OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

Training

Statewide Health Insurance Benefits Advisors (SHIBA)

Medicare complaints including appeals, grievances and SHIBA complaints

- Volunteer binders
- Appeals and grievances
- SHIBA complaint process
- Complaints and associated fraud
- VRPM update
- Resources and reminders

February 2018 volunteer training

Table of contents

Volunteer learning objectives

After completing the February 2018 monthly training, volunteer advisors and volunteer coordinators will be able to:

- ✓ Identify priority reference sources for their binders
- ✓ Describe the appeals process for Original Medicare, Medicare Advantage (MA) plans and Medicare Part D drug plans
- ✓ Differentiate between appeals and grievances
- ✓ List the steps to elevate a client case that needs further work
- ✓ Organize a system to track additional, more in-depth Medicare resources
- ✓ Explain the fraud and abuse issues of concern to clients in the community

Handouts for this training packet

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1. Complaints Process, two-page document
2. Medicare Appeals, 60-page booklet
3. Making Sense of Your Medicare Statements, three-page document
4. Medicare redetermination request form — 1st Level of appeal, one-page document
5. Welcome to Livanta, the BFCC-QIO for Washington, one-page document
6. Quick Facts about Medicare Plans & Protecting Your Personal Information, two-page document

Troubleshooting and sharing time

Please take some time to share with your group any thoughts on:

- Current issues and questions you're encountering
- New pertinent information you've learned (room for notes on page 5)

Volunteer advisor binder update for 2018

As a SHIBA volunteer advisor, you should have your training and reference materials on hand to use for counseling sessions.

Last month we discussed and brainstormed training and reference materials you need in your role as a volunteer advisor. Next month, we'll look at all your responses and compile a list of the top items you collectively think you should have for counseling sessions. SHIBA staff will create a final list. If you couldn't participate in January, please use the back page of this packet to let us know what you think those top items should be.

- Starting in March 2018, SHIBA expects you to keep your counseling files organized and current. Volunteer advisors should have a standard packet of materials on hand for all counseling sessions.
- You can keep your materials in a three-ring binder or accordion file…whatever works best for you.

What type of materials are helpful for you to have with you?

- QRCs, booklets, packets?
- Copies to include?
- Binders?
- Section dividers?
- Pens?
- SHIBA volunteer business cards?
- Sticky note pads?
- SHIBA rack cards?

Take a few minutes to share ideas from last month and any new ideas.

Next month, bring your own binder, accordion folder or whatever you prefer to use. Your Regional Training Consultant (RTC) will try to bring a few for those who may need one. **Please add your ideas about priority items for your counseling binder to the back page of this packet and return to your RTC!**

Notes:

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Medicare complaints: Messages and assistance process

This month we are covering complaints. There are different types of complaints including appeals, grievances and SHIBA complaints. In an effort to help you as a volunteer advisor, this training will cover the difference between these types of complaints and the processes for you to follow when working with clients.

This training packet and associated handouts will provide an overview of the following training **messages**:

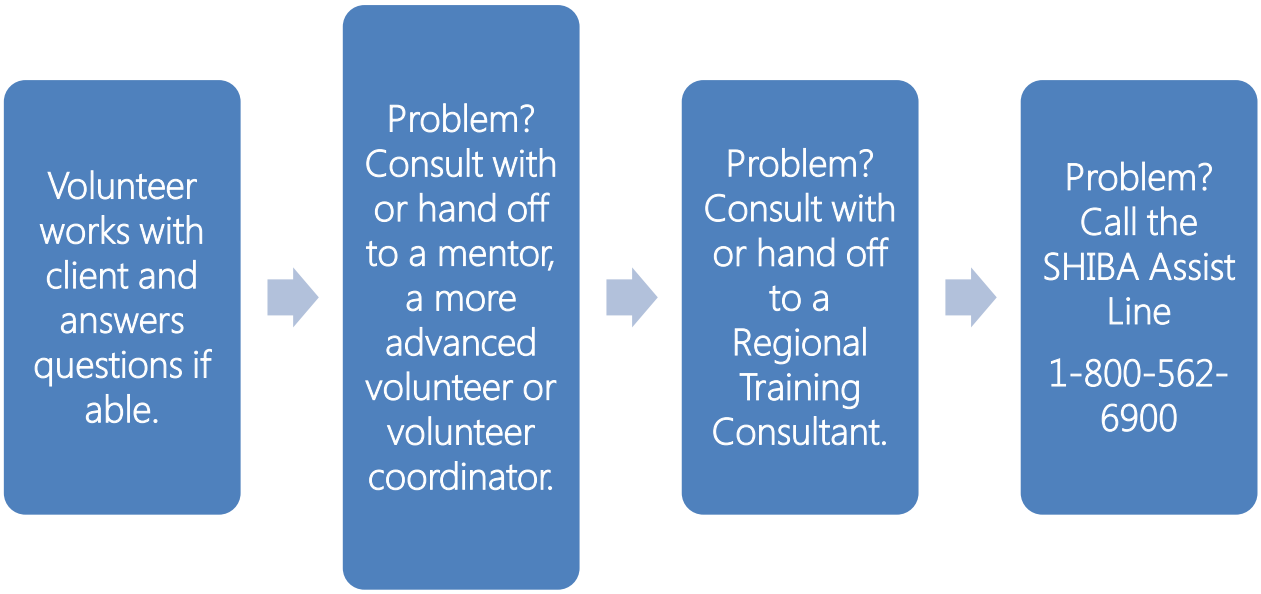
- *You* can help people with their questions as well as their appeal and complaint issues.
- You, along with your fellow volunteers or SHIBA staff, can handle client questions before escalating it to a SHIBA complaint.
- You can receive the support you need to help with more complicated issues.
- There are differences between appeals, grievances and SHIBA complaints.
- Start the process to help the client: Get the details, ask for help when you need it.
- If you aren't sure how to answer some of the client's questions, SHIBA staff can help you work with the client and the process about how to move it forward.
- There may be times when you need to correspond with clients or other SHIBA staff by email. This is OK to do. To better keep track of the details, we recommend you put any comments and questions in the notes field of the Client Contact Record (CCR). Then you can just send the CCR number via email. *Remember,* you might need to encrypt your email if you send more information than just the CCR number.

Here's the **assistance process** we recommend you follow when helping clients *(also see diagram for the process below):*

1. Volunteer advisor helps client by asking for and collecting the following information: Who, what, where, when, why and other details about what occurred.
2. If there is a problem with assisting the client, consult with or hand off to a mentor, a more advanced volunteer or your volunteer coordinator.
3. If you hit a road block and need additional help, consult with your Regional Training Consultant (RTC). Your RTC will provide you with guidance or if it's a complicated issue, he or she will take it on.

If there is still a problem, or you need an answer quickly, call the Office of the Insurance Commissioner's hotline at 1-800-562-6900 and ask for the SHIBA Assist Line, which goes to Tumwater SHIBA staff assigned to take calls (your call may go to a special voice mail box where staff frequently check the messages).

Medicare assistance process



We have a team ready to support you!

Dale Ensign, Regional Training Consultant
DaleE@oic.wa.gov | 360-725-7108

Terri Osborne, Regional Training Consultant
TerriO@oic.wa.gov | 360-725-7084

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JudithB@oic.wa.gov | 360-725-7107

Pam Brannan, Resolution Coordinator
PamB@oic.wa.gov | 360-725-7198

SHIBA Assist Line

1-800-562-6900

Medicare complaints: Overview and definitions

This section provides an overview of and definitions for different types of complaints including appeals, grievances, and SHIBA complaints. It'll also include a definition of fraud as it applies to Medicare complaints.

We'll look at the differences, some examples and do a group exercise to help with understanding appeals as they relate to:

1) Original Medicare;
2) Medicare Advantage (MA) plans; and
3) Medicare prescription drug plans.

It's important to know the **difference between appeals and grievances**. This will help you to coach your clients on how they can file an appeal with Medicare so they're not referred to the SHIBA Complaints Coordinator, whose role is to focus on complex issues.

What's the difference between an appeal and a grievance? Basically, an *appeal* is a type of complaint a client may have against a plan or provider over an issue such as something that wasn't paid for, wasn't approved or was denied. A *grievance* is about something a plan has done that a client is now unhappy about. Below are more detailed definitions of appeal and grievance along with examples.

An appeal: An appeal is the action a client takes if he or she disagrees with a coverage or payment decision made by Original Medicare, a Medicare Advantage plan or a Medicare prescription drug plan. The client can appeal if Medicare or his or her plan denies a request:

- For a health care service, supply, item or prescription drug he or she thinks they should be able to get

- For payment of a health care service, supply, item or prescription drug he or she already received – or stops providing or paying for all or part of a service, supply item or prescription drug he or she already received
- To change the amount he or she must pay for a health care service, supply, item or prescription drug he or she thinks they need

The client will need to follow the appeal process outlined by his or her Medicare Advantage plan, prescription drug plan or Original Medicare.

A grievance: This is about the quality of care or other services clients get from a Medicare provider. For example, clients may file a grievance if they have a problem calling the plan or if they're unhappy with the way a staff person at the plan treated them, or the conditions at a hospital (like the food is cold).

A grievance is not the process clients use when they have an issue with a plan's refusal to cover a service, supply or prescription. That's an appeal process.

See the *Medicare Appeals* booklet page 43 for additional information.

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A note about complaints and grievances

You can find more information at Medicare.gov. Search for "How do I file an appeal?" or "How do I file a complaint." This online section includes information about filing an appeal, including an explanation of what an appeal is and what the client can do if he or she decides to file an appeal.
www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html
or
www.medicare.gov/claims-and-appeals/file-a-complaint/complaint.html

Important! Medicare also refers to a complaint as a grievance and uses the terms interchangeably on their website. Make note of how SHIBA uses the terms appeal, grievance and SHIBA complaint. These are three different types of complaints and are differentiated so you are able to help your clients and work with SHBIA processes.

If there are ever questions about definitions, please be sure to ask!

An appeal should be a part of the process *BEFORE* a volunteer or client submits it as a SHIBA complaint.

What is a SHIBA complaint? In SHIBA, the process we use to elevate complaints to our Complaint Coordinator is to mark a Client Contact Record (CCR) as a complaint. ***SHIBA complaints should be a last resort.***

Please review this checklist BEFORE you submit a complaint to the SHIBA Complaints Coordinator:

- ☐ Is this actually a question about coverage or costs for services? If so, educate and assist the client to contact their plan to ask questions.
- ☐ Is this actually a GRIEVANCE? If so, educate and assist the client to submit it to the appropriate place.
- ☐ Is this actually an APPEAL? If so, educate and assist the client to submit it to Medicare or the plan as appropriate.
- ☐ Is this actually a billing problem? If so, educate and assist the client to contact the medical provider or billing office to make sure they have all the information they need to submit the bill to the correct payer for the correct service.
- ☐ If the issue does not fit into one of the above checklist items, and you are unable to help the client resolve it, consider consulting or handing the issue to a mentor, more experienced volunteer, volunteer coordinator or consult with your Regional Training Consultant.
- ☐ After considering the above checklist items, if you're unable to help the client resolve his or her issue, or if the issue is URGENT, submit it as a complaint using the two-page ***SHIBA Volunteer Complaint process*** document which is a February handout and on MyShiba.

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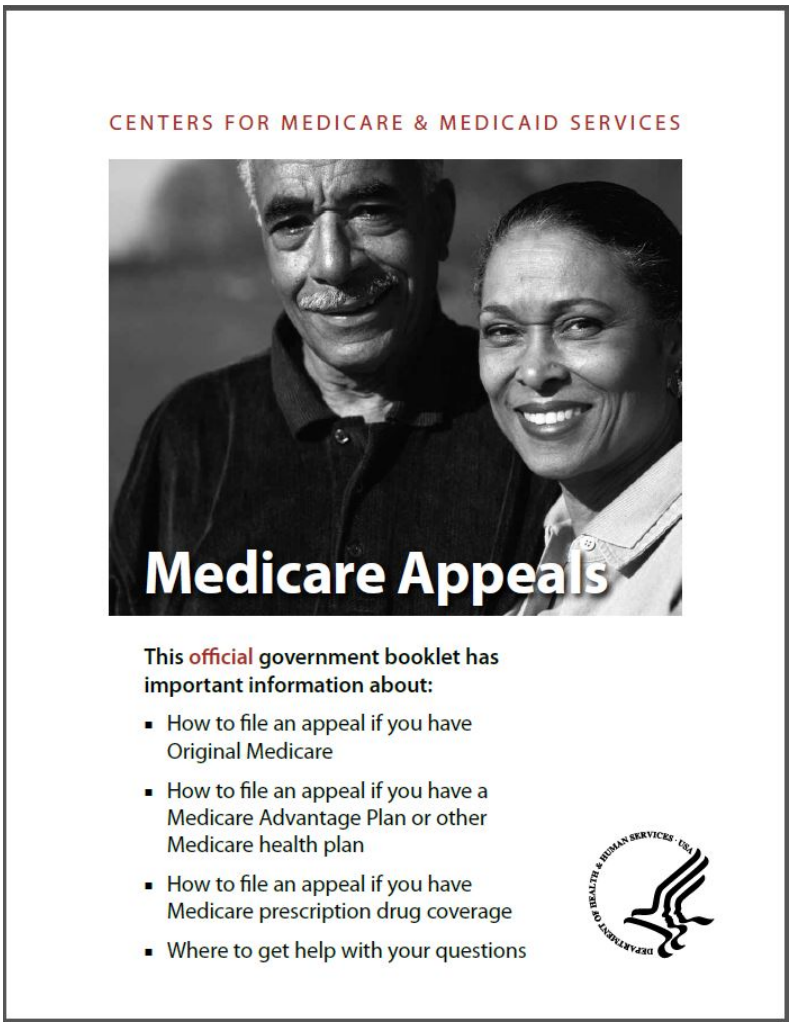
Volunteer activity



You should each have a *Medicare Appeals* booklet and hopefully you've had a chance to preview it before today's training—either a paper copy or online.

Source: www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf
62-page booklet, available online or with the February 2018 training packet handouts.

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Activity

Let's learn about the processes for Original Medicare (OM), Medicare Advantage (MA) and Part D. All have timelines and processes. Volunteer advisors should be able to help clients understand the rules and timing.

Activity Step 1. As a group, start by spending a few minutes reviewing and discussing Section 1: "What can I appeal?" Your RTC or VC will lead the discussion (see pages 7 – 10).

Section 1: What can I appeal?

Notes:

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Activity Step 2. Divide into three groups.

The RTC or VC will assign each group one section of the booklet to discuss for 15-20 minutes. Each group should choose one person take notes for the group. At the end of 15-20 minutes, choose a group member to share with everyone the highlights of your section.

Section 2: How do I appeal if I have Original Medicare? (See pages 11 – 30.)

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Section 3: How do I appeal if I have a Medicare Advantage plan or other Medicare health plan? (See pages 31 – 44.)

Notes:

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Section 4: How do I appeal if I have Medicare prescription drug coverage? (See pages 45 – 58.)

Notes:

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Activity Step 3. A member from each group will share key learning points from their section of the booklet with everyone.

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Activity Step 4. Share any comments or observations as a group.

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Notes:

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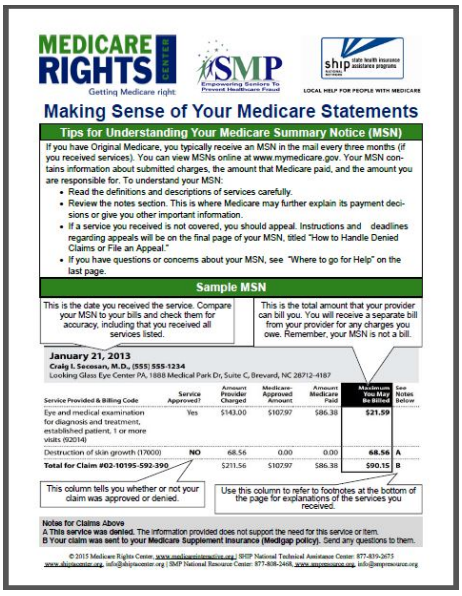
Other resources: Understanding and gathering client details

Sometimes questions from clients arise because they don't understand their Medicare Summary Notices or their Explanation of Benefits, or they have issues filling out forms.

Review the following document for more information about what type of client details to collect and where to send information.

MSN: Medicare Summary Notice
EOB: Explanation of Benefits

Making sense of your Medicare statements


MEDICARE RIGHTS CENTER
Getting Medicare right
SMP Empowering Seniors To Prevent Healthcare Fraud
ship state health insurance assistance program
LOCAL HELP FOR PEOPLE WITH MEDICARE

Making Sense of Your Medicare Statements

Tips for Understanding Your Medicare Summary Notice (MSN)

If you have Original Medicare, you typically receive an MSN in the mail every three months (if you received services). You can view MSNs online at www.mymedicare.gov. Your MSN contains information about submitted charges, the amount that Medicare paid, and the amount you are responsible for. To understand your MSN:

- Read the definitions and descriptions of services carefully.
- Review the notes section. This is where Medicare may further explain its payment decisions or give you other important information.
- If a service you received is not covered, you should appeal. Instructions and deadlines regarding appeals will be on the final page of your MSN, titled "How to Handle Denied Claims or File an Appeal."
- If you have questions or concerns about your MSN, see "Where to go for Help" on the last page.

Sample MSN

This is the date you received the service. Compare your MSN to your bills and check them for accuracy, including that you received all services listed.

This is the total amount that your provider can bill you. You will receive a separate bill from your provider for any charges you owe. Remember, your MSN is not a bill.

January 21, 2013
Craig I. Secesan, M.D., (555) 555-1234
Looking Glass Eye Center PA, 1888 Medical Park Dr, Suite C, Brevard, NC 28712-4187

Service Provided & Billing Code	Service Approved?	Amount Provider Charged	Medicare-Approved Amount	Amount Medicare Paid	Maximum You May Be Billed	See Notes Below
Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014)	Yes	$143.00	$107.97	$86.38	$21.59	
Destruction of skin growth (17000)	NO	68.56	0.00	0.00	68.56	A
Total for Claim #02-1019S-S92-390		$211.56	$107.97	$86.38	$90.15	B

This column tells you whether or not your claim was approved or denied.

Use this column to refer to footnotes at the bottom of the page for explanations of the services you received.

Notes for Claims Above
A This service was denied. The information provided does not support the need for this service or item.
B Your claim was sent to your Medicare Supplement Insurance (Medigap policy). Send any questions to them.

© 2015 Medicare Rights Center, www.medicarerights.org | SMP National Technical Assistance Center: 877-839-2675
www.shiptacenter.org, info@shiptacenter.org | SMP National Resource Center: 877-808-2468, www.smpresource.org, info@smpresource.org

This flyer helps clients understand how to read a Medicare Summary Notice (MSN) and an Explanation of Benefits (EOB).

Understanding the MSN and EOB may help ease their questions and issues that could lead to Medicare appeals, grievances and SHIBA complaints.

This document also defines some basic terms and provides tips on where clients can go for help on making sense of Medicare statements.

Source: www.insurance.wa.gov/sites/default/files/documents/medicare-statements-msn.pdf

This three-page document is a February handout.

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Homework

Medicare redetermination request form — 1st level of appeal

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: _____
2. Medicare number: _____
3. Item or service you wish to appeal: _____
4. Date the service or item was received: _____
5. Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)

5a. Name of the Medicare contractor that made the determination (not required):

5b. Does this appeal involve an overpayment? ☐ Yes ☐ No
(for providers and suppliers only)

6. I do not agree with the determination decision on my claim because:

7. Additional information Medicare should consider:

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.
☐ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative

10. Name, address, and telephone number of person appealing: _____

11. Signature of person appealing: _____

12. Date signed: _____

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further reconsider your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services or another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54689 (2006) or at http://www.cms.gov/Privacy/SystemsofRecords/downloads/0566.pdf

Form CMS-20027 (12/15)

This is a sample of the 1st level of appeal form (Form CMS-20027) and a quick scenario for homework is on the next page.

Make note of the questions the form asks and the type of information it requests from the beneficiary. These type of questions include the type of details you should collect from a client to help them file an appeal.

Source: www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20027.pdf

See the one-page document on page 22 of this packet. It is also a February handout.

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Homework Project

This is a project you can work on outside of today's class. We'll review the answers at next month's meeting. Do your best to complete the Medicare Redetermination Request Form on page 28 (or handout) using the following scenario:

You're working with client who can't fill out the form on their own. This is a 1st level of appeal.

Mr. Elvis H. Presley, Medicare number 324-86-xxxxa, claims he had an eye exam because his eye doctor is following up after cataract surgery. The doctor noticed a small growth on Mr. Presley's eyelid, which bothered him when he blinked. The doctor destroyed the skin growth on his eyelid. Medicare did not approve the service. Please outline the steps Mr. Presley should take before he files an appeal. Then help him complete the appeal form.

The name of the Medicare contractor is:

Noridian Healthcare Solutions
P.O. Box 6700
Fargo, ND 58108

See the next two pages for your homework instructions and the **Medicare redetermination request form**.

Homework Instructions

Work on this from home as you have time. See page 26 for instructions. ***Bring the filled out form with you next month*** and we'll discuss as a group.

1. Outline the steps your client should take before filing an appeal:

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2. Help your client by completing the one-page 1st level of appeal form. Where to find the form:
   - The form is on the next page and available as a February handout.
   - Online www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20027.pdf

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM — 1ST LEVEL OF APPEAL

1. Beneficiary's name: _____
2. Medicare number: _____
3. Item or service you wish to appeal: _____
4. Date the service or item was received: _____
5. Date of the initial determination notice (please include a copy of the notice with this request):
   (If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)

   _____

   _____

   _____

   5a. Name of the Medicare contractor that made the determination (not required):

   _____

   5b. Does this appeal involve an overpayment? ☐ Yes ☐ No
   (for providers and suppliers only)
6. I do not agree with the determination decision on my claim because:

   _____

   _____

   _____

7. Additional information Medicare should consider:

   _____

   _____

   _____

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.
   ☐ I do not have evidence to submit.
9. Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative
10. Name, address, and telephone number of person appealing: _____

    _____

11. Signature of person appealing: _____
12. Date signed: _____

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54489 (2006) or at http://www.cms.gov/PrivacyActSystemofRecords/downloads/0566.pdf

Form CMS-20027 (12/10)

Other resources for appeals and grievances

Livanta BFCC-QIO for Washington state


Quality Improvement Organizations | LIVANTA From practical innovations to results.

Welcome to Livanta, the BFCC-QIO for Washington

The Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) handles all Medicare beneficiary complaints, quality of care reviews, medical necessity reviews, and discharge appeals from hospitals, skilled nursing facilities, home health and hospice providers, and rehabilitation facilities.

Medicare patients have certain rights and protections, and Livanta is here to help.

Livanta BFCC-QIO HelpLine: 1-877-588-1123 Translation services are available

Please have the following information when calling:
- Medicare card & number
- Date of birth
- Address and phone number
- Dates of service
- Provider contact information

Livanta is Your QIO for Case Review

Appeals
- An appeal can be filed if you think your Medicare services are ending too soon. For example, you are told the nursing home is discharging you, but you do not feel healthy enough to leave.
- If you wish to file an appeal, call Livanta at 1-877-588-1123.

Complaints
- A complaint relates to a concern about the quality of care or other services you get from a Medicare provider. For example, you developed a hospital-acquired infection and did not receive treatment.
- If you wish to file a complaint, call Livanta at 1-877-588-1123.
- You will need to complete a Medicare Quality of Complaint Form found at: www.bfccqioarea5.com/states/wa.html.

You may mail the form to: BFCC-QIO Program, Area 5
9090 Junction Dr, Suite 10
Annapolis Junction, MD 20701

- Hours for Complaints: Monday - Friday: 9:00 a.m. - 5:00 p.m. (local time)
  Hours for Appeals: Monday - Friday: 9:00 a.m. - 5:00 p.m. (local time)
  Weekends - Holidays: 11:00 a.m. - 3:00 p.m. (local time)
  24 hour voicemail service is available

If a medical provider discharges a patient and the patient thinks they're being discharged from a hospital or skilled nursing facility (SNF) too soon, Livanta is the place for a client to call for help for an appeal with their rights at time of transition or discharge.

The client can also call Livanta to submit a grievance about his or her plan.

The two-page flyer serves people living in Washington state. It is available as a February handout.

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Source: bfccqioarea5.com/file/flyer_wa.pdf

Medicare appeals


CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Appeals

This official government booklet has important information about:
- How to file an appeal if you have Original Medicare
- How to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan
- How to file an appeal if you have Medicare prescription drug coverage
- Where to get help with your questions

Wherever this booklet mentions the BFCC–QIO, they are referring to Livanta.

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See the Livanta flyer (above) which is a February handout.

Complaints and fraud

Here are some pointers if you hear about possible fraud.

- Medicare fraud schemes can increase at different times of the year, especially during transitional times such as a move, Open Enrollment season or someone's issued a new Medicare card. To help prevent clients from becoming victims during a potential fraud situation, it's very helpful if you can to get as much information as possible from the client about the potential fraud situation. For example ask the client for:

  - Telephone number of the potential scammer
  - Company name
  - Copy of any mailers they received

- The SHIBA Complaints Coordinator submits suspected fraud complaints via our Senior Medicare Patrol (SMP) System called "SIRS." Again, if clients want to report possible fraud, collect as much information as possible and complete a CCR and mark it as a complaint. Be sure to note it's suspected fraud.

  If there are any supporting documents, such as advertising, etc., assist clients with arranging to send copies to the Complaints Coordinator in one of three ways:

  1. Fax to 360-664-2782, Attention: Liz Mercer
  2. US Mail to:
     Office of the Insurance Commissioner
     Attn: Liz Mercer
     PO Box 40255
     Olympia, WA 98504-0255
  3. Encrypted email to SHIBA at SHIBA@oic.wa.gov

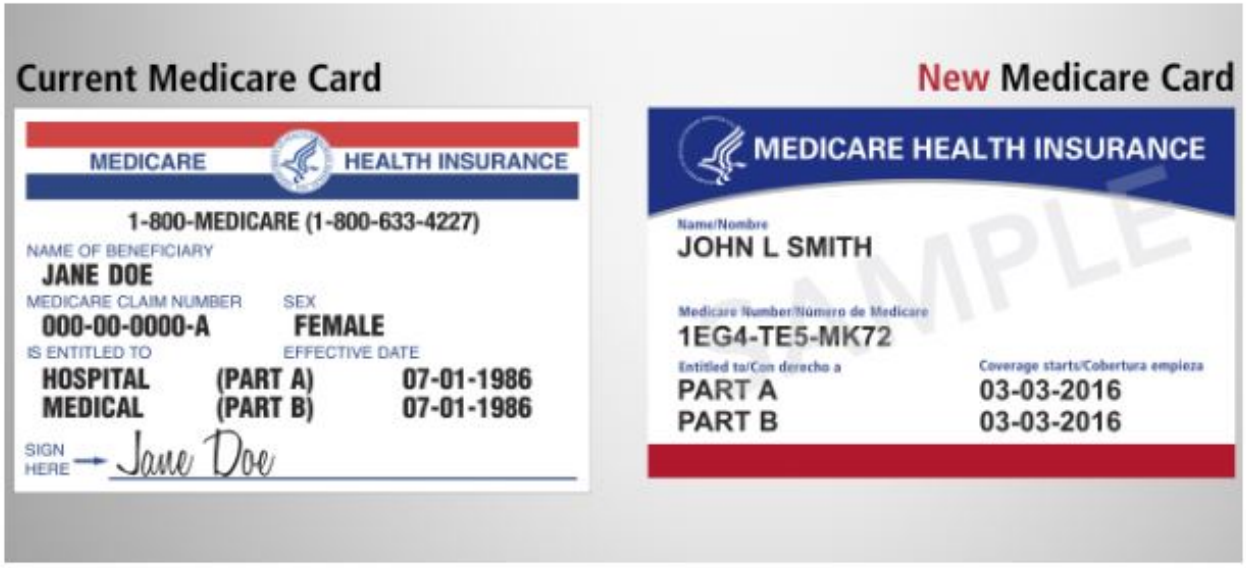
Fraud and the new Medicare card

Medicare will mail out new Medicare cards between April 2018 and April 2019.

Reminders:

- Review your **January 2018 materials** for a reminder on the new Medicare card and protection of this valuable card.
- Watch the *Guard Your Card* video:
  - www.youtube.com/watch?v=5KZpPrqMqCc

- Here is an example of the current Medicare card versus the new card.



- Flyer: *You're getting a new Medicare card!*

It's available in English and Spanish.

It's available from Fulfillment under the Medicare section when ordering SHIBA publications.

Fulfillment: www.insurance.wa.gov/order-shiba-publications

Notes:

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Fraud prevention reminders

Medicare **fraud** typically includes any of the following:

Clients are:

- Billed for services or equipment they didn't received
- Offered free testing or screening in exchange for their Medicare number
- Charged for filling out claim forms

Medical providers:

- Perform services that exceed what's medically necessary
- Offers or accepts referral feed from another provider for the referral
- Misrepresents services billed to Medicare
- Waives the coinsurance or deductible

Be sure to remind clients if they receive a phone call asking for his or her Medicare number, or other personal information, tell them to hang up and call **1-800-MEDICARE** (1-800-633-4227) to report the situation.

Also remind clients:

- Guard their Medicare card like they would a credit card.
- Don't share their Medicare number with anyone who contacts them by telephone, email or in person, unless they've given them permission in advance. Medicare will NEVER contact beneficiaries (unless the beneficiary asks them to) for their Medicare number or other personal information.
- Don't ever let anyone borrow or pay to use their Medicare number.
- Review their Medicare Summary Notice to make sure that they and Medicare are only being charged for actual items and services received.
- There are no "early bird discounts" or "limited time offers."

- Don't let anyone rush them to enroll by claiming they need to "act now for the best deal."
- They should be skeptical of free gifts, free medical services, discount packages or any offer that sounds too good to be true.

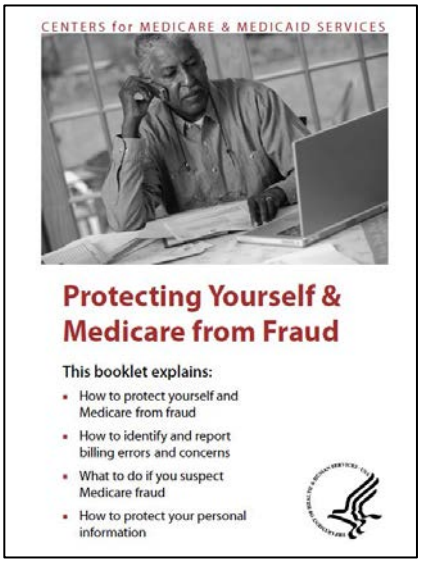
Help SHIBA by letting your RTC know if you are hearing any issues about fraud, especially as it relates to the new Medicare card.

Clients can learn more about protecting themselves from identity theft and health care fraud at www.Medicare.gov/fraud or they can contact our SHIBA program at 1-800-562-6900. SHIBA is Washington's Senior Medicare Patrol--we help prevent, detect and report Medicare fraud.

Fraud resources

Fight fraud: Guard your Medicare card

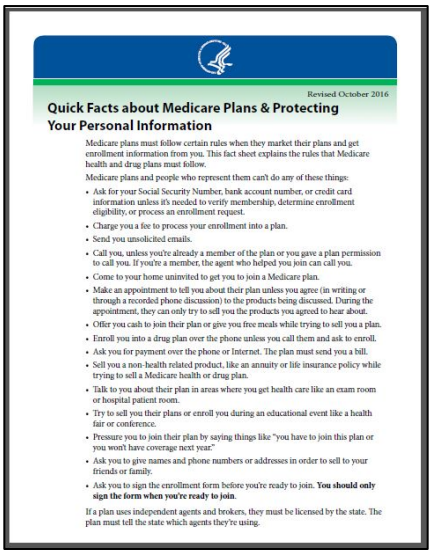
Guard your card just like you would a credit card.



***Protecting Yourself & Medicare from Fraud* booklet**

Source: www.medicare.gov/Pubs/pdf/10111-Protecting-Yourself-and-Medicare.pdf

You can order this 20-page publication from CMS, Product Order 11525.



***Quick Facts about Medicare Plans & Protecting Your Personal Information* flyer**

Source: www.medicare.gov/Pubs/pdf/11147-Medicare-Plans-and-Protecting-Your.pdf

This two-page document is a February handout. You can also order this publication from CMS. Product Order 11147.

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Volunteer Risk Program Management (VRPM) update

Calendar highlights:

December 2017

- Developed section 2.0 Risk Management & Health and Safety policies.
- Started planning for VRPM training.
- Reworked Path to SHIBA certification.

January – July 2018

- Develop section 3.0 Volunteer Program Management policies.
- Plan and train RTCs and VCs.

August – December 2018

- Update Volunteer Handbook and Sponsor Operations Manual with policies.
- Train VCs and volunteer advisors on new policies.
- Once training's completed, SHIBA will include VRPM information as a part of Basic Training.

Thanks to everyone who provided feedback on your agency policies along with questions and comments.

Here are two examples of Section 3.0 volunteer program management policies:

Administration for Community Living (ACL) required policy:	**SHIBA volunteer handbook policy**
3.5 Volunteer rights and responsibilities [Required]: Volunteers are viewed as a valuable resource to the SMP/SHIP, its staff, and its beneficiaries. Volunteers have the right to be given meaningful assignments, the right to be treated as equal co-workers, the right to effective supervision, the right to be informed about significant matters affecting their roles and the right to recognition for work done. In return, volunteers agree to actively perform their duties to the best of their abilities, comply with these Volunteer Polices and other work-related direction and provisions, and remain loyal to the values, goals and procedures of the SMP/SHIP.	Being reviewed: Volunteer Handbook as relates to page 9 or 21. Sponsor Operations Manual as relates to page 104.
3.7 Coordinator of volunteers [Required]: The SMP/SHIP has at least one staff person with designated responsibility for coordinating and managing the involvement of volunteers. As required by program or budgetary limitations, this role may be shared among staff.	Being reviewed: Volunteer Handbook as relates to page 33. Sponsor Operations Manual as relates to page 96.

Please contact your RTC or Diana at dianas@oic.wa.gov with any questions or ideas!

Review

We've covered:

- Training binders
- Appeals and grievances: You may want to consider having another small group discussion with your volunteer colleagues this month to review this topic.
- A group activity to discuss the appeals process for Original Medicare, Medicare Advantage plans and Medicare prescription drug plans
- Fraud as it applies to complaints and the new Medicare card
- VRPM

Reminders

- Please fill out the training evaluation. We want to hear how distance education training works for you—successes and challenges. **We value your feedback…thank you!**
- Add your "must have" counseling materials items to the list on the back page of this packet and return to your Regional Training Consultant, Diana Schlesselman (DianaS@oic.wa.gov) or Liz Mercer (LizM@oic.wa.gov). Or mail in care of Diana or Liz to: Office of the Insurance Commissioner, PO Box 40255, Olympia, WA 98504.
- Future months will include a variety of in-person and distance education-based training. We'll be coordinating with the RTCs, VCs and sponsors to help ensure a successful long-distance training.
- Homework: Review the assignment on page 26. We'll talk about it at our next meeting.
- Counseling materials in a binder or file…remember to bring yours to the March monthly training meeting.

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Training course evaluation

Date of Training: _____ Training Location: _____

How can SHIBA improve the monthly trainings?

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What additional trainings within our SHIBA scope would you like to see?

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What SHIBA training materials (including QRCs) would you like to see added to My SHIBA?

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Other:_____

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Optional: If you would like to be contacted, please provide your name and contact information. Someone in our office will contact you. Thank you!
Name:_____
Day Phone:_____Email: _____

If you prefer to give electronic feedback about curriculum or training, please contact: Diana Schlesselman: dianas@oic.wa.gov or
Liz Mercer: lizm@oic.wa.gov.

Recommended materials for counseling sessions:

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Please turn this page in to your Regional Training Consultant!