never administered, or were administered, but were medically unnecessary.

<http://www.justice.gov/usao/nys/pressreleases/February13/AymatRobertoPlea.php>

JONESBORO WOMAN ARRESTED FOR MEDICAID FRAUD

LITTLE ROCK – Attorney General Dustin McDaniel announced on March 1 that a Jonesboro medical provider has been arrested and charged with felony Medicaid fraud following an investigation by the Attorney General’s Medicaid Fraud Division. Katrina Lawson, 39, of Jonesboro turned herself in to Pulaski County authorities on Tuesday after the Attorney General’s Office had issued a warrant for her arrest. Lawson is accused of causing the state Medicaid program to be billed for services she did not perform. “Medicaid providers who falsify bills are stealing money from Arkansas taxpayers and harming a program that offers needed health services to thousands of Arkansans,” McDaniel said. “We will investigate all instances of fraud to preserve the integrity of our Medicaid program.” Lawson was employed by Mid-South Health Systems Inc. to provide Anger Management Intervention services to persons with mental illness. The Attorney General alleges that Lawson falsely submitted time sheets to Mid-South, which caused Mid-South to bill Medicaid for hours of service which were not provided to six Medicaid beneficiaries. The incorrect time sheets were submitted by Lawson between August 13, 2012, and August 27, 2012. Investigators said surveillance video from Lawson’s former place of employment shows that Lawson was not providing the services for which she sought payment. Medicaid fraud is a Class C felony, punishable by three to ten years in prison and a fine of up to \$10,000.

Be aware of the following **SCAM(S)**:

POSTCARD—"YOU HAVE WON!" An SMP Volunteer received a post card stating "You Have Won! You are eligible for \$100 in gift savings to Wal-Mart or Target! Call 1-855-628-7764 for more information and to collect! Your Claim #009724442"... Notice the card read "gift savings"...not \$100. It makes you think it is money that you win. The volunteer called the phone number and spoke to someone with an accent who asked for a credit card number in order to collect \$6.25 as a fee to receive the gift savings. When the volunteer told her she would pay cash the lady told her they could only accept a credit card. Volunteer then, thankfully, hung up!

FAKE ONLINE PHARMACIES. A new area of fraud exists—fake online pharmacies exist, which offer prescription drugs at prices that are too good to be true. The scam artists might receive money for selling old or dangerous drugs. One way to check out the online pharmacies is to go to the National Association of Boards of Pharmacy website: www.nabp.net.

ROBO CALLS. If you feel like your phone is ringing off the hook with illegal robo calls, you're not alone! This is happening statewide and nationwide! Technology makes it easy for crooks to make millions of calls a day from anywhere in the world, and they are targeting seniors! You are urged to simply hang up the phone – do not push any buttons when prompted, this will only let the scammer know your number is working and will lead to additional calls.



The best way to limit these calls is to register your phone number(s) (up to 3) on the Do Not Call Registry at 1-888-382-1222 or go online to www.donotcall.gov.

**REPORT ALL SCAMS TO THE
ARKANSAS SMP
(Senior Medicare Patrol)
1-866-726-2916**

OIG Most Wanted Fugitives

This Web page contains information about the Office of Inspector General's (OIG's) most wanted health care fugitives. More than 170 fugitives are being sought on charges related to health care fraud and abuse. Navigate to other sections of the site to learn more:



<https://oig.hhs.gov/fraud/fugitives/index.asp>

HAVING A COLONOSCOPY?

If so, here's SOMETHING YOU SHOULD KNOW!

A routine colonoscopy is supposed to be free under the new health care law, but then insurers began charging if doctors found and removed a polyp during the procedure - reclassifying it from a preventive test to a diagnostic procedure.

That's a no-no, announced the Department of Health and Human Services (HHS), explaining that "polyp removal is an integral part of a colonoscopy. Accordingly, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure."

If a health plan does not have a network doctor who performs a particular preventive service, "then the plan or issuer must cover the item or service when performed by an out-of-network provider," without charging the patient copays or additional charges.

AARP Blog 02/25/2013 by Candy Sagon

SOMETHING YOU SHOULD KNOW...

Smart911—You can register now, and the information will be saved until such time as the service is activated in your community.

Information can include allergies, mobility impairment, photos in the event of a lost child, bedroom locations, parental emergency contact information if a child calls 9-1-1 from their own phone, and other data, which will help first responders in the event of an emergency.

It is free to register and is completely private—sharing a registered safety profile automatically **ONLY IN THE EVENT OF A 9-1-1 CALL.**

*Because **EVERY** second counts!*

CHECK YOUR CREDIT REPORT!

Consumers may obtain a free copy of their credit reports annually from each of the three major credit bureaus: TransUnion, Experian and Equifax. A credit report is a comprehensive record of credit history, and it may include a large number of details about credit accounts, in addition to information as to whether a consumer has been sued, been subject to a tax lien, or filed for bankruptcy. To obtain a free copy of a credit report, visit www.annualcreditreport.com.

For consumers who find errors on their reports, the following is recommended:

- Write to the creditor and all three major credit bureaus to explain the problem with the item.
- All correspondence should be sent by certified mail with a return receipt requested. Copies of all correspondence should be kept.
- Keep all original documents such as receipts and billing statements.

Remember that it pays to be persistent. It may take more than one letter to solve the problem.

The credit bureau is required to investigate a claim within 30 days and either update or delete any inaccurate item. Credit bureaus must inform consumers when an investigation is completed and provide consumers with a revised report.

www.facebook.com/arsmp

Report Fraud

If you suspect errors, fraud, or abuse when you use Medicare—report it. Learn what to look for, and get details about preventing and detecting fraud.

What do I need to have to report errors, fraud, or abuse?

Before you report errors, fraud, or abuse, carefully review the facts and have the following information ready:

- The provider's name and any identifying number you may have.
- Information on the service or item you are questioning.
- The date the service or item was supposedly given or delivered.
- The payment amount approved and paid by Medicare.
- The date on your Medicare Summary Notice.
- Your name and Medicare number (as listed on your Medicare card).
- The reason you think Medicare should not have paid.
- **Any other information you have showing why Medicare should not have paid.**

Where do I report errors, fraud, or abuse?

To report suspected errors, fraud, or abuse, you can contact the Arkansas SMP —1-866-726-2916

HEALTHCARE FRAUD

Fiscal Deal Gives Medicare More Time to Recover Overpayments

1/3/13 - A little-noticed provision in the fiscal-cliff bill signed by President Barack Obama will give Medicare officials the ability to take back an estimated \$500 million in payments that hospitals and physicians received **as long as five years ago**.

The eight-line provision in the law, Section 638, "Removing Obstacles to Collection of Overpayments," says that Medicare contractors now have five years to collect on errors in Medicare payments. Previously, the statute of limitations on non-fraudulent Medicare overpayments was only three years.

But last May, HHS' inspector general's office wrote that the three-year limit had prevented CMS from collecting as much as \$332 million in overpayments that had already been identified by investigators because the auditing process takes so long.

Separately, a provision in the Affordable Care Act in 2010 gives the CMS the power to collect some overpayments going back ten years. However, that proposed rule for this practice—which has yet not been finalized—applies only to payments that are covered by the False Claims Act (Joe Carlson, ModernHealthcare).

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*Don't judge
each day
by the harvest
you reap,
but by the
seeds you plant.*

—Robert Louis Stevenson

TIP!

IF YOU FIND SOMETHING ON YOUR MEDICARE SUMMARY NOTICE (MSN) THAT JUST DOESN'T LOOK RIGHT, CALL THE PROVIDER **FIRST** FOR AN EXPLANATION. IF YOU ARE UNHAPPY WITH THE RESPONSE, CALL THE ARKANSAS SMP 1-866-726-2916.

RECORD-BREAKING RECOVERIES

(Continued from Page 1)

The strike force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes as well as with chronic fraud by criminals masquerading as health care providers or suppliers. In July, Attorney General Holder and Secretary Sebelius announced the launch of a groundbreaking partnership among the federal government, state officials, leading private health insurance organizations and other health care anti-fraud groups to share information and best practices to improve detection of and prevent payments to scams that cut across public and private payers.

In FY 2012, the Justice Department opened 1,131 new criminal health care fraud investigations involving 2,148 potential defendants, and a total of 826 defendants were convicted of health care fraud-related crimes during the year. The department also opened 885 new civil investigations.

The strike force coordinated a takedown in May 2012 that involved the highest number of false Medicare billings in the history of the strike force program. The takedown involved 107 individuals, including doctors and nurses, in seven cities, who were charged for their alleged participation in Medicare fraud schemes, involving about \$452 million in false billings. As a part of the May 2012 takedown, HHS also suspended or took other adminis-

trative action against 52 providers using authority under the health care law to suspend payments until an investigation is complete.

Strike force operations in the nine cities where teams are based resulted in 117 indictments, information and complaints involving charges against 278 defendants who allegedly billed Medicare more than \$1.5 billion in fraudulent schemes. In FY 2012, 251 guilty pleas and 13 jury trials were litigated, with guilty verdicts against 29 defendants, in strike force cases. The average prison sentence in these cases was more than 48 months.

The new authorities under the Affordable Care Act granted to HHS and the Centers for Medicare & Medicaid Services (CMS) were instrumental in clamping down on fraudulent activity in health care. In FY 2012, CMS began the process of screening all 1.5 million Medicare-enrolled providers through the new Automated Provider Screening system that quickly identifies ineligible and potentially fraudulent providers and suppliers prior to enrollment or revalidation to verify the data. As a result, nearly 150,000 ineligible providers have already been eliminated from Medicare's billing system.

CMS also established the Command Center to improve health care-related fraud detection and investigation, drive innovation and help reduce fraud and improper payments in Medicare and Medicaid.

From May 2011 through the end of 2012, more than 400,000 providers were subject to the new screening requirements and nearly 150,000 lost

the ability to bill the Medicare program due to the Affordable Care Act requirements and other proactive initiatives.

The Department of Justice and HHS also continued their successes in civil health care fraud enforcement during FY 2012. The Justice Department's Civil Division Fraud Section, with their colleagues in U.S. Attorneys' offices throughout the country, obtained settlements and judgments of more than \$3 billion in FY 2012 under the False Claims Act (FCA). These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the Food and Drug Administration, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks. This marked the third year in a row that more than \$2 billion has been recovered in FCA health care matters. Additionally, the Civil Division's Consumer Protection Branch, working with U.S. Attorneys' offices, obtained nearly \$1.5 billion in fines and forfeitures, and obtained 14 convictions in matters pursued under the Federal Food, Drug and Cosmetic Act.

The HCFAC annual report is available at www.oig.hhs.gov/publications/hcfac.asp. For more information on the joint DOJ-HHS Strike Force activities, visit: www.StopMedicareFraud.gov/.

For more information on the fraud prevention accomplishments under the Affordable Care Act visit: www.healthcare.gov/news/factsheets/2012/02/medicare-fraud02142012a.html

REMINDER!

If you have a Medicare Advantage plan, check to make sure your doctor is IN-NETWORK. Call your plan directly or your doctor if you are unsure. If you have Original Medicare, check to verify that your doctor is a participating provider.

Contact SHIIP (Senior Health Insurance Information Program) for more Information —1-800-224-6330.

FRAUD TIP!

Be suspicious of suppliers who offer you 'free' equipment and then ask for your Medicare number! Remember....**it's not free**—they are going to bill Medicare.

WHAT DOES THE LETTER AFTER MY MEDICARE NUMBER ON MY MEDICARE CARD MEAN?

Social Security pays benefits to over 50 million people. Social Security uses a series of codes to identify which individuals are receiving what types of benefits. The codes are assigned to people when they apply for benefits. The most common code is the letter "A," meaning that the applicant is a wage earner seeking normal retirement benefits.



A full list of the 34 frequently used codes can be found on the Social Security website:
http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1366/kw/letters%20after%20social%20security%20or%20medicare%20number.

A CALL TO VOLUNTEERS!

In 2012, Arkansas SMP staff and volunteers distributed information to 3,479 individuals at 16 community events and conducted 141 group education sessions reaching 5,246 people with the SMP message. These numbers may seem big, but Arkansas has approximately 550,000 Medicare beneficiaries so we need your help in reaching additional Medicare beneficiaries by joining our group of dedicated volunteers.

We offer an intensive six-hour training which includes information on the parts of Medicare, information on how to identify fraud, errors, and abuse, and an explanation of the roles of the Arkansas SMP volunteers. For additional information on these trainings, please call 1-866-726-2916.

For additional information about the Arkansas SMP, please visit our web site at www.daas.ar.gov/asmp.html or call 1-866-726-2916.

For a volunteer application, please contact Kathleen Pursell at 866-726-2916.

TOGETHER WE CAN

Empower Seniors to Prevent Healthcare Fraud!

IF YOU KNOW OF A HEARING-IMPAIRED AUDIENCE THAT WOULD BENEFIT FROM RECEIVING THE MESSAGE OF HEALTHCARE FRAUD PREVENTION, PLEASE CALL THE ARKANSAS SMP — 1-866-726-2916 —



Click on the following link - to view excellent, short videos on Medicare and Medicaid fraud:

<http://go.usa.gov/2mDz>

COORDINATION OF BENEFITS (COB)

If you have other health coverage besides Medicare, at some point you may be contacted by a CMS Coordination of Benefits contractor, who determines which insurance should pay the claim first— Medicare or another payer—such as Medicaid, VA benefits, no-fault or liability insurance, Worker's Compensation, etc.

The purpose of the COB program is to coordinate the payment process to prevent mistaken payment of Medicare benefits. To contact the COB call 1-800-999-1118.

What you will need to know:

- Medicare number;
- Address;
- Medicare effective date(s);
- Social Security number; and
- Whether or not the beneficiary has Part A and Part B coverage.

2013 *Original Medicare*:

Part B premium is: \$104.90

Part A deductible is: \$1,184.00

Part B deductible is: \$147.00

It's funny; I don't *remember* being absent-minded!



my Social Security
– a service for you!

my Social Security is an online account that allows people quick access to their personal Social Security information.

For people who already receive Social Security benefits, the **my Social Security** service can be used to get a benefit verification letter, to check benefit payment information, to start or change direct deposit and to report a change of address or phone number.

Go to: www.socialsecurity.gov/myaccount.

YOU Can Help Fight Medicare Fraud!
Join the Arkansas SMP!

FOR
VOLUNTEER OPPORTUNITIES CALL
—1-866-726-2916—

A new way to get health insurance: the Health Insurance Marketplace.

The Marketplace is designed to help you find health insurance that fits your budget with less hassle.

Every health insurance plan in the new Marketplace will offer comprehensive coverage from doctors to medications to hospital visits. You can compare all your insurance options based on price, benefits, quality, and other features that may be important to you in plain language that makes sense.

Starting in October, you'll be able to get information about all the plans available in your area. You'll be able to enroll yourself, directly through the website, or call a toll-free phone hotline.

If you're having difficulty finding a plan that meets your needs and budget, there'll be people available to give you personalized help with your choices. These helpers aren't associated with any particular plan, and they aren't on any type of commission so the help they give you will be completely unbiased.

Coverage from the Marketplace starts in January 2014.

www.healthcare.gov/marketplace/about/index.html

Get Ready - Learn what you can do now to get ready for Marketplace enrollment in October 2013 — <http://www.healthcare.gov/marketplace/get-ready/index.html>

ACA and Medicare

The Centers for Medicare and Medicaid Services (CMS) says that the Affordable Care Act (ACA) is good for Medicare and good for Medicare beneficiaries. A few examples:

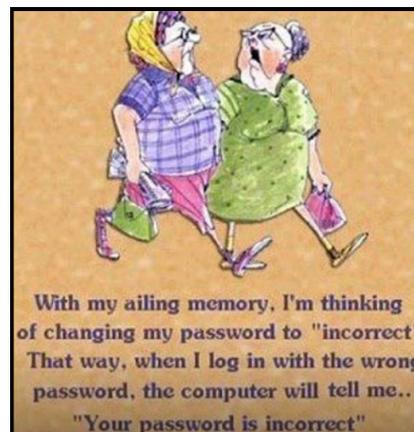
- **Closing the Medicare Drug Coverage Gap.** People with Medicare are already seeing a phase-out of the "Donut Hole" coverage gap. ACA is on track to fully eliminate the Donut Hole by 2020, ensuring that people enrolled in Medicare Part D have better access to the drugs they need. So far, this ACA provision has already saved Medicare beneficiaries over \$5.7 billion on their prescription drug costs, with the average beneficiary saving over \$600.
- **Free Preventive Services for People with Medicare:** ACA makes many preventive screenings and services free for people with Medicare as well as those with private insurance. Last year alone, over 34 million Medicare beneficiaries used at least one free preventive service including mammograms and other critical screenings.
- **Medicare Advantage (MA) Payment Changes.** Medicare Advantage payments are restructured at an increasingly smaller percentage of original Medicare rates. Prior to the restructuring, MA payments were, on average, 13% higher than those for traditional Medicare. Also, MA plans are prohibited from charging higher cost-sharing than original Medicare for skilled nursing facility care, chemotherapy and kidney dialysis.

MedicareAdvocacy.org

DID YOU KNOW?

Bundled Payment Initiative

More than 450 health care organizations will participate in this effort. It is a payment model program created in the health care reform law to test whether bundling payments to providers for services in a single episode of a patient's care can improve quality and lower costs without undermining the quality of care.



“LIKE” US ON *FACEBOOK!*

www.facebook.com/ARSMP

View pictures, latest fraud in the news, videos, etc.!

See what’s happening in the world of FRAUD!

Call **1-866-726-2916** to receive your copy of the quarterly **SMP Newsletter** in the mail!

MESSAGE FROM CMS: We are pleased to announce a new format for your Medicare Summary Notice (MSN) on **MyMedicare.gov** that features:

- Clearer language;
- Larger fonts;
- Consumer-friendly descriptions of medical procedures;
- Definitions of claims column headers;
- Information on how to check the form for important facts and potential fraud; and
- New information on how to appeal denied claims.

To view the newly formatted MSN use the same process as you always have to view your online MSN on MyMedicare.gov:

1. Select “Search Claims” on the Claims tab at the top of the page
2. Perform your claim search by date range, claim type, or claim number
3. Click on the “View MSN” link from the Claims Summary or Claim Detail page.

Medicare is making these same improvements to the printed MSNs that you receive in the mail. You will start to see this new format on your printed MSNs in 2013. Please remember that the version Medicare mails to you is still your official MSN.

Sincerely,
Centers for Medicare & Medicaid Services

Arkansas SMP (Senior Medicare Patrol) is very proud to be part of the dedicated team of professionals and volunteers who are working tirelessly across the country to crack down on healthcare fraud and save valuable taxpayer dollars.

Please join our team by contacting Kathleen Pursell at 1-866-726-2916 or kathleen.pursell@arkansas.gov.

It might be the best investment you ever make.

Medicaid Program—The

Medicaid program covered acute health care, long-term care and other services for about 70 million low-income people in fiscal year 2011; and it is one of the largest sources of funding for medical and health-related services for America's most vulnerable populations. Medicaid consists of more than 50 distinct state-based programs. The federal government matches state expenditures for most Medicaid services using the Federal Medical Assistance Percentage, a

statutory formula based in part on each state's per capita income. Medicaid is a significant expenditure for the federal government and the states with total expenditures of \$436 billion in 2011. CMS is responsible for overseeing the program at the federal level, while states administer their respective programs' day-to-day operations.

GAO designated Medicaid as a high-risk program because of its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight,

which is necessary to prevent inappropriate program spending. Both Congress and the administration have demonstrated commitment and leadership to making Medicaid fiscal and program integrity a priority.

Source: **Medicare and Medicaid – Still on GAO’s High-Risk List**
[GAO-13-433T](http://www.gao.gov/assets/13/433T)
Feb. 27, 2013
[View Full Report \(PDF 17 pgs\):](http://www.gao.gov/assets/660/652386.pdf)
www.gao.gov/assets/660/652386.pdf

TERMINOLOGY:

OBESERVATION STATUS—

The term used to define a beneficiary’s hospital stay under a doctor’s orders for “observation services” which helps the doctor determine if the patient needs to be admitted. The time doesn't count toward the three-day inpatient hospital stay needed for Medicare to cover subsequent skilled nursing facility care and often results in unexpected out-of pocket expenses for beneficiaries.

An Example of MEDICAID FRAUD—

Medicaid Card Sharing:

A general definition of Medicaid card or number sharing is giving your Medicaid card or number to someone other than your doctor, clinic, hospital, or other health care provider recommended to you by your doctor.

This can include sharing your card even when you are trying to help someone who really needs care.

It is important that you do not provide your Medicaid card or number to anyone else or you may not be able to get the care you need when the time comes.

Don't let aging get you down....it's too hard to get back up!

2013 SMP CALENDAR

DATE / TIME	EVENT	LOCATION
April 3—4	NASW (National Assoc. of Social Workers) Annual Conference	Wyndham Hotel, North Little Rock, AR
April 13 / 9am-12pm	Health Fair	Central Church of Christ Little Rock, AR
April 24	SMP Presentation	Caraway Senior Center Caraway, AR
April 29	SMP Presentation	Good Shepherd / Moore Building Little Rock, AR
May 8	PROTECTING ARKANSANS	White County Medical Center Hubach Center, Searcy AR
May 9	PROTECTING ARKANSANS	First Methodist Church/Fellowship Hall Pocahontas, AR
May 17	SMP Presentation	Atkins EHC Council Meeting Russellville, AR
May 29 / 8am-12pm	Health Fair	Good Shepherd—Moore Building Little Rock, AR
June 6-7	Arkansas Association of the Deaf (AAD) Biennial Convention	Little Rock, AR
June 13-14	Arkansas Registry of Interpreters for the Deaf Biennial Conference	Little Rock, AR
June 11	PROTECTING ARKANSANS	Dumas Community Center Dumas, AR
June 12	PROTECTING ARKANSANS	Delta AHEC Helena, AR
June 20	SMP Presentation Generations—Lunch & Learn	Saline Memorial Hospital Benton, AR
July 9	PROTECTING ARKANSANS	Mulberry Senior Center Mulberry, AR
July 10	PROTECTING ARKANSANS	Riordan Hall Bella Vista, AR
August 5-7	SMP National Conference	Washington, D.C.

PROTECTING ARKANSANS

Protecting Arkansans is a consumer awareness town-hall type seminar sponsored by AARP in partnership with the Office of the Arkansas Attorney General, Arkansas Securities Department, Arkansas Department of Insurance and the Arkansas Department of Human Services, *bringing state government to you with the message of consumer protection and fraud awareness.*

THE BEST DEFENSE AGAINST FRAUD IS YOU!

Go to www.daas.ar.gov/asmp.html or call 1-866-726-2916 for more information.

**ENGAGE
YOUR
WISDOM!**

IMPORTANT PHONE NUMBERS:

AANHR —AR Advocates for Nursing Home Residents	501-450-9619
AFMC —AR Foundation for Medical Care	1-888-354-9100
Area Agency on Aging	1-800-986-3505
Arkansas Attorney General Consumer Protection Division	1-800-482-8982
APS —Adult Protective Services (DHS)	1-800-482-8049
AR-GetCare —(Directory of Community-Based Services)	1-866-801-3435
Arkansas Rehabilitation Services	1-800-981-4463
AR SMP (Healthcare Fraud Complaints)	1-866-726-2916
Better Business Bureau (BBB)	501-664-7274
CMS —(Medicare)— (Centers for Medicare and Medicaid Services) (1-800MEDICARE)	1-800-633-4227
Community Health Centers of AR	1-877-666-2422
Coordination of Benefits	1-800-999-1118
DHS (Customer Assistance Unit)	1-800-482-8988
Do Not Call Registry	1-888-382-1222
Elder Care Locator	1-800-677-1116
Federal Trade Commission Report STOLEN IDENTITY	1-800-438-4338
ICan —Increasing Capabilities Access Network	501-666-8868
Medicaid —(Claims Unit)	1-800-482-5431
Medicaid Fraud Control Unit	1-866-810-0016
MEDICARE (CMS 1-800-MEDICARE)	1-800-633-4227
Medicare Part D	1-877-772-3379
Medicare Rights Center	1-800-333-4114
National Consumer Technical Resource Center	1-877-808-2468
National Medicare Fraud Hotline (1-800-HHS-TIPS) Office of Inspector General	1-800-447-8477
OLTC —Office of Long Term Care	1-800-LTC-4887
OLTC —Abuse Complaint Section	501-682-8430
Ombudsman —Statewide Office of Long Term Care	501-682-8952
Resource Center (ADRC) (DHS'S Choices in Living Resource Center)	1-866-801-3435
Senior Circle (Northwest Health System)	1-800-211-4148
SHIP (Senior Health Insurance Information Program)	1-800-224-6330
SMP Locator —(locate an SMP outside AR)	1-877-808-2468
SSA (Social Security Administration) Little Rock Office	1-800-772-1213 1-866-593-0933
SSA Fraud Hotline	1-800-269-0271
South Central Center on Aging	1-866-895-2795
Tri-County Rural Health Network	1-870-338-8900
UALR Senior Justice Center	501-683-7153
UofA Cooperative Extension Service	501-671-2000

HELPFUL WEBSITES:

ADRC —AR Aging & Disability Resource Center (DHS)— www.choicesinliving.ar.gov/
AR-GetCare — www.ARGetCare.org (Directory of Community-Based Services)
AR Advocates for Nursing Home Residents — www.aanhr.org ; e-mail: Info@aanhr.org
AR Long Term Care Ombudsman Program — www.arombudsman.com
Arkansas 2-1-1 — www.arkansas211.org (Get Connected. Get Answers)
Arkansas Aging Initiative — http://aging.uams.edu/?id=4605&sid=6
Attorney General — www.arkansasag.gov
Arkansas Attorney General Consumer Protection Division —e-mail: consumer@ag.state.ar.us
Area Agencies on Aging — www.daas.ar.gov/aaamap.html
Arkansas Foundation for Medical Care — www.afmc.org
Arkansas SMP — www.daas.ar.gov/asmp.html
BBB (Better Business Bureau) — scams and alerts— http://arkansas.bbb.org/bbb-news/
CMS (Medicare-Centers for Medicare and Medicaid Services) — www.cms.hhs.gov
Do Not Mail — www.DMAchoice.org
Elder Care Locator — www.eldercare.gov
H.E.A.T — www.stopmedicarefraud.gov/ (Healthcare Fraud Prevention and Enforcement Action Team)
ICan AT4ALL — Tools for Life— www.ar-ican.org
MEDICAID — www.Medicaid.gov
MEDICARE — www.medicare.gov
Medicare Interactive Counselor — www.medicareinteractive.org
Hospital Compare — www.hospitalcompare.hhs.gov
MyMedicare.gov — www.mymedicare.gov (Access to <u>your personal</u> Medicare claims information)
MyMedicareMatters.org (National Council on Aging)
Office of Long Term Care — http://humanservices.arkansas.gov/dms/Pages/oltcHome.aspx
Office of Inspector General —e-mail: HHSTips@oig.hhs.gov
Pharmaceutical Assistance Program — medicare.gov/pap/index.asp
Physician Compare — www.medicare.gov/find-a-doctor
SMP Locator — SMPResource.org (locate an SMP outside of AR)
Social Security Administration — www.ssa.gov/dallas/state_ar.html
TAP — www.arsinfo.org (Telecommunications Access Program)
Tri-County Rural Health Network — communityconnecting.net/home.html
UofA Cooperative Extension Service — www.uaex.edu (or) www.arfamilies.org
Working Disabled — www.workingdisabled-ar.org



OUR MISSION

TO EMPOWER SENIORS

- * Medicare/Medicaid beneficiaries
- * People with disabilities
- * Nursing home residents & their families
- * Caregivers



TO PREVENT HEALTH-CARE FRAUD

Protect Personal Information

- * Treat Medicare/Medicaid and Social Security numbers like credit card numbers
- * Remember, Medicare will not call or make personal visits to sell anything!
- * READ and SAVE Medicare Summary Notices (MSN) and Part D Explanation of benefits (EOB), but **shred** before discarding

Detect Errors, Fraud, and Abuse

- * Always review MSN and EOB for mistakes
- * Compare them to prescription drug receipts and record them in your Personal Health Care Journal
- * Visit **www.mymedicare.gov** to access your personal account online to look for charges for something you did not get, billing for the same thing more than once, and services that were not ordered by your doctor, etc.

Report Mistakes or Questions

- * If you suspect errors, fraud, or abuse, report it immediately! Call your provider or plan **first**.
- * If you are not satisfied with their response, call the Arkansas SMP

TO RECRUIT & TRAIN VOLUNTEERS

- * Retired seniors
- * Retired health-care providers
- * Retired professionals, *e.g.*, teachers, accountants, attorneys, investigators, nurses

SMP PARTNERS

El Dorado Connections RSVP
El Dorado, AR

EOA of Washington County RSVP
Springdale, AR

Texarkana RSVP
Texarkana, AR

RSVP of Central Arkansas
Little Rock, AR

Garland County RSVP
Hot Springs, AR

**Tri-County Rural Health
Network, Inc.**
Helena, AR

**Senior Health Insurance
Information Program (SHIIP)**
Little Rock, AR

**UAMS Arkansas Aging Initiative
CENTERS ON AGING**

**Arkansas Foundation for Medical Care
(AFMC)**
Fort Smith, AR

To receive the Arkansas SMP Newsletter electronically
email: kathleen.pursell@arkansas.gov

Current and archived newsletters available at:
www.daas.ar.gov/asmpnl.html



P. O. Box 1437 Slot S530
Little Rock, AR 72203-1437
<http://www.daas.ar.gov/asmp.html>

To Report Fraud, Waste & Abuse
Call the Toll-Free **Helpline**
8:00am-4:30pm: **1-866-726-2916**