



ASMP NEWSLETTER

Report Fraud, Waste & Abuse Call Toll-free 1-866-726-2916

March 2006

Written/edited by Diana Carey, ASMP

Medicare Part D Under the Microscope

Progress, Problems, Issues of Interest



A little more than two months into the most sweeping change in Medicare since its inception 40 years ago, the Medicare Part D Drug Prescription Program is still all the buzz in Medicare, Medicaid, advocacy, aging and human services circles. We will attempt to take a concise look at progress, thorny issues and local impact of the implementation of the new drug benefit in this issue of the newsletter, as well as reporting on fraud news in Arkansas and the nation, and other issues of interest to Medicare and Medicaid beneficiaries.

Important Date

May 15, 2006

Initial enrollment period for Medicare Part D drug plan ends

Those who elect not to sign up by May 15, 2006 and who do not already have "creditable coverage" through another insurance plan may be subject to a premium penalty if they choose to sign up at a later date.

Resources to Contact

Medicare

1-800-MEDICARE or www.medicare.gov

SHIP (Seniors Health Insurance Information Program in Arkansas)

1-800-224-6330

Medicare Rx Education Network

1-800-670-9006 or www.medicarerxeducation.org

Area Agencies on Aging 1-866-651-2273



News from Washington DC

Attempts to introduce legislation extending the deadline for Medicare Part D enrollment have been made, but the progress of such bills has been sluggish or halting to date.

According to AP/Long Island Newsday, at least 140 lawmakers— most of whom are Democrats— support various bills that would extend the enrollment deadline. In the House, 10 bipartisan co-sponsors support a bill that would extend the enrollment deadline to June 30, 2007. A second House bill, which has 131 co-sponsors, would extend the deadline to Dec. 31, 2006 and allow beneficiaries to change plans once during the year.

A senate bill (S.2168) has been introduced by Sens. Olympia Snow (R-Maine) and Bill Nelson (D-Fla) to extend the benefit to Dec. 31, allow enrollees to change plans once during the year, and would authorize grant money to state and non-profit organizations to conduct outreach.

Sharon Marcum, ASMP Project Administrator, took the opportunity at the January 24, 2006 Advisory Council quarterly meeting to render a heartfelt Thank You to the partners and volunteers who have "stepped into the gap" with Medicare Part D education and assistance. With little or no funding, these organizations and individuals have made it possible for the most vulnerable of our population to get the assistance they need. A total of 57 volunteers with ASMP have had training to make Part D presentations and assist with enrollment.





Stumbling Start Results in Bailout

When computer glitches in January prevented payouts for some who had enrolled in Part D drug plans, at least 26 states, including Arkansas, passed emergency laws to pay for drugs so that seniors would not have to do without.

An estimated 24 million people have now enrolled in the Medicare Part D drug plan nationwide, and of that number nearly 7 million recipients are low-income seniors, many of whom were auto-enrolled in the new drug plan from their state-run Medicaid plans. Dual-eligibles have been the hardest hit from the shaky transition at the beginning of the year, according to state-by-state reports. Many were turned away at the pharmacy because their names weren't on file with their drug plan, and some have been charged undue co-pays for the prescriptions they were able to have filled.

Despite the glitches, the program is successfully filling 1 million prescriptions every day, but many stopgap measures have had to be put in place. The American Association of Pharmacists reports that, in some cases, pharmacists have taken out lines of credit to pay for their regular customers' drugs out of their own pockets until the confusion is settled.

In Arkansas, Gov. Mike Huckabee invoked the state Emergency Powers Act and authorized state aid for pharmacies with problems created by the enrollment of dual-eligibles. As of January 27th, the state had paid \$3.8 million to pharmacists, and the bailout could reach \$5 million, according to Arkansas Department of Health and Human Services (DHHS) estimates. Huckabee ordered DHHS to continue paying claims from pharmacists at least until February 15.

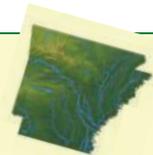
Under the stopgap measure, pharmacists are required to first file a claim with the benefit plan covering the dual-eligible senior seeking the medication. If the benefit does not pay, the pharmacist is instructed to bill DHHS. The pharmacist will repay the state if the benefit plan eventually accepts the claim, otherwise DHHS is relying on the federal government for reimbursement.

DHHS Director John Selig says the federal Health and Human Services agency has assured him they will collect the money from the private companies administering benefit plans, then reimburse the states. (See Sec. Mike Leavitt's report on pages 2-3.)

Funding for the Part D assistance and stopgap measure is taken from Arkansas DHHS' \$4 billion operating budget, according to DHHS spokesperson Julie Munsell. She reports the bailout should not affect other DHHS services since it is early in the department's fiscal year, but the department could face problems later in the year if the state is not reimbursed.

More than 62,000 Arkansans voluntarily signed up for the Medicare prescription drug benefit during the first two months it was offered.

The Arkansas Angle



246,000 Medicare recipients in Arkansas now have some form of drug coverage. Just under half of the state's 475,000 recipients continue to lack coverage, and about 20 percent of those who previously lacked coverage had signed up by January 13.

There are 62,000 dual-eligibles in Arkansas, and about 17,000 of them have had problems with the new benefit.

13 percent of the state's Medicare population signed up for stand-alone drug plans by January 13, ahead of the national average of 8 percent.



Thorny Issues with Part D

Seniors in Long-Term Care

A problem has surfaced for some spouses of seniors in long-term care. Seniors in long-term care with little or no financial resources are covered under Medicare and Medicaid, but many still may carry retiree health benefits for themselves and their spouses.



This group of “dual-eligibles” was automatically enrolled in new Medicare Part D drug plans prior to January 1, 2006. At that point they were dropped from their retiree health plans, at times leaving spouses who are not in long-term care with no health coverage. While the numbers affected by this glitch are not enormous, for those who are affected the problem is huge.

Some nursing homes with alert managers advised their residents to keep retiree benefits, but many did not foresee the implications of the auto-enrollment. In some locales, advocates are attempting to get retiree health plans to take these patients back, but are meeting with varied success. Source: Grand Rapids Press



Reading the Fine Print

Along the same lines, any retiree with employee-sponsored health coverage needs to be aware of the company’s policies regarding Part D. Some 60 percent of large employers are now saying that if a retiree 65 or older signs up for Medicare Part D, they will terminate that person’s drug coverage, and in many cases **all** of his health care coverage. The findings are from a study by the Kaiser Family Foundation and Hewitt Associates, a benefits consulting firm.

Specifically, the survey of 300 companies with 1,000 or more employees found that of the companies continuing to provide drug coverage, 31 percent said retirees who sign up for Part D will lose the company’s drug coverage, and 29 percent said such retirees will lose **all** retiree medical coverage from the company.

Some retirees may sign up for a Medicare prescription drug plan without realizing the potential consequences in terms of forfeiting their employer-sponsored benefits, the Kaiser study notes. The important thing for retirees of any income level, or their caretakers, is to give careful attention to all notices received concerning Medicare or Medicaid. The information should be read and kept. If the information is unclear, a retiree or caretaker should contact the former employer or talk to an expert such as an elder-law attorney. Source: Washington Post

Transition Policies

For some people who have successfully enrolled in a Part D plan, the failure of some plans to implement required “transition policies” for new members remains a barrier to obtaining medicines. The critical component of a transition policy is the provision of temporary, initial fills for drugs that otherwise would not be covered. The intent is to allow the beneficiaries a temporary bridge until an appeal can be filed with the drug plan, or a physician can prescribe an alternate drug.



In early January, CMS advised plans to provide at least 30-day transition supplies of such drugs, and followed reports of Medicare beneficiaries walking out of pharmacies without their prescriptions or being forced to pay the full retail price with several letters to the plans stating that such actions were inappropriate. On February 1, 2006, Health and Human Services Secretary Michael Leavitt ordered that those transition supplies of prescriptions be provided for 90 days. Source: medicarights.org



Dual-Eligibles

The new Medicare Part D drug benefit program has particular relevance for the six million low-income Medicare beneficiaries who are also enrolled in Medicaid, and known as dual-eligibles. These Medicare beneficiaries typically have incomes of less than \$10,000 a year and often face serious health challenges. Nearly one in four lives in a nursing home.

Dual-eligibles are the one group whose current drug coverage is directly terminated by the Medicare Modernization Act. As of January 1, 2006, Medicaid will no longer pay for prescription drugs for this group of beneficiaries. If they did not sign up for a Medicare Part D drug plan by January 1, 2006, they were automatically enrolled in one on a random basis.

If a dual-eligible beneficiary was unaware of the need to sign up for a plan and was auto-enrolled, he or she might have ended up in a plan that does not cover the medications previously covered by Medicaid. While the law allows dual-eligibles to switch plans throughout the year, the potential for medications being denied at the outset is inherent in the random assignment of drug plans.



To choose among plans, dual-eligibles need to understand what drugs are on the formularies; how the drugs will be ordered and delivered; and how this plan is related to their other providers. The task of selecting a plan will rest with the beneficiary, family and other informal support.

There is no special plan to assist enrollment of the more than 1.5 institutionalized dual-eligibles. With no clarification who has authority to act when the eligible individuals are not capable of enrolling themselves, institutional residents will be dependent on facility staff and their own families to make a selection.

Currently, most nursing homes use institutional pharmacies which specialize in servicing long-term care facilities. Services are tailored to provide each resident's prescriptions in individual blister packs, designed to avoid error in the administering of medications. Institutional pharmacies also typically provide additional services such as a monthly review of each resident's medication by a consultant pharmacist to avoid adverse drug interactions.

The potential for disruption of the current administrative and commercial arrangements among Medicare, Medicaid, nursing facilities and institutional pharmacies is apparent. If a dual-eligible either selects or is auto-enrolled in a plan that does not include that nursing facility's pharmacy, it is not clear how the drugs will be provided.



The limited time-frame for educating and enrolling dual-eligibles likely led to a high level of automatic enrollment. If you or someone you are a caretaker for is a dual-eligible, be aware of the right to switch drug plans, and use available resources to determine the plan which best meets your specific drug needs and will work along with any institutional facility

No Independent Review

Part D grievance procedures, unlike the Medicare appeals process for medical claims, are handled entirely by the private plans and not subject to independent review. While CMS does require the inclusion of a hearing in disenrollment cases, it does not require that the hearing occur before the termination, nor does it include the opportunity to present evidence. These are the findings of the California Health Advocates in a report released December 9, 2005.

Source: CA Health Advocates, *Consumers Face Inadequate Protections Concerning Medicare Part D Enrollment and/or Disenrollment Problems*.





What does this mean for me?

IF THE PHARMACY WON'T FILL YOUR PRESCRIPTION OR CHARGES YOU MORE THAN YOU KNOW YOU SHOULD HAVE TO PAY BECAUSE IT CANNOT CONFIRM YOU ARE ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN, HERE'S WHAT TO DO:

- If you do not have a membership card yet, you can show the pharmacist the letter you received from the plan that confirms you have enrolled.
- If you don't have a letter, ask your pharmacist to call 1-800-MEDICARE (1-800-633-4227). The customer service representative can tell the pharmacist which plan you are enrolled in.
- If you are eligible for Medicare and Medicaid and find out you are not enrolled in a plan, you can go to the pharmacy and be enrolled in a plan, fill your prescription, and you will be charged a \$1 or \$3 co-payment for your prescription.

You must provide proof of identity (state law), like a personal photo identification card.

You can also choose to pay for your prescription at the pharmacy and then work with you plan to be reimbursed. If you cannot afford to pay out-of-pocket and going without the prescription is very serious, call 1-800-MEDICARE and tell the customer service representative that you are having trouble filling a prescription that is an emergency need.

Source: Medicare website

ROUNDING UP PART D ~ THINGS TO REMEMBER

Enroll early in the month, before the 15th, to avoid glitches at the pharmacy your first month of coverage.

Clarification on the "Donut Hole" coverage gap: Be aware that the coverage gap begins when you reach expenses of \$2,250 for your drugs. This is the total cost incurred by both you and Medicare. If you have a co-pay of \$15 for a drug which costs \$60, the total \$60 figure is what is added into your tally. This may put you into the coverage gap sooner than you were expecting if you did not realize the total drug cost is counted. Look carefully at the figures which show the total estimated cost to you on Plan Finder (at www.medicare.gov) when choosing a plan.

"Gap Coverage" is offered by 7 plans in Arkansas.

Mail-Order Option is offered on every PDP in Arkansas except CommunityCareRx. Be aware of this option when choosing a plan, as you can typically receive 90 day supplies of your prescriptions for a reduced cost over visiting the pharmacy every month.

Be aware that a Prescription Drug Plan (PDP) can change its formulary or prices with only 60 days notice, but you as a beneficiary can only change plans once a year. Pay attention to any notices you receive from your PDP and be prepared to contact your physician and then your plan to request an exception, if that is the best treatment per your physician.

1% Premium Penalty clarification. If you do not have creditable coverage and wait beyond May 15 to sign up, you will pay a 1% per month penalty for every month you delay. If you were to wait 5 years to sign up, you would at that time pay a 60% premium penalty, and the penalty would last for your lifetime. (5 years x 12 months x 1% = 60%). The premium penalty will be calculated on the average premium for the geographical region in which you reside at that time.

Remember that you can change your plan each year during the open enrollment period in November. If you sign up for a plan which doesn't work particularly well for you, you will be able to switch in November to a better plan. Don't panic.





Dear Marci,

I just got a new prescription from my doctor and when I went to fill the prescription, the pharmacist told me that this medication is not on my Medicare private drug plan's formulary. Is there anything I can do? ~ John (Huntsville, AL)

Dear John,

Yes, there are a couple of things that you can do. First, you should ask your doctor if any of the drugs covered by the plan would work for you. If so, ask for a new prescription for that drug.

Second, if your doctor feels that only the drug originally prescribed will work for you, you should file an **exception request**.

You have the right to an exception to the plan's formulary (list of covered drugs) when

- your doctor prescribes a drug not on your plan's formulary because your doctor believes the drugs on the plan's formulary will not work for you; **or**
- you are using a drug covered by your plan, but that drug is removed from your plan's formulary for reasons other than safety

You generally **cannot** file an exception request at the pharmacy. You must call your Medicare private drug plan directly to request an exception. (You, someone you appoint, your legal representative or your prescribing doctor can file an exception for you.)

Your doctor will have to submit an oral or written statement certifying that the drug prescribed is medically necessary because other drugs are not as effective or may be harmful for you.

Generally, plans must grant these requests when they determine that it is medically appropriate to do so. **Plans must respond to your request in writing within 72 hours, or sooner if your health requires quicker attention.**

You can also ask for a faster response (an expedited request) when your "life, health or ability to regain maximum function" is in jeopardy. (Plans must expedite exceptions if your doctor certifies that such action is necessary for your health.) **Plans must respond to expedited requests within 24 hours or sooner if your health requires immediate attention.**

If a plan grants your request, it determines what your copayment will be for that drug. The plan must continue to cover refills at that copayment for the rest of the calendar year as long as the doctor continues to prescribe that drug, and it continues to be safe. It is up to the plan to decide whether you have to file a new exception request for that drug the next calendar year (if you renew membership).

Notes:

- You cannot ask for an exception for drugs specifically excluded from Medicare coverage by law.
- You can request an exception to get a lower copayment for a drug assigned to a higher-cost tier that is already included in your drug plan's formulary. But if you had to request an exception to get your plan to cover your prescription, you cannot then file a second exception to get a lower copayment for that drug.
- You can request an exception to other coverage restrictions, such as dose and dosage limitations, substitution requirements and step therapy.



The latest Kaiser Family Foundation tracking poll finds that **45%** of seniors say they have enrolled or plan to enroll in a drug plan, **29%** say they do not intend to enroll in a drug plan, and another **23%** say they are uncertain. Seniors are now almost twice as likely to say they view the benefit unfavorably (**45%**) as favorably (**23%**). That reflects a shift since August, when seniors' positive views peaked and they were as likely to view the benefit favorably as unfavorably.



FRAUD ALERT... FRAUD ALERT... FRAUD ALERT... FRAUD ALERT...

Be very aware that **marketing and retail pharmacists/pharmacies or physicians** may not conduct marketing activities at the site of care delivery. This means that no marketing of Medicare prescription drug plans may take place in front of where you pick up prescriptions or interact with your pharmacist or pharmacy staff, or in a waiting room at a doctor's office. **Most importantly**, pharmacy providers are prohibited from steering beneficiaries into specific plans. There have been several reports of all of these activities occurring in the state. If you have encountered such situations in your community, please send specific information in writing (or email) with details to our Fraud Patrol office.

ASMP John Pollett
PO Box 1437 Slot S530
Little Rock AR 72203-1437

email: John.Pollett@arkansas.gov
Kathleen.Pursell@arkansas.gov

Fraud in the News



which the doctor filled out "certificates of medical necessity" saying the patients needed the wheelchairs.

WHEELCHAIR SCAM SHUT DOWN IN ARKANSAS MAGNOLIA—

Nationwide, Medicare spending on power-wheelchairs spiraled from \$289 million in 1999 to \$1.2 billion in 2003, leading regulators to pronounce power-wheelchair fraud the "fastest growing scam in Medicare." Last year the spending declined to \$822 million due in large part to increased scrutiny and criminal prosecutions.

The first Arkansas physician convicted in the crackdown is now awaiting sentencing in a scheme that included kickbacks from wheelchair suppliers. Patrick Antoon Sr., a popular family doctor in Magnolia, was carrying a caseload of some 4,500 patients when a federal jury convicted him last November in Dallas.

Antoon, 51, and a pair of Nigerian wheelchair suppliers from Texas were found guilty of a conspiracy to defraud Medicare. A doctor from Dallas and a recruiter from Arkansas both pleaded guilty in the case, which prosecutors say accounts for at least \$2.65 million in fraud.

The scheme worked much like others which have been prosecuted: Unscrupulous medical equipment suppliers would dispatch recruiters to canvass neighborhoods which had concentrations of senior citizens. Recruiters would then promise Medicare beneficiaries "free" power wheelchairs and drive them to a doctor for an exam, after

The supplier, who paid the doctor a fee for each certificate he signed, would then deliver the patients a power wheelchair, a scooter which costs one-fifth of the price, or sometimes nothing at all. The supplier always billed Medicare for a \$5000 power wheelchair, however.

In the scam in Magnolia, Universal Health Services Inc., which was owned and operated by Ignatius Chuka "Chuck" Ogba and Ifeanyi Boniface "Iffy" Ogba, set up a satellite business in Magnolia in 2003. Apex Medical Services began operating from a strip center near the campus of Southern Arkansas University. Soon, recruiters were going door-to-door in Magnolia and other towns in south Arkansas.

Antoon's attorney, Dan Guthrie of Dallas, says that Antoon saw about 125 patients and received payment of \$200 for examining each one. Antoon thought the money was proper exam fees and the need of his patients for the power wheelchairs was legitimate, according Guthrie. The federal jury clearly saw things differently.

Source: Arkansas Democrat Gazette

IF YOU KNOW OF SUSPECTED POWER WHEELCHAIR FRAUD, REPORT IT!

1-866-726-2916 ASMP Toll-free Hotline

1-800-447-8477 Medicare Fraud hotline

HHSTips@oig.hhs.gov Medicare email hotline



FRAUD NEWS ACROSS THE NATION

ARIZONA SUES DRUGMAKERS

In December, Arizona State Attorney General Terry Goddard filed a suit against 42 drug companies. He asserts that the companies have cheated Arizona consumers and Medicare out of tens of millions of dollars by inflating or misstating the average wholesale price of their drugs, listing prices much higher than what they actually charge some doctors or pharmacies.

Insurers, including the state's Medicaid program, reimburse doctors and pharmacies for those drugs using the average wholesale price. In effect, the insurers end up paying out hugely inflated prices, sometimes as much as several thousand percent more than the doctors and pharmacies paid. The enormous profits generated for the doctors and pharmacies encourage more business for the drug companies. Goddard's assessment is, "It's a fraud. Insurance companies and consumers are being ripped off."

At least 14 other states are pursuing similar actions against both domestic and foreign drug companies, with the objective of recovering damages and forcing the companies to change their pricing practices.

Goddard noted that only physicians who administer drugs in their offices (typically drugs used in chemotherapy or transplant treatment) could be involved in the pricing scheme. The profits can be astronomical. As an example, some drug firms sell sodium chloride, a salt solution, to pharmacies and physicians for about \$4, but list the average wholesale price at \$670. This would mean the physician or pharmacy would make a \$666 profit when reimbursed by an insurer. That translates to a profit margin of 16,650 percent.

Goddard says the attorneys general in many states with whom he has consulted agree that the drug companies must stop inflating prices. Citing research which says Americans pay 174 percent higher drug prices on average than the rest of the world, Goddard notes, "We want to drive home a lesson. There is no transparency in the drug-pricing situation and there needs to be."



MEDICARE PAYMENTS FOR AMBULANCE TRANSPORTS

The Office of Inspector General (OIG) has issued a report finding that 25 percent of ambulance transports reimbursed by Medicare in 2002 did not meet Medicare program requirements, resulting in an estimated \$402 million in improper payments.

Medicare covers and pays for emergency and non-emergency ambulance transports when a beneficiary's medical condition, at the time of the transport, is such that other means of transportation, such as taxi, private car, wheelchair van, or other type of vehicle, would jeopardize the beneficiary's health.

Despite previous OIG inspections indicating that transports for dialysis treatment and other non-emergency transports were particularly vulnerable to abuse, 27 percent of dialysis transports and 20 percent of non-emergency transports continue to not meet Medicare's requirements. In contrast, only 7 percent of emergency transports failed to meet the requirements.

Any potentially fraudulent or abusive ambulance transport providers should be reported to the Fraud Patrol hotline **1-866-726-2916**, or the OIG fraud hotline.

By phone: 1-800-HHS-TIPS (1-800-447-8477)

By fax: 1-800-223-8164

By email: HHSTips@oig.hhs.gov

By mail: Office of Inspector General
Dept of Health and Human Services
Attn: HOTLINE
330 Independence Ave, SW
Washington, DC 20201

Don't call us ...

Percentage of adults who say they registered for the "Do Not Call" registry:



September
2003



January
2004



December
2005

Source: Harris Interactive online surveys of 1,011 , 3,378 and 1,961 adults. Margins of error ranged from ± 2 or 3 percentage points.

WHAT YOU SHOULD KNOW ABOUT THE NATIONAL DO NOT CALL REGISTRY:



The National Do Not Call Registry gives you a choice about whether to receive telemarketing calls at home. Most telemarketers should not call your number once it has been on the registry for 31 days. If they do, you can file a complaint at this Website. You can register your home or mobile phone for free. Your registration will be effective for five years.

Go to: www.donotcall.gov to register.

You must have a valid email address to use the website.

"But I don't have online access! How do I register??"

You can register by telephone. Call **1-888-382-1222** from the phone number you wish to register.

The Do-Not-Call registry does not prevent **all** unwanted calls. It does **not** cover the following:

- calls from organizations with which you have established a business relationship;
- calls for which you have given prior written permission;
- calls which are not commercial or do not include unsolicited advertisements;
- calls by or on behalf of tax-exempt non-profit organizations.

What can I do about endless CREDIT CARD offers in my mailbox??



If you receive unwanted pre-approved credit card offers in your mail weekly or even daily, you are probably aware of the potential for fraud and identity theft. There are steps you can take to restrict or reduce the offers being sent to you.

Under the Fair Credit Reporting Act (FCRA), the Consumer Credit Reporting Companies are permitted to include your name on lists used by creditors or insurers to make firm offers of credit or insurance. The FCRA also provides you the right to "**Opt-Out**", which prevents those companies from providing your credit file information for firm offers of credit or insurance that are not initiated by you.

www.optoutprescreen This website will allow you to opt-out of receiving offers from four major lists. **IMPORTANT NOTE:** The website asks for your Social Security number and birthdate, then notes those numbers are not required to process your request. To safeguard your personal information **DO NOT ENTER YOUR SOCIAL SECURITY NUMBER**, and you may choose to not enter your birthdate as well.

You may also contact three of the companies by mail or phone to tell them you wish to opt-out.

Write to TransUnion: TransUnion Corporation's Name Removal Option, PO Box 97328, Jackson, MS 39288-7328 (1-888-5OPTOUT or 1-888-567-8688)

Write to Equifax: Equifax, PO Box 105873, Atlanta, GA 30348

Write to Experian: Consumer Opt Out, 701 Experian Parkway, Allen, TX 75013



WELCOME TO OUR NEW PARTNERS

We welcome to Arkansas Senior Medicare/Medicaid Fraud Patrol new regional partners, some of which have partnered with us before. For the 2006 grant year we now have 10 regional partners and a collective of GACA volunteers.

AAA of Northwest Arkansas

Jerry Mitchell
1510 Rock Springs Road
PO Box 1795
Harrison AR 72602-1795
870-741-1144

new!!

EOA of Washington County RSVP

Katy Young
614 E. Emma Ave Suite M401
Springdale AR 72764
479-872-7479

new!!

ANTs

(Advocates Needed Today)

Rebecca Riggs
8500 W. Markham Suite 215
Little Rock AR 72205
501-372-0607

new!!

Jefferson County RSVP

Denise Grace
211 West 3rd Ave Suite 125
Pine Bluff AR 71601
870-534-2156

ARVAC

Annia Via & Sue Bradford
613 North 5th Street
PO Box 808
Dardanelle AR 72834
479-229-4861

Mid-Delta Community Services

Clarice Sanders
53 Poplar Street
Marianna AR 72360
870-295-3697

CareLink

Elaine Eubank
706 West 4th Street
North Little Rock AR 72119
501-372-5300

new!!

Texarkana RSVP

Ermer Pondexter
3rd & Walnut Streets
PO Box 2711
Texarkana AR 71854

El Dorado RSVP

Linda Fitts
824 Camp Street
El Dorado AR 71730
870-864-7080

new!!

WestArk RSVP

Susan Reehl
401 North 13th Street
Fort Smith AR 72901
479-783-4155

Partnership Focus



The **Governor's Advisory Council on Aging (GACA)** serves the purpose of advising the Governor and the Division of Aging and Adult Services about the needs of older Arkansans and the programs that serve them. GACA is governed by a set of by-laws established by council members. The Governor appoints members who serve a four-year term and meet quarterly in Little Rock.

Currently serving as president of the council, Lamar Cole notes that GACA has representatives with varied backgrounds from all parts of the state, with one shared goal: to make life better for the older citizens of Arkansas.

Several members of GACA have come onboard with ASMP to serve as Fraud Patrol volunteers, and we are spotlighting this excellent group of volunteers this month with biographies of a few of these active and proactive volunteers.

SPOTLIGHT ON VOLUNTEERS



HARRIET RALEY— Harriet was born in Murphreesboro, TN and graduated from Mississippi State College for Women with a degree in Nutrition. Her husband worked for IBM, which Harriet notes stands for “I’m Being Moved.” When they lived in Minnesota, Harriet completed a dietetic internship with St. Mary’s Hospital, which is connected with the Mayo Clinic. They also lived in Ohio and Maryland, during which years Harriet held various positions, diagnosing nutritional problems for children with developmental disabilities as food services director, co-writing a newspaper column, and serving on the board of directors for the Maryland Diabetes affiliate.

Once retired, the Raleys moved to Arkansas. Both of their children had graduated from Harding University, and Harriet and her husband felt that living in Searcy would put them in a place where their children would often be returning for school events. Their theory proved correct and in recent years both Harriet’s mother-in-law and mother have also made the move to Arkansas.

Harriet has served on GACA for 7 or 8 years, and currently is the vice-president of the council. In volunteering for ASMP, Harriet notes that education of our seniors is paramount, and emphasized the need for fraud awareness so that seniors can safeguard their assets for themselves.



ELLA TAYLOR— Ella was born in Cumberland, MD and graduated from Wheaton College in Illinois with a degree in chemistry. She earned her PhD in chemistry from the University of Illinois on a Wednesday, and married her husband on Saturday, moving to Arkansas where he had relocated to benefit from the “land of opportunity” and abundant acreage. Except for teaching one year at a local high school, Ella says she did not use her chemistry degree in the typical or expected way. She has worked

for their family business for years as they grew to farm 4,000 acres of rice and soybeans raised for seed, and owned their own seed plant with as many as 30 employees. Ella and her husband raised six children who have diversified in life and taken career paths as a doctor, missionary, registered nurse, home-ec teacher/homemaker, chemical engineer and a physical therapist.

Ella has served with GACA for five years now. Noting that she was raised during the depression and developed a sense of frugality and fiscal restraint, she feels that education in financial matters is the key to overcoming a pervasive attitude of entitlement and financial irresponsibility for the next generation, and even seniors today can benefit from adjusted attitudes and financial wisdom.

LAMAR COLE— Lamar hails from the Helena/West Helena area and graduated from Arkansas State College with a degree in Music Education. He earned a Masters degree in Administration from Arkansas State University and did further graduate work at UALR. Married to Dot since 1953, Lamar spent fifteen years in eastern Arkansas as a high school band director and school administrator. During the Korean War, Lamar served two years with the 74th Army Band. He held a position as an administrator with the Arkansas Activities Association for 26 years, including 13 years as the executive director.

While living in the North Little Rock area, Lamar chaired several commissions and served as a member on numerous boards and associations reflecting his interests in music, education, sports, business, health services and aging. The Coles now make their home in Fayetteville, where Lamar continues to serve, currently as a board member of the Washington County Council on Aging, the president of the Governor’s Advisory Council on Aging, and as a volunteer for Arkansas Senior Medicare/Medicaid Patrol, among other activities. The Coles have two daughters.

Lamar relates that he felt compelled to join ASMP as a volunteer after hearing a presentation by Sharon Marcum at a GACA board meeting. He says that after seeing how much fraud is involved with the Medicare/Medicaid programs and how gullible “we” are about the fraud waste and abuse, he decided to do something about it. By informing seniors in his area about what to look for and how to report suspected fraud, waste and abuse, he feels that the program is making a difference.

Be Informed...Be Aware...Be Involved!

To Report Suspected Medicare or Medicaid Fraud

Call Toll-free 1-866-726-2916

Mark Your Calendars!

Quarterly Advisory Council Meetings

**April 25, 2006
July 25, 2006
October 24, 2006**



**All meetings will be held at the DHHS
Central Complex in Little Rock.
Donaghey Plaza South Building,**

**700 Main Street, Little Rock.
Conference Room B , 10-noon.**

**Some meetings will have additional
training/work sessions with lunch
provided, lasting until 2 or 3 pm. You will
be notified in advance of the extended
schedule.**