

ALASKA LEGISLATURE COMMITTEE FILES, 2005-2006 86/2

11745 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

**OVERVIEW  
MEDICARE  
PART D,  
3/22/06**



# Comparison of Qualifications and Benefits

Beginning January 2006 to June 2007

	SeniorCare Cash Assistance	SeniorCare Prescription Drug Assistance
<b>Qualifications</b>	<ul style="list-style-type: none"> <li>Annual Income below 135% of 2005 federal poverty level               <ul style="list-style-type: none"> <li>\$15,133 Single</li> <li>\$21,641 Couple</li> </ul> </li> <li>Liquid Assets below               <ul style="list-style-type: none"> <li>\$6,000 Single</li> <li>\$9,000 Couple</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Annual Income below 175% of 2005 federal poverty level               <ul style="list-style-type: none"> <li>\$20,913 Single</li> <li>\$28,053 Couple</li> </ul> </li> <li>Liquid Assets below               <ul style="list-style-type: none"> <li>\$50,000 Single</li> <li>\$100,000 Couple</li> </ul> </li> </ul>
<b>SeniorCare Benefit January 2006</b>	\$120 a month cash assistance (up to \$1,440 annual)	\$670 Annual Medicare/Comparable Insurance Prescription Drug Premiums and Deductible
<b>Medicare Benefit January 2006</b>	<ul style="list-style-type: none"> <li>Annual Medicare Premiums and deductible covered \$670</li> <li>Full prescription drug coverage Medicare Part D</li> </ul>	Standard Medicare Part D, prescription drug coverage
<b>Seniors Served (Total 11,000)</b>	7,000	4,000 *

\* Estimated number of people served under SeniorCare

State of Alaska  
**DEPARTMENT OF HEALTH & SOCIAL SERVICES**

Frank H. Murkowski, Governor

**Karleen Jackson**  
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**NEWS RELEASE**



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FOR IMMEDIATE RELEASE: Jan. 11, 2006

Contact: Jeff Kasper, (907) 465-8194, Cell (907) 321-3158  
Sherry Hill, (907) 465-1618, Cell (907) 321-2838

## **Community volunteers available to assist seniors with Medicare Part D enrollment**

(Anchorage, Alaska) — Medicare-trained volunteers throughout Alaska continue to provide information and help seniors with enrollment in the Medicare Part D drug plan. These volunteers have been trained to help guide seniors through the various aspects of the federal drug plan, and provide this service within their own community. A list of volunteers, contact information and the communities served is attached.

The Alaska Department of Health & Social Services SeniorCare Information Office will refer seniors to local community volunteers, as well as help seniors compare all the plans. The seniors will then be able to choose their own Medicare drug plan.

The initial enrollment period for Medicare Part D ends May 15, 2006. Medicare Part D prescription drug insurance coverage is voluntary. Seniors who choose to enroll in Medicare Part D must choose the plan that will best serve their prescription needs. Applications for Alaska's revised SeniorCare benefit are also available now.

For qualified seniors, Alaska's SeniorCare will augment the new Medicare prescription drug plan by covering Medicare prescription drug plan premiums and deductibles. This subsidy will be available for seniors with incomes below \$20,913 for individuals or \$28,053 for couples, with liquid assets of up to \$50,000 for an individual and \$100,000 for a couple.

SeniorCare cash assistance of \$120 a month will continue for seniors who meet income and asset guidelines. Seniors with incomes below \$16,133 for individuals, or \$21,641 for couples are eligible to receive the SeniorCare \$120 monthly cash assistance, with liquid assets of up to \$6,000 for an individual and \$9,000 for a couple.

For Medicare or SeniorCare information, call the SeniorCare Information Office at 1-800-478-6065 (within Alaska), or in Anchorage, 269-3680; visit the DHSS Web site at [www.seniorcare.alaska.gov](http://www.seniorcare.alaska.gov), or reference the attached volunteer list to locate a volunteer in local areas.

2005 State of Alaska Medicare Volunteer Counselor  
List By City

	A	B	C	D	E
1	Name	Organization Volunteer Belongs to	Email	Phone	City
2	Juli Quezada	Anchorage Senior Center & Alaska SHIP Medicare Coord	asc-info-assist@ak.net	907-258-7823	Anchorage
3	Lue Rae Erickson	Alaska Native Tribal Health Consortium (ANTHC)	lerickson@anthc.org	907 729-2382	Anchorage
4	Pat Kouris	Access Alaska	pkouris@accessalaska.org	907-248-4777	Anchorage
5	Richard Rainery	Governor's Council on Disabilities and Special Education	richard_rainery@health.state.ak.us	907-269-5703	Anchorage
6	Rita Hatch	Older Persons Action Group (OPAG)	chitina@gci.net	907-276-1059	Anchorage
7	Serena Dowling	Access Alaska, Inc.	sdowling@accessalaska.org	907-248-4777	Anchorage
8	Tami Eller	Volunteers of America	grands@voaak.org	907-522-9866	Anchorage
9	Theresa Pancho	Marlow Manor Assisted Living	theresa@marlowmanor.com	907-338-8708	Anchorage
10	Millie Prokopeuff	Aleutian Pribilof Islands Association, Inc. (APIA)	mdprokopouff@yahoo.com	907-839-2256	Atka
11	Karen Sidell	Yukon Kuskokwim Health Corporation	karen_sidell@ykhc.org	907-543-6389	Bethel
12	Martina Gil	Yukon Kuskokwim Health Corporation	martina_gil@ykhc.org	907-543-6470	Bethel
13	Sophie Jacob	Yukon - Kuskokwim Health Corporation	sophie_jacob@ykhc.org	907-543-2692	Bethel
14	Anne Mauer	AARP	mauer@wildak.net	907-895-4956	Delta Junction
15	Basil Backford	City of Dillingham Senior Center	director@nushtel.com	907-842-2457	Dillingham
16	Janice Rodland	Bristol Bay Area Health Corporation	jrodland@bbahc.org	907-842-9328	Dillingham
17	Kimberly Govig	Marrulut Eniit Assisted Living	marrulut@yahoo.com	907-842-5064	Dillingham
18	Lauralee Mitchell	City of Dillingham Senior Center	director@nushtel.com	907-842-1231	Dillingham
19	Priscilla Dray	Bristol Bay Area Health Corp	pdray@bbahc.org	907-842-5201	Dillingham
20	Charlotte A. Gisvold	Aleutian Pribilof Islands Association, Inc. (APIA)	charlottteg@apiia.org	907-581-2742	Dutch Harbor
21	Mica Dean	Oonalaska Wellness Center	micad@apiia.org	907-581-2742	Dutch Harbor
22	Joaquin M. Barbachano	Retired & Seniors Volunteer Program (RSVP)	joaquin@barbachano.net	907-279-9622	Eagle River
23	Hal Levey	AARP, Interior Community Aging Network (ICAN)	hlevey@gci.net	907-458-7161	Fairbanks
24	Ruth C. L'Hommedieu	ICAN, & Governor's Committee	ruth_fairbanks@yahoo.com	907-479-8514	Fairbanks
25	Valene J. Dewey	Tanana Chiefs Conference	vdewey@tananachiefs.org	907-452-8251 x3322	Fairbanks
26	Theresa Palmer	Access Alaska Fairbanks	tpalmer@accessalaska.net	907-479-7940	Fairbanks
27	Brenda Steenblock	Homer Senior Citizens, Inc.	brenda@cosmichamlet.net	907-235-7655	Homer
28	Charlene Sykes	Southeast Alaska Regional Health Consortium, SEARHC	charlene.sykes@searhc.org	907-364-4465	Juneau
29	Diana Kreick	No organization-Private Individual	kreick@ptialaska.net	907-364-1528	Juneau
30	Julie D. DeLong	Senior & Caregiver Resource Center	julie.delong@ccsjunior.org	907-463-6177	Juneau
31	Sarah Bosma	Southeast Alaska Independent Living	sbosma@sailinc.org	907-586-4920	Juneau
32	Kathy Romain	Kenai Senior Center	senior@ci.kenai.ak.us	907-283-4156	Kenai
33	Elena Rath	Rendezvous Senior Day Services, INC.	rendezvous@kpunet.net	907-247-1961	Ketchikan
34	Nancy Tietje	AARP	nancy@davies-barry.com	907-225-2176	Ketchikan
35	Susan Pickrell	Ketchikan Indian Community	spickrell@kictribe.org	907-228-5227	Ketchikan
36	Wendy Hoppe	AARP	wendylee@bristolbay.com	907-246-7429	King Salmon
37	Dana R. Krawchuk	State of Alaska Office of Rep David Guttenberg	dana_krawchuk@legis.state.ak.us	907-456-8172	Legislative Staff
38	Katie Shows	State of Alaska Office of Representative Paul Seaton	katie_shows@legis.state.ak.us	907-235-2921	Legislative Staff
39	Julie Welch	Ninilchik Senior Citizens, Inc.	seniors@ptialaska.net	907-567-3988	Ninilchik
40	Darlene Dewey	Norton Sound Health Corporation	ddewey@nshcorp.org	907-443-4590	Nome
41	Shellene Castleman	Nome Community Center	seniors@nomecc.org	907-443-4150	Nome
42	Sara Trigg	Arctic Access	Suki@nome.net	907-443-7644	Nome

*September 2005*

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# Information for State & Local Government Officials

Providing Information for Dual Eligibles  
and their Caregivers about the New  
Medicare Prescription Drug Benefit

MedicareRx  
Prescription Drug Coverage X

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**DISCLAIMERS:**

This package does not include information for those dual eligibles affected by hurricane Katrina and Rita. For more information, please go to [www.cms.hhs.gov/katrina](http://www.cms.hhs.gov/katrina) or [www.cms.hhs.gov/rita](http://www.cms.hhs.gov/rita).

# Important Dates

## September 15–November 15, 2005

- Medigap insurance companies will mail information to Medigap policy holders who have a policy that covers prescription drugs

## October 3, 2005

- Begin comparing prescription drug plans
  - ▶ [www.medicare.gov](http://www.medicare.gov)
  - ▶ 1-800-MEDICARE (1-800-633-4227)
  - ▶ TTY users should call 1-877-486-2048

## October 2005

- “Medicare & You 2006” handbook mailed
- Medicare notifies people with Medicare and Medicaid of the plan they will be automatically enrolled in on January 1, 2006, if they do not enroll on their own
- Employer plans send coverage information to enrollees
- Begin monthly mailing to people with Medicare who newly qualify for the extra help automatically

## November 15, 2005

- Initial enrollment period begins

## January 1, 2006

- Medicare Prescription Drug Plan coverage begins for enrollees
- Dual eligible coverage begins

## May 15, 2006

- Initial enrollment period ends

## June 1, 2006

- Facilitated enrollment of people entitled to extra help who did not enroll by May 15, 2006

**As a state/local policymaker or an advocate, you are in a key position to inform and educate your constituents, colleagues, friends, family members or other loved ones about the new Medicare prescription drug benefit.**

The Medicare Prescription Drug Program takes effect January 1, 2006. The Centers for Medicare & Medicaid Services (CMS) is implementing this important new program. People who assist individuals with both Medicare and Medicaid will play an important role in helping people get information about the new prescription drug coverage. This resource guide provides information you need to help your constituents, colleagues and others better understand the new Medicare prescription drug coverage.

Beginning January 1, 2006, Medicare will provide prescription drug coverage for people with both Medicare and Medicaid.\*

Below is a summary of what people who get both Medicare and Medicaid need to know:

- Prescription drug coverage for dual eligibles is changing.
- Beginning January 1, 2006, Medicare, instead of Medicaid, will cover prescription drugs.
- Dual eligibles will have continuous drug coverage during the transition.
- In order for dual eligibles to receive drug coverage, they must join a Medicare prescription drug plan.
- In October 2005, Medicare will automatically enroll dual eligibles in a prescription drug which has been chosen for them.
- Beginning November 15, 2005, anyone who is a dual eligible can switch to a different prescription drug plan if they choose. They may change plans any time after that.
- Medicare prescription drug plans may charge a small co-payment for each prescription—between \$0 and \$5.
- Medicaid will continue to pay for other health costs for dual eligibles, and may choose to pay for non-Medicare covered prescription drugs.
- If a dual eligible is enrolled in a Medicare Advantage health plan, that plan will include prescription drugs beginning January 2006.
- If a dual eligible is enrolled in the Program of All-Inclusive Care for the Elderly (PACE), that program will continue to include prescription drugs after the beginning of January, 2006.

Thank you for your valuable contribution to this important effort. We look forward to working with you in the coming months as we spread the message about Medicare's new prescription drug coverage to America's seniors and people with disabilities.

Please distribute the attached information. We will provide more information to you as it becomes available.

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\*Dual eligibles are the group of Medicare eligibles who also qualify for Medicaid.

Disclaimer: People with both Medicare and Medicaid who live in American Samoa, Commonwealth of Northern Mariana Islands, Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands can receive "extra help" in paying for their prescription drugs. The "extra help" program may not be the same as provided elsewhere in the United States. To find out more about the Medicare Prescription Drug program in your location, call 1-800-MEDICARE (1-800-633-4227) or the phone numbers listed on page 11 of this package. TTY users should call 1-877-486-2048.

# What I Need to Know about the New Medicare Prescription Drug Coverage

## **What are the Medicare prescription drug plans?**

Beginning January 1, 2006, prescription drug coverage will be available to everyone with Medicare. Every person with Medicare, no matter how they get their health care today (including people with both Medicare and Medicaid) will be eligible for drug coverage under a Medicare prescription drug plan. Insurance companies and other private companies will work with Medicare to offer these drug plans. Medicare prescription drug plans will be available in every part of the country, and all plans will cover both brand name and generic drugs.

Drug plans may vary in which prescription drugs are covered. All drug plans will have to provide at least a minimum standard level of coverage, which Medicare will set.

## **I am enrolled in both Medicare and my state's Medicaid program. How will these changes affect me?**

Your prescription drug coverage is changing. Until December 31, 2005, Medicaid will continue to pay for prescription drugs for you. Beginning January 1, 2006, Medicare will start paying for your prescription drugs. Medicare will enroll you in a Medicare prescription drug plan effective January 1, 2006, to make sure you don't miss a day of coverage. The new plan may charge a small co-payment for each prescription—between \$0 and \$5. Medicaid will continue to pay for other health services for you including, at state option, prescription drugs not included in the Medicare program.

## **When will people with both Medicare and Medicaid join a Medicare prescription drug plan?**

In October 2005, Medicare will enroll people with both Medicare and Medicaid in a prescription drug plan so that prescription drug coverage continues without a gap. Medicare will let you know the plan it has chosen for you in October 2005. Beginning November 15, 2005, you can switch to another prescription drug plan and change your plan anytime, for any reason. The change will be effective on the first day of the month following the month you make the change.

## **Medicaid does not pay for health services for me, but it does pay for my Medicare premiums. How am I affected by the Medicare prescription drug program?**

People who get help from their state paying for their Medicare premiums, people in the Medicare Savings Program—QMB, SLMB, and QIs, will continue to receive assistance with their Medicare premiums and will also receive a low income subsidy and can enroll in a Medicare drug plan beginning November 15, 2005. If you receive help through a Medicare Savings Program and do not choose a plan by May 15, 2006, Medicare will enroll you in a plan to make sure that you do not miss a day of drug coverage.



## **What I Need to Know about Enrolling in a Plan**

### **I have received my plan assignment from Medicare in the mail, what do I do now?**

Decide if this plan is the right plan for you. Read the materials your plan sends you about the drug plan Medicare will enroll you in. If you don't like the plan, you can get information about the other Medicare drug plans. For example, find out if the prescription drugs you are currently taking are covered by your assigned plan's list of covered prescription drugs, also called a formulary. Make sure the pharmacy you use works with this plan. If you are happy with the plan you have been assigned to you, need not do anything. Beginning January 1, 2006, you will receive your drugs through that plan and its pharmacy network. If, after reviewing the plan's information and you find that this plan is not right for you, you can switch to another prescription drug plan and change your plan any time, beginning November 15, 2005.

### **Can someone who makes health care decisions for me enroll me in a Medicare prescription drug plan?**

Yes. If someone has the legal right to make health care decisions on your behalf, (such as through a power of attorney), this person can enroll you in a Medicare prescription drug plan that meets your needs. This person is sometimes called an "authorized representative."

### **If I want to change plans at some other point in the future, can I?**

Yes. A person with Medicare and full Medicaid coverage is entitled to a "Special Enrollment Period." This means you can change your prescription drug plan at any time, and as often as each month if you wish.

### **What should I do if I am now enrolled in a Medicare Advantage Plan?**

If you are already enrolled in a Medicare Advantage (MA) plan you will be enrolled in your MA's prescription drug plan. Check with your MA plan to learn more about its prescription drug coverage.

### **Will people with both Medicare and Medicaid living in a nursing home be enrolled in a Medicare prescription drug plan or will Medicaid continue to cover their drug costs?**

People with both Medicare and Medicaid living in a nursing home will be enrolled in a Medicare prescription drug plan. At state option, Medicaid may pay for some non-Medicare prescription drugs.

### **Will I get a new card when I enroll in a plan?**

Medicare prescription drug plans will issue new cards to people enrolled in their plan. The cardholder ID will be assigned by the plan. Plans are not to use an enrollee's Social Security Number as the cardholder ID.

## What I Need to Know about How Much I Will Have to Pay

### How much will I have to pay?

Medicare will help pay the cost of your prescription drugs. Anyone who is enrolled in both Medicare and Medicaid will not pay a monthly premium. You may need to pay a small copayment for each prescription—between \$0 and \$5.\*

### How much will people in institutions, like a nursing home, have to pay for prescription drugs?

If you have both Medicare and Medicaid and live in an institution like a nursing home for at least one month, you will pay nothing for your covered prescription drugs.

## What I Need to Know about Where I Get My Prescription Drugs

### Will my pharmacy and/or pharmacist change?

If you want to make sure you stay with the same pharmacy, you need to contact the Medicare prescription drug plans and choose a plan that works with your pharmacy. You may also want to ask your pharmacist which plans she/he works with.

### What is a “preferred” pharmacy? Do I have to use one?

Plans may offer “preferred” pharmacies within their pharmacy networks. Plans may offer lower cost sharing for covered drugs purchased by enrollees at certain pharmacies within their networks (the “preferred” pharmacies) compared to other network pharmacies (“non-preferred” pharmacies).

### What happens if I need to go to an out-of-network pharmacy?

There may be instances where you may need to purchase your drugs at an out-of-network pharmacy, like when you are on vacation. Plans are required to assure that their enrollees have adequate access to drugs dispensed at an out-of-network pharmacy.

### Will I pay more to use an out-of-network pharmacy?

Ultimately no. Because an out-of-network pharmacy, by definition, does not have a contract with your drug plan, you will be charged more than your normal \$0–\$5 co-payments when you buy your drugs at an out-of-network pharmacy. However, your plan will reimburse you for that cost once it receives your receipt for the prescription drugs. You will still have to pay the normal co-payment amount for that medicine just as if you had purchased it at your home pharmacy.

\* If you join a plan that has a premium higher than a standard plan, you will have to pay the difference (for example, if a standard plan costs \$32 per month, and you join a plan that costs \$35 per month, you will have to pay the \$3 difference each month).

## **Can a plan require me to get my drugs through a mail-order pharmacy?**

No. Plans cannot require enrollees to use a mail-order pharmacy. However, because many people like the convenience of mail order, many plans will offer mail-order services.

## **What I Need to Know about Drug Coverage (Formularies) in the New Medicare Prescription Drug Program**

### **What will my Medicare drug plan cover?**

Each Medicare drug plan will have its own list of covered drugs (or formulary) that will include generic and brand-name drugs. Plans may have rules about what specific prescription drugs are covered to treat different medical conditions. Every Medicare drug plan must comply with federal rules about the types and number of drugs covered.

### **How do I know if my prescription drugs will be covered by a particular Medicare prescription drug plan?**

Make a list of all of your current prescription drugs including name, dose size (for example: 2 pills, 300mg in each pill), and dosage frequency (for example: 2 times a day). You can use this information to compare the list of drugs that are covered under each plan. You can get the list of drugs a plan covers by calling the plan, visiting the plan's website, or visiting [www.medicare.gov](http://www.medicare.gov) on the Internet. This information will be available from the plans in October 2005. On October 13, 2005, this information will be available on the web at [www.medicare.gov](http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227).

### **Can my plan's formulary change?**

Yes. A plan's formulary can change when a plan gets new information. But, the new formulary must meet Medicare's requirements and the plans must tell you about any upcoming changes 60 days in advance.

### **How will I know if my plan discontinues coverage of my drug?**

Your plan must let you know at least 60 days before a drug you use is removed from the formulary.

### **Will I be able to get my drugs on January 1, 2006?**

Medicare prescription drug plans must establish a transition process for all Medicare beneficiaries as they enroll in the new Medicare prescription drug coverage from another drug program. These transition processes must show how they will help people who are on a drug either stay on that drug or safely change to another appropriate drug. You should check with your plan to see what their policy is for continuing a particular drug.

## **Do I have to change my antidepressants, antipsychotics, anticonvulsants, HIV drugs, cancer medications and immunosuppressants?**

No. CMS requires that Medicare prescription drug plan formularies include "all or substantially all" of the drugs in the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories. In addition, plans must give special attention to patients already stabilized on drugs in these classes. If you are already on these drugs when you join the plan, the plan usually cannot require preauthorization or ask you to try other drugs first. For individuals who begin treatment with these drugs after they are in the plan, other than HIV/AIDS drugs, plans may use these techniques to manage therapy. However, for HIV/AIDS drugs, these techniques are not allowed.

## **I've heard that certain prescription drugs are not covered by the Medicare Prescription Drug Program (i.e. barbiturates, benzodiazepines, or prescription vitamins). Will Medicaid still pay for these drugs?**

A state Medicaid agency may choose to continue to pay for some or all non-Medicare prescription drugs. Contact your State Medicaid Agency to find out what drugs, if any, they have decided to cover.

## **What if I am taking a drug that is not on my plan's formulary?**

Medicare prescription drug plans must have a process for you to get drugs that are not on the formulary when the drug is medically necessary. If your doctor thinks you need a drug that isn't on the formulary, you or your doctor can apply for an exception. If the exception is denied, you can appeal the decision.

## **How do I apply for an exception if a drug I need is not on my plan's formulary?**

First, you should talk to your doctor and make sure no other drug can be used. If your doctor thinks this is the only drug that is appropriate, then you need to file an exception. To file an exception, you should contact your plan.

If the plan denies an exception, then you can appeal the plan's decision. To file an appeal, follow the procedure described in the handbook you received from your plan, or talk to your plan to find out how to file an appeal.

## **Who may help me with my exception and/or appeal?**

In addition to allowing you to file an exception and/or appeal, prescribing physicians or your appointed representative can file appeals on your behalf.

## **Are plans required to cover a temporary/emergency supply of non-formulary Medicare prescription drugs while an exception request is being processed?**

For people living at home and in the community, you should check with your plan to see its policy on covering drugs while an exception request is being processed. Medicare prescription drug plans must cover an emergency supply of non-formulary drugs for long-care residents.

## **Can long term care residents receive an emergency supply of medications?**

Yes. Medicare prescription drug plans must cover an emergency supply of non-formulary drugs for long-term care residents as part of their transition process.

## **Where I Can Go for More Information about Medicare Prescription Drug Coverage**

For more information on Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov) on the web and get personalized information.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. When you call, have ready: your Medicare card, a list of drugs you use, and the name of the pharmacy you use.
- Read the "Medicare & You 2006" handbook that will be mailed to you in October 2005.
- Get a free copy of the booklet "Your Guide to Medicare Prescription Drug Coverage," (CMS Pub. No. 11109) on [www.medicare.gov](http://www.medicare.gov) or by calling 1-800-MEDICARE.
- Call your State Health Insurance Assistance Program for free personalized health insurance counseling. (Phone numbers are in the back of this package.)
- Check for local events for help joining a plan.
- Contact your local office on aging. For the telephone number, visit [www.eldercare.gov](http://www.eldercare.gov) on the web or call: 1-800-677-1116.
- Contact your state Medicaid agency if you have any questions about your Medicaid health benefits.

# Web Resources for States

## **MMA States Listserv**

- On [www.cms.hhs.gov](http://www.cms.hhs.gov) scroll down and click on "Mailing Lists" on the right yellow sidebar. Enter your information in the requested fields and choose the subscribe button for "MMA\_States"

## **State MMA Information**

- [www.cms.hhs.gov/medicarerreform/states](http://www.cms.hhs.gov/medicarerreform/states)

## **Beneficiary-Friendly Publications**

- [www.medicare.gov/publications](http://www.medicare.gov/publications)

## **Outreach Toolkit**

- [www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp](http://www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp)

## **MMA Questions & Answers**

- Submit Questions: <http://mmaissuesform.cms.hhs.gov>
- Browse answers: <http://www.cms.hhs.gov/medicarerreform/medicarerreformfaqs.asp>, click on "Prescription Drug Coverage"

## State Health Insurance Assistance Contact Information

*Your state receives a CMS State Health Insurance Assistance Program (SHIP) grant to support local personalized counseling and assistance to people with Medicare and their families. To contact the SHIP in your state, please consult this listing.*

**ALABAMA**  
Ph: (334) 353-9636

**ALASKA**  
Ph: (907) 269-3669

**ARIZONA**  
Ph: (602) 542-6439

**ARKANSAS**  
Ph: (501) 371-2785

**CALIFORNIA**  
Ph: (800) 434-0222

**COLORADO**  
Ph: (303) 894-7552

**CONNECTICUT**  
Ph: (860) 416-7206  
Ph: (860) 424-5322

**WASHINGTON, DC**  
Ph: (202) 496-6240  
Ph: (202) 727-8367

**DELAWARE**  
Ph: (302) 739-4251  
Ext. 174

**FLORIDA**  
Ph: (850) 414-2157

**GEORGIA**  
Ph: (404) 657-5347

**GUAM**  
Ph: (671) 735-7382

**HAWAII**  
Ph: (808) 586-7299

**IDAHO**  
Ph: (208) 334-4350

**ILLINOIS**  
Ph: (217) 524-1631

**INDIANA**  
Ph: (317) 233-3551

**IOWA**  
Ph: (515) 242-5190

**KANSAS**  
Ph: (785) 368-7331

**KENTUCKY**  
Ph: (502) 564-7372

**LOUISIANA**  
Ph: (225) 342-6334

**MAINE**  
Ph: (207) 287-9207

**MARYLAND**  
Ph: (410) 767-1100

**MASSACHUSETTS**  
Ph: (617) 222-7436

**MICHIGAN**  
Ph: (517) 886-1339  
Ph: (517) 373-4071

**MINNESOTA**  
Ph: (651) 296-3839

**MISSISSIPPI**  
Ph: (601) 359-5131

**MISSOURI**  
Ph: (573) 893-7900  
Ext. 191

**MONTANA**  
Ph: (406) 444-7870

**NEBRASKA**  
Ph: (402) 471-2599  
Ph: (402) 471-4506

**NEVADA**  
Ph: (702) 486-3796

**NEW HAMPSHIRE**  
Ph: (603) 223-4158

**NEW JERSEY**  
Ph: (609) 943-3378

**NEW MEXICO**  
Ph: (505) 255-0971

**NEW YORK**  
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**VIRGIN ISLANDS**  
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**WASHINGTON**  
Ph: (206) 389-2752

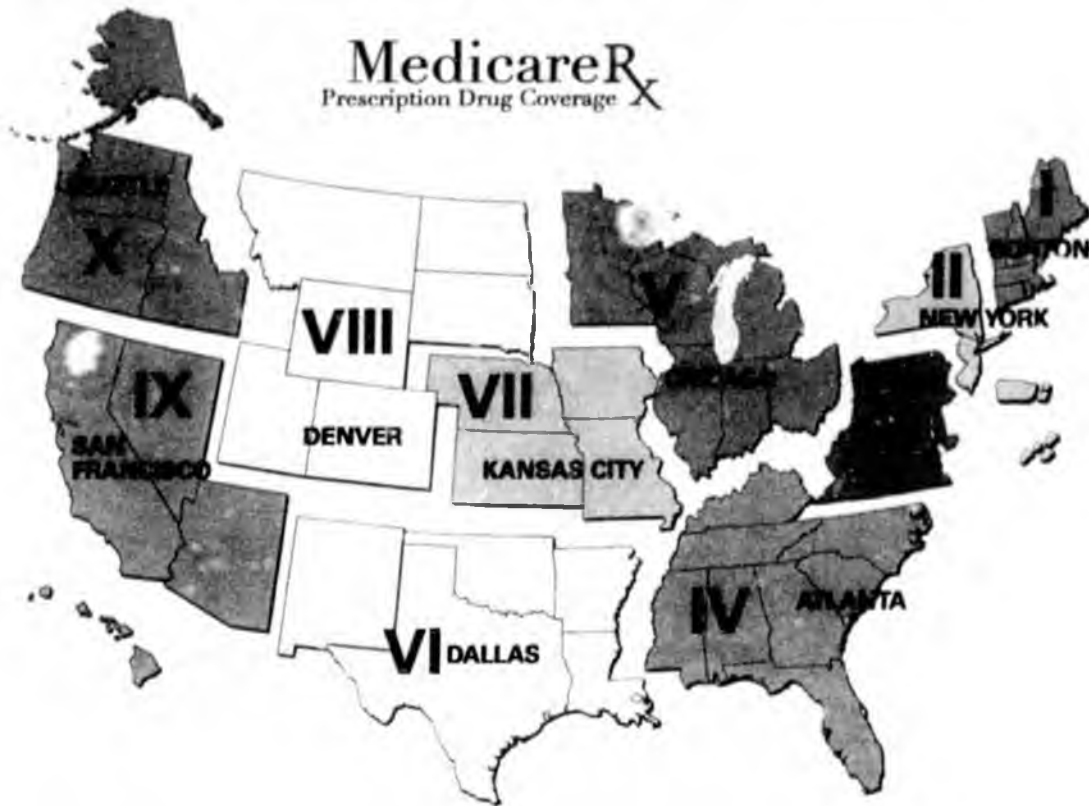
**WEST VIRGINIA**  
Ph: (304) 558-3317

**WISCONSIN**  
Ph: (608) 267-3201

**WYOMING**  
Ph: (307) 777-7401  
Ph: (307) 856-6880

# Centers for Medicare & Medicaid Services

## Regional Map and Contact Information



### REGIONAL OFFICES

### PHONE NUMBERS

	Centers for Medicare & Medicaid Services	Social Security Administration
REGION I – BOSTON	617-565-1188	617-565-2881
REGION II – NEW YORK	212-616-2205	212-264-2500
REGION III – PHILADELPHIA	215-861-4140	215-597-4456
REGION IV – ATLANTA	404-562-7150	404-562-5500
REGION V – CHICAGO	312-886-6432	312-575-4053
REGION VI – DALLAS	214-767-6401	214-767-4207
REGION VII – KANSAS CITY	816-426-5233	816-936-5740
REGION VIII – DENVER	303-844-2111	303-844-0840
REGION IX – SAN FRANCISCO	415-744-3501	510-970-8431
REGION X – SEATTLE	206-615-2306	206-615-2100

For more information, call 1-800-MEDICARE, or visit [www.medicare.gov](http://www.medicare.gov)



# Guide to Medicare's Preventive Services

**This official government  
booklet explains...**

- What prevention is and why it's important
- Which preventive services are new
- Which preventive services Medicare covers and how often
- Who can get them
- What you pay

**CMS**

CENTERS for MEDICARE & MEDICAID SERVICES

The best way to stay healthy is to live a healthy lifestyle. You can live a healthy lifestyle by exercising, eating well, keeping a healthy weight, and not smoking.

Another important way to stay healthy is to use preventive services provided by doctors and health care providers. Preventive services can find health problems early when treatment works best and can keep you from getting certain diseases or illnesses. Preventive services include exams, lab tests, and screenings. They also include shots, monitoring, and information to help you take care of your own health. Medicare pays for many preventive services to keep you healthy.

### How Can this Booklet Help Me?

The preventive services listed in this booklet are covered no matter what kind of Medicare health plan you have. However, the amount you pay for these services varies depending on the type of health plan. This booklet explains the way preventive services are covered if you have Part B under the Original Medicare Plan (sometimes called fee-for-service). If you have another type of Medicare health plan, call your plan for more information.

### This booklet can help you learn...

- How to stay healthy
- About these Medicare-covered services:
  - One-time "Welcome to Medicare" physical exam (if your Medicare Part B begins on or after January 1, 2005)
  - Cardiovascular screening
  - Tests for breast, cervical, vaginal, colorectal, and prostate cancers
  - Flu, pneumococcal, and Hepatitis B shots
  - Bone mass measurements
  - Diabetes screening and self-management
  - Glaucoma testing

**Note:** The information in this booklet was correct when it was printed. Changes may occur after printing. For the most current information, look at [www.medicare.gov](http://www.medicare.gov) on the web. Select "Your Medicare Coverage." Or, call 1-800-MEDICARE (1-800-633-4227). A customer service representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

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*Medicare's Guide to Preventive Services* isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

### **Why Prevention is Important**

You can stay healthy, live longer, and delay or prevent many diseases by...

- **exercising**—Do any physical activity you enjoy for 20–30 minutes 5 or 6 days a week.
- **eating well**—Eat a healthy diet of different foods like fruit, vegetables, protein (like meat, fish, or beans), and grains (like rice), and limit the amount of saturated fat you eat.
- **keeping a healthy weight**—Watch your portions, and try to balance the number of calories you eat with the number you burn by exercising.
- **not smoking**—Talk with your doctor about getting help to quit smoking.
- **getting preventive services**—Delay or lessen the effects of diseases by getting preventive services like shots to keep you from getting dangerous infections and screening tests to find diseases early.

**Note:** Talk to your doctor about the right exercise program for you.

### **Newly-covered Preventive Services**

Medicare covers many different preventive services. Starting January 1, 2005, Medicare will now cover these three preventive services:

- One-time “Welcome to Medicare” Physical Exam (page 3)
- Cardiovascular Screening (page 4)
- Diabetes Screening to check for diabetes (page 10)

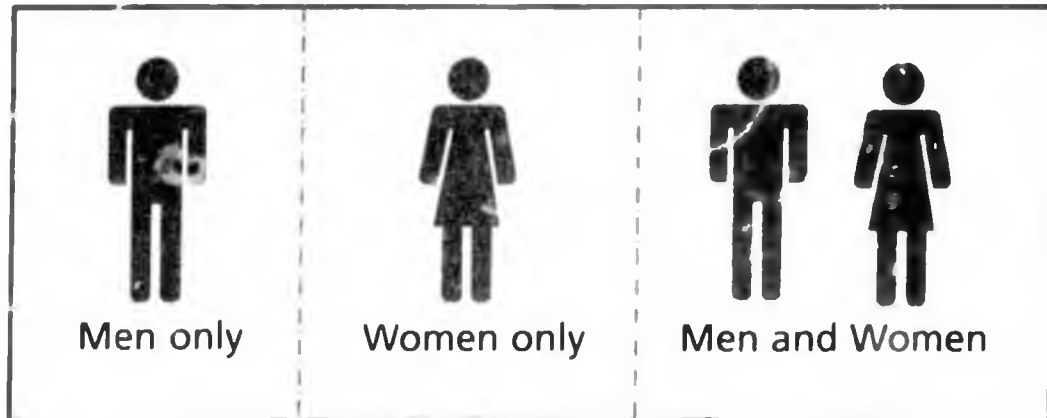
Keep reading to find out how Medicare covers these and other preventive services. You can also look at [www.medicare.gov](http://www.medicare.gov) on the web, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

### **Talk to Your Doctor**

In providing good care, your doctor or health care provider may do exams or tests that Medicare doesn't cover. Your doctor or health care provider may also recommend that you have tests more or less often than Medicare covers them. Talk to your doctor or health care provider to find out how often you need these exams to stay healthy.

**Things to Know as You Read this Booklet****Symbols**

You will see one of the following symbols next to each preventive service. It tells you for whom Medicare covers the test.

**Risk Factors**

You will also see lists of factors that increase your risk of developing a certain disease. If you're not sure if you're at high risk, talk to your doctor.

**Part B Deductible**

The Part B deductible in 2004 is \$100 and will increase to \$110 in 2005. This amount may change annually.

**Medicare-approved Amount**

The Medicare-approved amount is the amount Medicare pays for an item or service.

**NEW - One-time "Welcome to Medicare" Physical**

If your Medicare Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time preventive physical exam within the first six months that you have Part B. The exam will include a thorough review of your health, education and counseling about the preventive services you need like certain screenings and shots, and referrals for other care if you need it. The "Welcome to Medicare" physical exam is a great way to get up-to-date on important screenings and shots and to talk with your doctor about your family history and how to stay healthy.

**How often is it covered?** One time only within the first six months that you have Part B

**For whom?** All people whose Medicare Part B begins on or after January 1, 2005

**Your costs in the Original Medicare Plan?** You pay 20% of the Medicare-approved amount after the yearly Part B deductible

### NEW - Cardiovascular Screening



Medicare covers cardiovascular screenings that check your cholesterol and other blood fat (lipid) levels. High levels of cholesterol can increase your risk for heart disease and stroke. These screenings will tell if you have high cholesterol. You might be able to make lifestyle changes (like changing your diet) to lower your cholesterol.

**What is covered?** Tests for cholesterol, lipid, and triglyceride levels beginning January 1, 2005

**How often is it covered?** Talk with your doctor about how often

**For whom?** Talk with your doctor to see if you qualify

**Your costs in the Original Medicare Plan?** You pay nothing

### Breast Cancer Screening Mammograms



Breast cancer is the most common non-skin cancer in women and the second leading cause of cancer death in women in the United States. Every woman is at risk, and this risk increases with age. Breast cancer can usually be successfully treated when found early. Medicare covers screening mammograms and digital technologies for screening mammograms to check for breast cancer before you or a doctor may be able to feel it.

**How often is it covered?** Once every 12 months

**For whom?** All women with Medicare age 40 and older can get a screening mammogram every 12 months. Medicare also pays for one baseline mammogram for women with Medicare between ages 35 and 39.

**Your costs in the Original Medicare Plan?** You pay 20% of the Medicare-approved amount with no Part B deductible

**Are you at high risk for breast cancer?**

Your risk of developing breast cancer increases if you...

- had breast cancer in the past
- have a family history of breast cancer (like a mother, sister, daughter, or two or more close relatives who have had breast cancer)
- had your first baby after age 30
- have never had a baby

## Cervical and Vaginal Cancer Screening



Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare covers a clinical breast exam to check for breast cancer.

**How often is it covered?** A Pap test and pelvic exam are covered by Medicare once every 24 months. However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months, or if you are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam every 12 months.

**For whom?** All women with Medicare

**Your costs in the Original Medicare Plan?** You pay nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, you pay 20% of the Medicare-approved amount with no Part B deductible.

**Are you at high risk for cervical cancer?**

Your risk for cervical cancer increases if ...

- you have had an abnormal Pap test
- you have had cancer in the past
- you have been infected with the Human papillomavirus (HPV)
- you began having sex before age 16
- you have had many sexual partners
- your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you

**Colorectal Cancer Screening**

Colorectal cancer is usually found in people age 50 or older, and the risk of getting it increases with age. Medicare covers colorectal screening tests to help find pre-cancerous polyps (growths in the colon) so they can be removed before they turn into cancer. Treatment works best when colorectal cancer is found early.

How often is it covered?

- **Fecal Occult Blood Test**—Once every 12 months
- **Flexible Sigmoidoscopy**—Once every 48 months
- **Screening Colonoscopy** —Once every 24 months (if you're at high risk)

Once every 10 years, but not within 48 months of a screening sigmoidoscopy (if you're not at high risk)

- **Barium Enema**—Your doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.

**For whom?** All people with Medicare age 50 and older, except there is no minimum age for having a screening colonoscopy

**Your costs in the Original Medicare Plan?** You pay nothing for the fecal occult blood test. For all other tests, you pay 20% of the Medicare-approved amount after the yearly Part B deductible.

If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department, you pay 25% of the Medicare-approved amount after the yearly Part B deductible.

**Are you at high risk for colorectal cancer?** Risk for colorectal cancer increases if you or a close relative have had colorectal polyps or colorectal cancer, or if you have inflammatory bowel disease (like ulcerative colitis or Crohn's disease).

### Prostate Cancer Screening



Prostate cancer can often be found early by testing the amount of PSA (Prostate Specific Antigen) in your blood. Another way prostate cancer is found early is when your doctor performs a rectal exam. Medicare covers both of these tests so that prostate cancer can be detected and treated early.

How often is it covered?

- **Digital Rectal Examination**—Once every 12 months
- **Prostate Specific Antigen (PSA) Test**—Once every 12 months

For whom? All men with Medicare age 50 and older (coverage for this test begins the day after your 50th birthday)

Your costs in the Original Medicare Plan? Generally, you pay 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. There is no coinsurance and no Part B deductible for the PSA Test.

Are you at high risk for prostate cancer? While all men are at risk for prostate cancer, your risk increases if you have a father, brother, or son who has had prostate cancer. The list below shows the people at risk for prostate cancer from higher to lower amount of risk:

- African Americans
- Whites
- Hispanics
- Asians
- Pacific Islanders
- Native Americans

### **Shots (Flu, Pneumococcal, Hepatitis B)**



Medicare covers flu, pneumococcal, and Hepatitis B shots. Flu, pneumococcal infections, and Hepatitis B can be life threatening to an older person. All adults 65 and older should get flu and pneumococcal shots. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot. People at medium to high risk for Hepatitis B should get Hepatitis B shots.

#### **Flu Shot**

How often is it covered? Once a year in the fall or winter

For whom? All people with Medicare

Your costs in the Original Medicare Plan? You pay nothing

#### **Pneumococcal Shot**

How often is it covered? Most people only need this shot once in their lifetime

For whom? All people with Medicare

Your costs in the Original Medicare Plan? You pay nothing

#### **Hepatitis B Shots**

How often are they covered? Three shots are needed for complete protection. Check with your doctor about when to get these shots if you qualify to get them.

For whom? People with Medicare at medium to high risk for Hepatitis B

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at high risk for Hepatitis B?

Common factors that put you at medium to high risk for Hepatitis B include...

- hemophilia
- End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)
- a condition that lowers your resistance to infection

Other factors may increase your risk for Hepatitis B. Check with your doctor to see if you are at medium to high risk for Hepatitis B.

## Bone Mass Measurements



Medicare covers bone mass measurements to determine whether you are at risk for a fracture (broken bone). People are at risk for fractures because of osteoporosis. Osteoporosis is a disease in which your bones become weak. In general, the lower your bone density, the higher your risk is for a fracture. Bone mass measurement test results will help you and your doctor choose the best way to keep your bones strong.

**How often is it covered?** Once every 24 months (more often if medically necessary)

**For whom?** All people with Medicare who are at risk for osteoporosis

**Your costs in the Original Medicare Plan?** You pay 20% of the Medicare-approved amount after the yearly Part B deductible

**Are you at risk for osteoporosis?**

Your risk for osteoporosis increases if you...

- are age 50 or older
- are a woman
- have a family history of broken bones
- have a personal history of broken bones
- are White or Asian
- are small-boned
- have low body weight (less than about 127 pounds)
- smoke or drink a lot
- have a low-calcium diet

**Diabetes Screening, Supplies, and Self-Management Training**

Diabetes is a medical condition in which your body doesn't make enough insulin or has a reduced response to insulin. Diabetes causes your blood sugar to be too high because insulin is needed to use sugar properly. A high blood sugar level is not good for your health. For all people with Medicare, Medicare covers screenings to check for diabetes. For people with diabetes, Medicare covers certain supplies and self-management training to find and treat diabetes.

**NEW - Diabetes Screening (Fasting Plasma Glucose Test) beginning January 1, 2005**

How often is it covered? Talk with your doctor

For whom? Talk with your doctor

Your costs in the Original Medicare Plan? You pay nothing

**Diabetes Glucose monitors, test strips, and lancets**

For whom? All people with Medicare who have diabetes

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

**Diabetes Self-Management Training**

For whom? This training is for certain people with Medicare who are at risk for complications from diabetes. Your doctor must request this service.

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

For more information, get a free copy of *Medicare Coverage of Diabetes Supplies & Services* (CMS Pub. No. 11022) at [www.medicare.gov](http://www.medicare.gov) on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048.

## **Glaucoma Tests**



Glaucoma is an eye disease caused by high pressure in the eye. It can cause you to gradually lose sight without warning and often without symptoms. The best way for people at high risk for glaucoma to protect themselves is to have regular eye exams.

How often is it covered? Once every 12 months

For whom? People with Medicare at high risk for glaucoma

Your costs in the Original Medicare Plan? You pay 20% of the Medicare-approved amount after the yearly Part B deductible

Are you at high risk for glaucoma?

Your risk for glaucoma increases if you...

- have diabetes
- have a family history of glaucoma
- are African American and age 50 or older

## **For More Information**

You can learn more about Medicare's preventive services by looking at [www.medicare.gov](http://www.medicare.gov) on the web, or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.





**U.S. DEPARTMENT OF  
HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**  
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Publication No. CMS - 10110  
Revised August 2004

Medicare is here for you 24 hours a day, every day.

For help with your Medicare questions

- visit [www.medicare.gov](http://www.medicare.gov)
- call 1-800-MEDICARE (1-800-633-4227)
- call 1-877-486-2048 (TTY users)

To get this booklet in Spanish, call  
1-800-633-4227. TTY users should  
call 1-877-486-2048.

Para conseguir este folleto en español llame  
gratis al 1-800-MEDICARE  
(1-800-633-4227). Los usuarios  
de TTY deben llamar al 1-877-486-2048.

***CMS***

***CENTERS for MEDICARE & MEDICAID SERVICES***

# Did You Know...

that Medicare will pay for

- ✓ Cardiovascular Screening
- ✓ Diabetes Screening
- ✓ Physical Examination for New Beneficiaries
- ✓ Diabetes Management Training and Supplies
- ✓ Mammograms
- ✓ Cancer Screenings
- ✓ Bone Mass Measurement
- ✓ Glaucoma Screening
- ✓ Immunizations
- ✓ Prescription Medicines



www.medicaretoday.org  
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Suite 550 South  
Washington, DC 20004



**Medicare has New  
Preventive Care Benefits**

Medicare is improving to keep beneficiaries healthier. In addition to prescription drug assistance, Medicare is offering important preventive care benefits.

Every Medicare beneficiary now has access to new Medicare Part B-covered preventive care benefits. This new coverage will help doctors diagnose and treat conditions in the early stages, helping to avoid serious illness. With the new benefits in place, every beneficiary should be aware of the full menu of preventive care services covered by Medicare.

## **1** Cardiovascular Screenings

Medicare will now pay for blood tests that measure cholesterol, lipid and triglyceride levels. These measurements are used by doctors to help assess risk for heart attacks, strokes and other cardiovascular illness.



## **2** Diabetes Screening

Medicare will now pay for fasting plasma glucose testing if you are at risk for developing diabetes. Talk to your doctor to determine if you need this screening procedure.



## **3** Physical Examination for New Beneficiaries

This important new benefit has been called the "Welcome to Medicare Physical." Medicare will now pay for a complete physical anytime during the first 6 months after a person enrolls in Part B Medicare. Health care providers can then make a complete assessment of each new beneficiary and work with them to prevent, manage or treat any and all conditions that are impacting their health.



## **4** Diabetes Management Training and Diabetes Supplies

Medicare will pay for diabetes monitors, test strips and lancets that are needed by diabetes patients. For those diabetes patients who are at risk of complications from their illness, Medicare will also pay for training to help them better monitor and care for themselves.

## **5** Mammograms

Medicare pays for annual screening mammograms for all women on Medicare who are over age 40. Medicare pays for a baseline mammogram for female beneficiaries under 40.

## **6** Cancer Screenings

Medicare pays for various types of procedures that screen for cancers including:

- Cervical and vaginal cancer
- Colorectal cancer
- Prostate cancer

## **7** Bone Mass Measurements

Medicare pays for bone mass measurements every two years (more often if medically necessary) to determine a patient's risk for broken bones due to osteoporosis, a serious condition in older women.

## **8** Glaucoma Screening

Medicare pays for annual glaucoma screenings for those who are at risk for developing this condition which can result in blindness.

## **9** Immunizations

Medicare pays for all beneficiaries to have immunizations to prevent flu and pneumonia. Hepatitis B vaccines are also covered for those at risk.

## **10** Prescription Drugs

Throughout 2005, Medicare will continue to offer all Medicare beneficiaries (who do not get their medicines through Medicaid) the opportunity to purchase their prescriptions at a discount using one of the Medicare-approved discount cards.



For low income beneficiaries, there is a cash credit of up to \$600 that can be applied to the cards of those who qualify. This credit will help them pay for their medicines.

In 2006, Medicare beneficiaries who choose to do so will have the opportunity to enroll in a Medicare prescription drug coverage plan. Medicare beneficiaries will have a choice of plans and coverage options. Information about the plans that will be offered in your area will be available later this year. Beneficiaries will receive detailed information from Medicare about choices well before the time decisions about enrollment are required.

For more information about the Medicare prescription drug benefit, any of the Medicare preventive benefits discussed in this brochure, or to ask any questions about Medicare, visit [www.Medicare.gov](http://www.Medicare.gov) or call Medicare at 1-800-Medicare (1-800-633-4227). A trained staff person, not a recording, will answer your call every day, around the clock.

*\*Additional information: For some of these procedures and tests, beneficiaries are responsible for making a 20% co-payment. The cost of some procedures, including the "Welcome to Medicare Physical" applies to the annual deductible which Medicare beneficiaries are required to meet.*

Medicare is improving to keep beneficiaries healthier. In addition to prescription drug assistance, Medicare is offering important preventive care benefits.

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How the New  
*Medicare Drug Plan*  
Could Help You Save

# Medicare **R<sub>x</sub>** Made Simple

There is a new benefit to the Medicare you know and trust. Beginning in 2006, Medicare will offer prescription drug coverage to help you cut the cost of your drug bills. The Medicare drug plan passed with support from Republicans and Democrats in Congress, the AARP, physician groups, and hundreds of other health advocates.

The Medicare Rx Made Simple wheel was designed to estimate your out-of-pocket costs in 2006 under this new drug coverage—**assuming you currently lack coverage**. And if you are a person with Medicare that has limited income and resources, there is extra help.



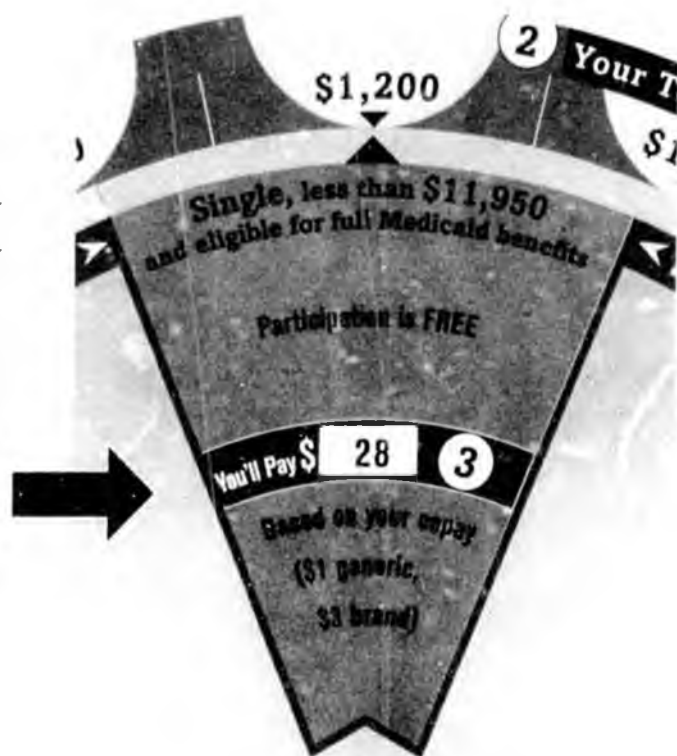
# See How This New Medicare Drug Plan Could Help You...

## Easy as...

- 1 Find the window for your marriage status and household income.
- 2 Align the annual drug cost arrow with your marriage status and household income. (If you are married, find the drug cost that reflects your individual drug spending only.)

- 3 The number in the window is your estimated share of annual costs under the new drug coverage, including your deductible, copayment, coinsurance and other out-of-pocket costs. Any annual premium should be added to the number that appears in the "You'll Pay" window.

People with limited income will pay low or no annual premiums.



# QA Medicare Rx Made Simple

**Q.** Does the wheel estimate payments just for seniors who currently lack drug coverage?

**A.** Yes, the wheel estimates out-of-pocket costs under the new Rx coverage for those individuals currently lacking drug coverage.

**Q.** After using the wheel, what if I decide that I am not interested in enrolling?

**A.** No problem, participation in the Medicare Rx coverage is *entirely optional*. The wheel provides a better understanding of how the coverage could help you. Because your future drug spending may change over time, you may want to try different annual drug costs to better understand this coverage.

**Q.** What if my drug costs are less than the annual premiums I will pay?

**A.** Like home and car insurance the coverage provides protection against high costs. Some people will not use all parts of the coverage right away but can be confident that this coverage will be there if they need it.

**Q.** Does the wheel factor in discounts on drugs?

**A.** Yes, the wheel includes estimated drug cost savings of 20% resulting from the ability of your Medicare sponsored plan to negotiate discounts with drug manufacturers. Overall,

the program is estimated to save 10 to 25% on drug costs. The wheel also accounts for the share of discounted costs your Medicare sponsored plan will pay on your behalf.

**Q.** I hear that the Medicare drug plans include more generous coverage for seniors that have high levels of drug spending. Does the wheel account for this?

**A.** Yes, it does. The coverage will pay 95% of your drug costs above \$3600 in annual out-of-pocket spending. Although you may not spend at high levels now, the coverage provides peace of mind that this insurance will be there if you need it.

**Q.** I currently have drug coverage from a former employer. Do I have to drop my coverage?

**A.** No, if you have drug coverage through a former employer, you can keep it. In addition, by providing financial assistance to employers who offer prescription drug coverage, this law will help many employers continue to provide retiree health coverages.

**Q.** Will the new Medicare drug plans help people on Medicare with limited income?

**A.** Yes, seniors with limited income will have low or no annual premiums and low co-payments, depending on income levels.



# Medicare **R<sub>X</sub>** Made Simple

## Timeline

**May 2005**  
Applications for  
Extra Financial  
Help Available

**Oct. 2005**  
CMS mails  
*Medicare & You*  
Handbook with  
information on  
plans in your area

**Nov. 15, 2005**  
First day you can  
join a plan

**Jan. 1 2006**  
Coverage begins  
for those who join  
by Dec. 31, 2005

**May 15, 2006**  
Last day to join a  
plan for 2006

## Have Additional Questions?

[www.medicare.gov](http://www.medicare.gov)

1-800-MEDICARE (1-800-633-4227)

TTY users should call 1-877-486-2048.

Or call Medicare Today at 1-866-723-0416

[www.medicaretoday.org](http://www.medicaretoday.org)

**THE FOLLOWING DOCUMENT  
HAS NOT BEEN FILMED BUT IS  
AVAILABLE IN THE ORIGINAL FILE**



# Medicare Rx Made Simple

See how this new Medicare Rx plan could help you

Easy as

- ① Find the window that describes your marriage status and total household income.
- ② Align the total annual individual drug cost arrow with your marriage status and total household income.
- ③ The number in the window is your share of annual individual drug costs excluding the premium.

The wheel describes out-of-pocket costs under the new Rx plan for beneficiaries currently lacking drug coverage. It includes estimated savings of 20% on Rx drugs resulting from savings achieved by your insurer.

\* For more information on eligibility and benefits call 1-800-MEDICARE (1-800-633-4227).

AK

Marriage Status  
 Single  Married

Married, greater than \$24,045  
 Est. annual premium of \$187 plus  
 You'll \$ 267

Based on your deductible and co-insurance responsibilities.

Prepared by The Lewin Group  
 THE LEWIN GROUP

**OVERVIEW**

**NO CHILD**

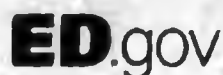
**LEFT**

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**OF ED.),**

**1/18/06**



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## Center for Rural Education Established at Education Department; William Smith Named Director

**FOR RELEASE:**  
December 16, 2005

**Contacts:** Jim Bradshaw  
(202) 401-1576

Tucson, Ariz. — The U.S. Department of Education today announced the creation of the Center for Rural Education to address challenges facing rural schools and named former U.S. Commissioner of Education William L. Smith as its director.

Housed within the Office of Vocational and Adult Education (OVAE) and working in tandem with the Secretary's Task Force for Rural Education, the center will serve as an information resource for policymakers at the local, state, and federal levels.

Beto Gonzalez, acting assistant secretary for the Education Department's Office of Vocational and Adult Education, made the announcement in remarks to a national meeting of the Council of Chief State School Officers in Tucson, Ariz.

Gonzalez also chairs the department's Rural Education Task Force, which met this week in Washington to discuss efforts to promote excellence in rural education through the *No Child Left Behind Act*.

In a statement from Washington, U.S. Secretary of Education Margaret Spellings hailed the creation of the new center and said, "I believe that every child, including those who attend a rural school, deserves the benefit of a quality education promised under *No Child Left Behind*."

"I am committed to addressing the needs of our students, educators, and parents in rural America," the secretary said. "This new center will take a leadership role in advancing the cause of rural education."

The center's director, William Smith, was the last U.S. commissioner of education in the former Office of Education, located in the former Department of Health, Education and Welfare, before it became a separate department in 1980.

Since that time, Smith has served in various management roles within the Education Department.

The U.S. Department of Education estimates that nearly 42 percent of the nation's public schools are in rural communities or small towns.

A primary goal of the center will be to update *The Condition of Education in Rural Schools*, a report last released by the U.S. Department of Education in 1994. The center will also host a series of focus groups and forums to highlight issues facing rural education.

The Office of Vocational and Adult Education in which the center will be located has a long history of helping rural America. For years, the office has included liaison staff to the National FFA Organization, formerly known as the Future Farmers of America.

The *No Child Left Behind Act* is the bipartisan landmark education reform law designed to change the culture of America's schools by closing the achievement gap, offering more flexibility to states, giving parents more information and options and teaching students based on what works. Under the law's strong accountability provisions, states must describe how they will close the achievement gap and make sure all students, including those with disabilities, achieve academically.

More information about the Center for Rural Education is available at: <http://www.ed.gov/nclb/freedom/local/rural/index.html>.

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Back to December 2005



**A National Dialogue:  
The Secretary of Education's  
Commission On The Future Of Higher Education**

**FACT SHEET**

*"It is time to examine how we can get the most out of our national investment in higher education. We have a responsibility to make sure our higher education system continues to meet our nation's needs for an educated and competitive workforce in the 21<sup>st</sup> century." –Secretary Margaret Spellings*

**About the Commission**

**Developing a National Strategy**

On September 19, 2005, United States Secretary of Education Margaret Spellings announced the establishment of A National Dialogue: The Secretary of Education's Commission on the Future of Higher Education. Its charge is to ensure that America's system of higher education remains the finest in the world and continues to meet the needs of America's diverse population by expanding opportunity, innovation, and economic growth. Composed of nineteen representatives from both public and private sectors as well as *ex officio* members from the Department of Education and other Federal agencies, the Commission will address vital questions such as:

- How can we ensure that college is affordable and accessible?
- How well are institutions of higher education preparing our students to compete in the new global economy?

The Commission will submit a final report by August 1, 2006 to the Secretary.

**More information about the Commission is available at:**

<http://www.ed.gov/about/bdscomm/list/hiedfuture/about.html>

**Secretary Spellings' Remarks**

**Announcement of the Establishment of the Commission**

<http://www.ed.gov/news/speeches/2005/09/09192005.html>

**Webcast of Proceedings, Transcript & Testimonies**

<http://www.ed.gov/about/bdscomm/list/hiedfuture/meetings.html>

**Upcoming Meetings**

**February 2-3, 2006**

Paradise Point  
San Diego, CA  
(Commission Meeting)

**February 7, 2006**

Crowne Plaza  
Seattle, WA  
(Field Hearing)

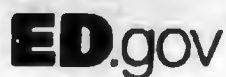
**April 6-7, 2006**

Hilton Indianapolis  
Indianapolis, IN  
(Commission Meeting)

**To Register:**

Contact Carrie Marsh  
202-205-8741  
[carrie.marsh@ed.gov](mailto:carrie.marsh@ed.gov)

*Registration is also available upon arrival.*



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## Growth Models: Flexibility and Accountability

November 1<sup>st</sup> 2005

"A growth model is a way for states that are already raising achievement and following the bright line principles of the law to strengthen accountability. We're open to new ideas, but we're not taking our eye off the ball."  
 – Secretary of Education Margaret Spellings

**In April, Secretary Spellings announced a New Path for No Child Left Behind—a set of common-sense principles to guide States in meeting the law's goals.**

- This New Path "equation" includes the primary elements of the law, such as annual testing and reporting of subgroup data, plus increasing student achievement and a narrowing of the achievement gap, plus overall sound state education policies that ensure that progress is being made.
- States that show results and follow the requirements of NCLB are eligible for new tools to help them meet the law's goals of getting every child to grade level by 2014.

**One of the approaches States have requested is the use of growth-based accountability models. They show promise as fair, reliable and innovative methods to measure school and student improvement.**

- Growth models give schools credit for student improvement over time by tracking individual student achievement year to year.
- The Department convened a group of experts and policymakers to examine and compare various models to determine how growth models could meet the goals of NCLB.
- A pilot program gives the Department the ability to rigorously evaluate growth models and their alignment with NCLB, and to share results with other states.

**As part of this new pilot program, States may propose a growth-based accountability model for use in AYP purposes, as long as they meet certain principles. The Department will approve no more than 10 high-quality growth models in this pilot program for 2005-06. The models must:**

1. Ensure that all students are proficient by 2014 and set annual goals to ensure that the achievement gap is closing for all groups of students;
2. Set expectations for annual achievement based upon meeting grade-level proficiency, not based on student background or school characteristics;
3. Hold schools accountable for student achievement in reading/language arts and mathematics;
4. Ensure that all students in tested grades are included in the assessment and accountability system, hold schools and districts accountable for the performance of each student subgroup, and include all schools and districts;
5. Include assessments in each of grades three through eight and high school in both reading/language arts and mathematics, must have been operational for more than one year, and must receive approval through the NCLB peer review process for the 2005-06 school year. The assessment system must also produce comparable results from grade to grade and year to year.
6. Track student progress as part of the State data system; and
7. Include student participation rates and student achievement on a separate academic indicator in the state accountability system.

**The Department will rigorously monitor and evaluate States that receive approval under the pilot this year.**

- Outside peer reviewers with technical expertise will evaluate proposals.
- States that receive approval must provide data to the Department on how the growth model works compared to the current AYP model. This information will be useful to the Department and policymakers and will help inform future actions.
- States that wish to apply and meet the core requirements should submit their proposals to the Department by February 17, 2006, to allow sufficient time for review.

**Some States do not have the assessment systems or data capabilities to use a growth model according to the principles above. But under *No Child Left Behind*, States currently have the flexibility to use an index model.**

- For States that cannot track individual student progress, an index model provides an alternative that gives schools credit for moving students from "below basic" to "basic" even if they are not yet proficient. The end target of having students proficient in reading and math by 2014 still remains, however.
- Currently, nine states (Massachusetts, Minnesota, Mississippi, New Mexico, New York, Oklahoma, Pennsylvania, South Carolina, and Vermont) use index models to determine AYP.

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Last Modified: 11/22/2005



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## Key Policy Letters Signed by the Education Secretary or Deputy Secretary

November 21, 2005

November 21, 2005

Dear Chief State School Officers:

Earlier this year in a speech at Mount Vernon, I announced that the Department would take a commonsense approach to implementing the *No Child Left Behind Act of 2001* (NCLB). This approach, crafted as an equation called *Raising Achievement: A New Path for No Child Left Behind*, established that, when States show results and follow the tenets of NCLB, they will be eligible for new tools to help them meet the law's goal of getting every child to grade level proficiency by 2013-14. As part of this approach, and in response to educators across the country, the Department has been exploring how accountability models that measure improvements in student achievement (i.e., "growth models") could be one such tool to help schools meet the requirements of NCLB.

This summer the Department convened groups of various experts, including researchers, stakeholders, and policy officials, to inform this work. We discussed a number of critical issues related to growth models that are worth highlighting here. First, we discussed the importance of accelerated student progress—the reality that not just any level of growth is enough to meet the bright line principles of NCLB. Substantial growth is needed to ensure all students are proficient by 2013-14 and to close achievement gaps. A proposed growth model that only expects "one year of progress for one year of instruction" will not suffice, as it would not be rigorous enough to close the achievement gap as the law requires. Second, we discussed the infrastructure required to implement a growth model. To implement this sophisticated approach, a State needs certain foundational elements in its standards and assessment system. NCLB has played a critical role in helping States build these elements. The annual assessments that form the basis of a growth model must work together as a coherent system—the achievement standards must be aligned with state content standards and must produce comparable results from grade to grade and year to year. These conversations were productive and have informed how we are moving forward.

These discussions confirmed our belief that growth models may show promise for measuring school accountability, giving schools credit for improvement over time, and measuring individual student progress. We also believe that this is the appropriate time to move forward with a pilot project on this issue, as the assessment and data infrastructure system of many States is more sophisticated now than when NCLB was first implemented. This pilot gives us an opportunity to build on the critical elements of NCLB, State resources, and the current AYP model.

Using this letter as a guide, I am inviting States to propose to the Department, a growth model to be used for NCLB accountability purposes as a part of this new pilot project. States that wish to use growth models as part of their NCLB accountability systems must demonstrate that these models can raise student achievement and enhance school accountability.

Our purpose in inviting these proposals is two-fold. First, the Department wants to evaluate how these growth models might help schools meet the NCLB proficiency goals and close the achievement gap. Second, this pilot project will provide the Department and other States useful information to improve the quality of data, assessment, and accountability systems. Consistent with the particular model a State is proposing, a State proposal must show how it meets a set of core principles, detailed below and in the enclosure, thus ensuring that its growth model aligns with NCLB and that its standards and assessment system contains necessary foundational elements.

### Core Principles

1. The accountability model must ensure that all students are proficient by 2013-14 and set annual goals to ensure that the achievement gap is closing for all groups of students.
2. The accountability model must establish high expectations for low-achieving students, while not setting expectations for annual achievement based upon student demographic characteristics or school characteristics.
3. The accountability model must produce separate accountability decisions about student achievement in reading/language arts and in mathematics.
4. The accountability model must ensure that all students in the tested grades are included in the assessment and accountability system. Schools and districts must be held accountable for the performance of student subgroups. The accountability model, applied statewide, must include all schools and districts.
5. The State's NCLB assessment system, the basis for the accountability model, must include annual assessments in each of grades three through eight and high school in both reading/language arts and mathematics, must have been operational for more than one year, and must receive approval through the NCLB peer review process for the 2005-06 school year. The assessment system must also produce comparable results from grade to grade and year to year.
6. The accountability model and related State data system must track student progress.
7. The accountability model must include student participation rates in the State's assessment system and student

achievement on an additional academic indicator.

Further details on these core principles are included in the enclosure that follows. These details explain what we mean by each principle and also provide direction to States regarding the evidence needed to show how their proposal addresses these issues.

In addition to meeting these seven principles, we are interested in approving accountability models under this pilot project that are reasonable, based on common sense, and understandable to educators and the public. We know that States may meet each of these core principles through various means, given differences in their standards, assessments, data systems, and other foundational elements. We welcome that creativity and thoughtfulness, as no two models will likely be alike.

It is important to emphasize that the Department will only approve a proposed growth model that can meet each of the core principles. I understand that this is a high bar and that not every State's data or assessment infrastructure will currently meet these requirements. It is, however, an attainable bar, as we have seen examples of State systems that, for instance, measure individual student progress or have multiple years of annual assessment data. This task will immediately be easier for those States who have developed coherent data and annual assessment systems over the years. These pieces, when put together and combined with the goal of universal proficiency by 2014, can form a growth model that meets the core principles and achieves the requirements of NCLB. I also know that while the State growth models in use today have utility and value, to the best of our knowledge, none currently meets all of these core principles.

The attachment includes four parts. Part I describes the process by which States may submit growth model proposals to the Department. The deadline for submitting such proposals is February 17, 2006. The Department will review submitted proposals, a process that will include the use of outside peer reviewers, and may attach reasonable conditions of approval. In addition, we will consider how States are meeting the *Raising Achievement* principles (such as narrowing the achievement gap, and creating easily accessible and understandable school and district report cards) that I outlined at Mount Vernon. For those States that propose a model meeting the elements outlined in this letter, we are willing to enter into a flexibility agreement to permit them to develop and use a growth model to hold schools and districts accountable under NCLB.

Please note that States must receive approval from the Department, and make any required amendments to their accountability plans, before implementing their proposed growth models. States that receive approval from the Department to be a part of this pilot project would be able to apply the growth model to their accountability decisions for the 2005-06 school year.

Part II of the attachment covers the core principles of NCLB that must be preserved under any growth model proposal. Part III presents a set of key questions that States must answer to provide evidence that their growth models meet NCLB requirements and help the Department evaluate their proposals. The answers will be considered as a whole by the Department in reviewing each State's proposal.

In addition, we know that many States do not have the assessment systems or data capabilities to be able to meet the core principles outlined above and in the enclosure. Currently, nine states are using an index to calculate AYP. In those instances where implementing a growth model is not possible or desirable, a State may want to consider amending its accountability plan to incorporate an index, especially those States who may not have all the necessary elements at this time to implement a growth model. Part IV of the attachment outlines how States may use an index to calculate AYP.

The Department will rigorously evaluate this pilot, review information on how the pilot project is working, and share results with other States, policymakers, and the public. To that end, States receiving approval to implement a growth model will be expected to provide data showing how the model works compared to the current AYP model, and to analyze the effects of a growth-based accountability model on student achievement. The Department is interested in using the data generated by approved States to conduct an evaluation so that we can share information on the results of the pilot with Congress, State officials, educators, and the public. Outside of accountability plan amendments to adopt an index as a way of measuring AYP, I plan on approving no more than ten high-quality State proposals within the context of this pilot this year. The approval of a growth model applies to the accountability system during the 2005-06 school year and is subject to a review at the end of the school year.

Please do not hesitate to contact the Department with any additional questions or concerns. We look forward to working with interested States on these issues.

Sincerely,

/s/

Margaret Spellings

Enclosure

cc: Governors

### Growth Model Pilot Proposals

#### I. Process:

- *What should the State include in its proposal?* States should submit applications seeking approval for the use of growth models as part of their No Child Left Behind (NCLB) accountability systems to Dr. Henry Johnson, Assistant Secretary of Elementary and Secondary Education. Applicants should clearly and concisely describe their proposals, with particular attention to how these proposals meet each of the requirements outlined below in sections II and III. A State should also include any relevant evidence. States submitting a proposal are encouraged to send it electronically to [conreport@ed.gov](mailto:conreport@ed.gov).
- *When should a State submit its proposal?* A State that wishes to incorporate a growth model in calculating adequate yearly progress (AYP) for the 2005-06 school year should submit its proposal to the Department by February 17, 2006. This timeline is designed to provide sufficient time for the Department to review the proposal, and notify the State of its decision so that the State can apply it without delaying AYP determinations and school improvement identifications. A State that wants to submit other amendments to its accountability plan should do so by April 1, 2006, and follow the guidance released previously by the Department: <http://www.ed.gov/admins/lead/account/amproc.doc>
- *What is the approval process?* Upon receipt of a growth model proposal, the Department will review it and initiate discussions with the State. The Department will use a peer-review process to help evaluate the proposal. Similar to State accountability plan amendment requests, the Department will ask a State whose growth model is approved to submit electronically the final proposal as part of its amended accountability workbook with the date of submission and amended elements noted on the cover page.

Additionally, depending on the particular model a State is proposing, the Department may work with the State to enter into a flexibility agreement. In the flexibility agreement, the Department may require reasonable conditions on the State in exchange for the additional flexibility granted to permit the use of a growth model.

After the flexibility agreement has been finalized and the amended accountability workbook is received, the Department will notify the State that its proposal has been approved and will post this information on the Department's website so that it is readily accessible to the general public. Please note that a State should not implement its proposed growth model until these steps are completed.

#### II. Core principles:

Each State's proposal must include information and evidence to show how it meets the core principles outlined below.

1. The accountability model must ensure that all students are proficient by 2013-14 and set annual goals to ensure that the achievement gap is closing for all groups of students.
  - How does the model ensure that schools and districts are held accountable for getting all students to proficiency by 2014? A proposed growth model that only expects "one year of progress for one year of instruction" will not suffice, as it would not be rigorous enough to close the achievement gap by 2014.
  - How does the model set reasonable, challenging, and continuously improving annual expectations for growth? Growth models that rely on substantial increases in the growth rates of students or schools in the last few years are not acceptable, but the Department is open to models that set a point in time as the goal (e.g., end of grade in a particular school; within four years). In setting these standards, the State should demonstrate how accountability is distributed among all grades and not postponed to this point in time. The Department is concerned that if the State's growth model allows attainment of the proficiency standard by individual students to be delayed or is tied to standards that are not considerably more rigorous with each consecutive grade, then it becomes too easy to minimize or delay the importance of accelerated growth.
  - How does the proposal incorporate the growth model into measures of status and safe harbor? States receiving approval to implement a growth model will be expected to provide data showing how the model works compared to the current AYP model. As a possible condition for implementing a growth model, the State may need to explain how it plans to focus its school intervention efforts incorporating the results from a growth model. For instance, a State should be prepared to explain how a school that does not meet either traditional AYP goals or growth-based accountability goals might be subject to more rigorous intervention efforts than schools not making AYP on only one accountability measure.

2. The accountability model must establish high expectations for low-achieving students, while not setting expectations for annual achievement based upon student demographic characteristics or school characteristics.
  - How does the model ensure that student growth expectations are not set or moderated based on student demographics or school characteristics? The model must have the same proficiency expectations for all students while setting individual growth expectations for students to enable them to meet that grade level standard.
  - How does the model ensure that growth is measured relative to achievement standards and not "typical" growth patterns or previous improvement?
3. The accountability model must produce separate accountability decisions about student achievement in reading/language arts and in mathematics.
  - How does the model ensure that students are improving in their achievement in reading/language arts and mathematics? How does the model hold schools accountable for such achievement? The growth model proposal should include separate decisions for reading/language arts and mathematics, although we recognize that it is also important to design accountability systems that maintain validity and reliability, minimize measurement error, and support empirical integrity in the accountability system. How does the model achieve these specifications, especially in small schools or schools with high mobility?
  - Does the model include assessments for other content areas? If so, the state should demonstrate that achievement on those other assessments does not compensate for low achievement in reading/language arts and mathematics tests.
4. The accountability model must ensure that all students in the tested grades are included in the assessment and accountability system. Schools and districts must be held accountable for the performance of student subgroups. The accountability model, applied statewide, must include all schools and districts.
  - How does the model maximize inclusion of students, particularly in light of missing data problems or student mobility? Because of these concerns, and depending upon the proposed State model, the Department may expect States to continue calculating and using the "status" approach to AYP.
  - If appropriate, how does the State proposal address the needs of students displaced by Hurricanes Katrina and Rita? In particular, the Department will need details on how this proposal interacts with any State plans to develop a separate subgroup of displaced students, consistent with the Secretary's guidance of September 29, 2005. <http://www.ed.gov/policy/elsec/guid/secletter/050929.html>
  - How does the State measure growth of students who are in the first tested grade? How do these issues interact with the State's "full academic year" definition? How do the Department's policies about assessing limited English proficient students and students with disabilities affect missing data policies?
  - How does the model hold schools accountable for the achievement of all student groups?
  - How does the model ensure that all schools receive an AYP determination each year? The Department expects that States will implement the accountability model in a consistent fashion across the State. Subject to that requirement, the Department is open to States using one model for schools with consecutively tested grades (i.e., elementary/middle) and a different AYP model for schools without consecutively tested grades (i.e., high schools).
  - How does the model ensure that all schools and districts are accountable for student achievement, even when the number of tested students in the school or district is small or constantly changing?
5. The State's NCLB assessment system, the basis for the accountability model, must include annual assessments in each of grades three through eight and high school in both reading/language arts and mathematics, must have been operational for more than one year, and must receive approval through the NCLB peer-review process for the 2005-06 school year. The assessment system must also produce comparable results from grade to grade and year to year.
  - How does the State's assessment system support the use of a growth-based accountability model? Please provide evidence explaining how students will be assessed with tests that produce comparable results from

grade to grade and year to year, such as through vertical scales or vertically moderated achievement levels.

○ How does the State demonstrate that its assessment system is stable and produces reliable and valid data?

6. The accountability model and related State data system must track student progress.

○ How does the State demonstrate that its data system can track student growth over time, across schools, and across districts? The State should provide evidence on the capacity of its data system to implement a growth model.

○ How does the model use individual student growth (such as through an individual student identifier)?

7. The accountability model must include student participation rates in the State's assessment system and student achievement on an additional academic indicator.

○ How does the model ensure that students participate in the assessment system and that schools are held accountable for such participation? School and district accountability must continue to take participation into consideration. Calculation of participation rates must be based on all students enrolled in the grades tested during the testing window.

○ How does the model ensure that schools are accountable for performance in one other academic indicator besides reading/language arts and math? School and district accountability must take another academic indicator into consideration as is the case with current systems.

### III. Questions to be answered by the State:

A State's proposal must also address the issues below. The Department will evaluate how these elements work together to create a coherent accountability system during the review process.

1. *Uniform averaging.* What role, if any, will the uniform averaging procedures have in a model that incorporates "growth" in the State's AYP definition?
2. *AYP formula issues.* What is the State's minimum group size? Does the State use confidence intervals? How will each of these continue in a State AYP definition that uses growth?
3. *Assessments.* What happens to the model when States use various assessments to assess the same content (e.g., a regular assessment, a native language assessment, or an alternate assessment aligned with grade-level achievement standards)? What happens under the model when, for instance, a student takes a reading assessment based on regular achievement standards in year one and a reading assessment based on alternate achievement standards in year two?
4. *Higher-achieving students.* Does the model assign schools any credit for higher achieving students of two types: 1) students who were previously low-achieving and are now above proficient, and 2) students who have always been high achieving.
5. *Reporting.* How will the State report data in a transparent, understandable manner to districts, schools, the community, and the Department?

### IV. Indexes

Under NCLB, States currently have the flexibility to take into account the percentage of students who improve their achievement levels through the development of what is commonly referred to as an "index model."

An index model provides a way for States to recognize schools that improve achievement among students at the below proficient level(s), thus providing an alternative to the "status" model of AYP decision-making that emphasizes the percentage of students at or above the proficient level. An index model does this by assigning a value (determined by the State) to various levels of achievement, with the highest value assigned to students at the proficient/advanced level and progressively lower values for each level below that.

Although an index does not measure individual student growth, it gives schools and districts "credit" for improving the achievement of students who are "below proficient." For example, a school will receive some credit if it moves students from "below basic" to "basic" even if they are not yet proficient. The end target of having 100 percent of students proficient in reading and math by 2014 still remains, however.

The Department has allowed States to base AYP on an index score when the following conditions are met:

1. The index does not give extra weight to students scoring above proficiency so as to mask performance in the lower achievement levels;

2. The index can be calculated separately for reading and mathematics and for each relevant student subgroup;
3. The index does not allow schools to make AYP without also increasing the percentage of students who are proficient; and
4. The index must be consistent with NCLB and the regulations promulgated under it, including provisions on annual measurable objectives and intermediate goals.

Currently, nine States are using such index models in their AYP determinations under their approved accountability plans: Massachusetts, Minnesota, Mississippi, New Mexico, New York, Oklahoma, Pennsylvania, South Carolina, and Vermont.

For examples, more information about the Minnesota and Massachusetts index models can be found online at:  
<http://education.state.mn.us/mde/static/2005%20Business%20Rules.doc>  
<http://www.doe.mass.edu/sda/ayp/about.html?section=3>

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Last Modified: 11/22/2005

## Raising Achievement of Students with Disabilities

December 2005

Educators and families know that the vast majority of students with disabilities can achieve to grade level standards. Thanks to the *No Child Left Behind Act*, signed into law by President Bush in 2002, for the first time the nation is making sure that they do. By assessing students annually and breaking down results by student groups, States are held accountable for continuous improvement toward the goal of having all students read and do math at grade level and closing the achievement gap by 2014.

Last April at Mt. Vernon, Secretary Margaret Spellings promised a new, common-sense approach to implementing *No Child Left Behind*, and committed to using the best and latest research to ensure students with disabilities are learning and taking meaningful tests. Today the U.S. Department of Education announced proposed regulations that would enable States to improve how they measure the achievement of students with disabilities.

- States may develop modified achievement standards and give assessments to qualified students based on those standards.
- States may include "proficient" scores from the modified assessments toward determining Adequate Yearly Progress [AYP] (capped at 2 percent of the total tested population at the district and State levels).
- In addition, States may continue to include the "proficient" scores of students with the most significant cognitive disabilities (capped at 1 percent of the total tested population at the district and State levels).
- For AYP purposes, States may include within the "students with disabilities" subgroup the test scores of students previously identified as having disabilities for up to 2 years after they no longer receive special education services.
- The proposed regulation gives States credit for doing good work to raise the achievement levels of students with disabilities.

**The proposed regulations are designed to meet the needs of students with disabilities who may not reach grade level within the same time frame as their peers, but who can make significant strides given the right instruction. They also contain key criteria to protect students with disabilities from being inappropriately assessed against modified achievement standards.**

- States must establish guidelines for Individualized Education Program [IEP] teams to determine which students are most appropriately assessed against modified achievement standards.
- Standards must continue to hold students to high expectations; modified standards must be aligned with grade-level curriculum.
- Students assessed under modified achievement standards must receive grade-level instruction in the relevant subjects.
- Modified achievement standards may not preclude a student from earning a regular high school diploma.

**The Department invites State officials, local educators and the general public to offer their opinions.**

- The draft regulations will be published in the Federal Register on Thursday, December 15. The deadline for submitting comments is 75 days after publication. An informal version is currently available on the Department of Education's website, [www.ed.gov](http://www.ed.gov)

**Under the *No Child Left Behind Act*, the immediate needs and academic potential of students with disabilities have been made a national priority.**

- Test scores must be disaggregated so parents and educators can follow their academic progress.
- The Department of Education is making available nearly \$14 million in technical assistance to assist States and conduct long-term research on the assessment of students with disabilities.
- A comprehensive Tool Kit for Students with Disabilities is being compiled for educators and school officials.

***No Child Left Behind* has removed the final barrier to full participation in the classroom, completing the effort begun 30 years ago with the passage of the *Individuals with Disabilities Education Act [IDEA]*.**

- Under NCLB, students with disabilities have made gains in reading and math at every level (Nation's Report Card).
- Under NCLB, students with disabilities are receiving more classroom time and attention, and at-risk students are being helped at an earlier stage (Center on Education Policy).
- Students with disabilities enjoy lower dropout rates and higher rates of postsecondary enrollment and employment than students 25 years ago (U.S. Department of Education).

## To Raise Achievement of Students with Disabilities, Greater Flexibility Available for States, Schools

Proposed Regulations to be Published in Federal Register

### FOR RELEASE:

December 14, 2005

**Contacts:** Jim Bradshaw  
(202) 401-2310

COLUMBIA, Md. -- U.S. Secretary of Education Margaret Spellings today announced proposed regulations to enhance the ability of schools and states to more effectively measure the achievement of America's students with disabilities.

With *No Child Left Behind*, parents, teachers, and the federal government committed to closing the achievement gap by 2014 for all children including students with disabilities. Ensuring that all students can read and do math on grade level remains a top priority.

Speaking to more than 100 policymakers and educators at Guilford Elementary School in Columbia, Md., Secretary Spellings said, "We're committed to using the best research to make sure students with disabilities are learning and taking tests that are meaningful to them."

The proposed rules to be published in Thursday's Federal Register are designed to meet the needs of students with disabilities who may not reach grade level within the same time frame as their peers, but who can make significant strides, given the right instruction.

Following is the prepared text of Secretary Spellings' remarks.

SECRETARY SPELLINGS: Thank you. You're lucky to have Nancy Grasmick as your superintendent in Maryland. She began her career in Baltimore as a teacher working with deaf students, and she's been a leader on special education issues in the policy arena as well. She's been a powerful voice for higher standards and accountability for results for all students.

Before I begin, let me say, tomorrow we'll have the chance to see history unfold before our eyes in Iraq. Millions of men and women—ordinary Iraqis—will show extraordinary courage as they take their place at polls all across the country. The people of Iraq will come together to defy terror and elect a parliamentary government. And they will be sending a powerful message of hope throughout the Middle East.

It's an honor to be here today at Guilford Elementary School with my deputy secretary, Ray Simon. I want to thank Principal Varlack for sharing her school with us today. I get asked all the time to point to places that are closing the achievement gap and proving we can leave no child behind. And this school is getting the job done for all students, including students with disabilities. The percentage of students here with disabilities meeting state standards in reading has increased by 17 points since just 2003. And the gap between all students and students with disabilities is shrinking in reading.

Just a few years ago, this school was falling short of standards. But you made improvements under *No Child Left Behind*. And today, you're a shining example for schools across the country. You're proving every child can learn with a quality education.

The key is setting high expectations for all students. And for parents like Catriona Johnson that makes all the difference. I met with Catriona and a group of other parents of students with disabilities earlier today. Catriona's son has autism, but his teachers here at Guilford saw his potential. And they worked with his mom to give him the support and instruction he needed.

As many of us know, it wasn't always like this for parents of students with disabilities. When I was in school—and it wasn't all that long ago—many states still had policies excluding students with disabilities from public schools. In 1970, schools in this country only educated one in five students with disabilities.

That all started to change when Congress passed the *Education for All Handicapped Children Act* in 1975. Last month, we celebrated the 30th anniversary of this law, which is now known as the *Individuals with Disabilities Education Act* or *IDEA*. It guarantees students with disabilities access to a free and appropriate public education. More than two decades after *Brown v. Board of Education* opened the schoolhouse to students of all races, this law opened our schools to students with disabilities.

As a result, there has been a dramatic increase in the number of students with disabilities graduating from high school and taking challenging courses. Today, virtually all these students take the full range of academic classes. That includes classes in English, math, social studies, science, and more. In fact, about one out of every five high school students with a disability is learning a foreign language.

We've come a long way in the last 30 years. But before *No Child Left Behind*, we still often underestimated what students with disabilities could learn. Many were victims of what President Bush calls the "soft bigotry of low expectations." We held them to lower standards, and we didn't hold ourselves accountable for their success.

Today, we know the vast majority of students with disabilities can achieve grade-level standards. And thanks to *No Child Left Behind*, we are holding ourselves accountable for making sure they do. For the first time ever, we as a nation have made a commitment to close the achievement gap by 2014 and ensure all students can read and do math on grade level.

That's why we're asking states to annually assess students and then break down the results by student groups so we can be sure all students, including students with disabilities, are getting ahead. For example, in the 2003-04 school year, about 95 percent of students with disabilities participated in state reading assessments.

As a result, we now have a laser-like focus on helping these students. Special education is no longer a peripheral issue. *IDEA* and *NCLB* have put the needs of students with disabilities front and center. We've torn down the final barrier between special and general education. And now every one in the system has a stake in ensuring students with disabilities achieve high standards.

At the same time, we know not all students learn the same way. And we want to give states the flexibility to design assessments that match the needs of their students. We're committed to using the best research to make sure students with disabilities are learning and taking tests that are meaningful to them.

As you know, *No Child Left Behind* already allows students with the most significant cognitive disabilities—about 1 percent of all students—to take alternate assessments. Further research suggests that an additional 2 percent of students should be assessed with modified standards. These are students who can achieve high standards but may not reach grade level in the same time frame as their peers, even with the best instruction.

Last spring, I announced the Department would work with states to help them establish more appropriate assessments for these students. And 31 states, including Maryland, Tennessee, and North Dakota, signed up to implement this policy for this school year.

Today, we are taking the next step forward by releasing proposed regulations on how states can implement this new policy long term. These regulations provide guidance on how states can identify these students and modify grade-level standards for them. We have published the proposed regulations in the Federal Register, and I want to invite you all to comment on them. We want your input.

I want to thank my assistant secretary for elementary and secondary education, Henry Johnson, and my assistant secretary for special education and rehabilitative services, John Hager, for being here today and for working together to develop this policy.

We're providing states with a technical assistance packet today on raising achievement for students with disabilities. It includes information on how *NCLB* and *IDEA* work together for students. And in the next few months, we'll also be releasing more material and information on teaching and assessing students with disabilities. At its heart, this policy is all about improving the way we educate and assess children with disabilities. It's a smarter, more sophisticated way of serving their needs.

Since taking office in January, I've been traveling around the country talking with parents, educators, and policymakers about how *No Child Left Behind* is working and what needs to work better. And wherever I go, I hear the same three questions: How can we do a better job assessing and serving students with disabilities? What's the best way to measure and enhance the progress of students new to the English language? And how can we reward schools for improving from year to year?

I promised to work with folks like you to address these issues in a sensible, workable way that makes raising student achievement our top priority. We're open to new ideas, just so long as we all stick to what I call the bright lines of the law—annually assessing students, disaggregating data, and closing the achievement gap by 2014. And we've taken some important steps forward together.

For example, last month, I announced a new pilot program where states can apply to use growth models to measure the progress students and schools make from year to year. And we've been working with the nation's top researchers to study the best way to educate and assess students new to the English language as well as students with disabilities.

With all these measures, our focus has been on helping students who in the past have been left behind. And states like Maryland, Massachusetts, Kansas, North Dakota, and Tennessee have been leading the way by shining the light on strategies that work for students with disabilities.

I want to thank Tennessee Commissioner of Education Lana Seivers for being here along with North Dakota special educator director Bob Rutten. They understand that ensuring students with disabilities learn is everybody's issue.

Last year, over 90 percent of districts in North Dakota made adequate yearly progress targets for students with disabilities. And in Tennessee, the percentage of elementary and middle school students with disabilities meeting state standards in reading increased by 15 points. These states have used the best research to ensure all students are included in the general curriculum and annual assessments. I like to say, "What gets measured gets done."

We're seeing the hard work pay off across the country. The latest nation's education report card shows students with disabilities are making gains at every level in both reading and math. And they're catching up to their peers, particularly in reading. As I like to say, "In God we trust—all others bring data." And with this data, we can see we're moving in the right direction. Scores are rising. And the achievement gap is closing. In other words, *No Child Left Behind* is working, and we must stick with it.

For folks like Lana Seivers, this isn't just a policy issue. It's a family issue. Her son has a disability. And for the last three decades, she's been fighting to raise standards for students with disabilities as a teacher, as an administrator, as a policymaker, and as a mom.

And thanks to *No Child Left Behind*, the conversation has finally shifted from "can these students learn" to "how can we make sure they learn." For the first time ever, we're demanding results. It's a national priority. And it's the right thing to do for parents and students across this country.

Thank you.

###

**OVERVIEW**  
**OBESITY**  
**PREVENTION,**  
**AMER. HEART**  
**ASSOC.,**  
**4/26/06**

## Did you know?

For the first time in history, today's children are not expected to outlive their parents, due to inactivity and obesity-related illnesses.

And, each year the State of Alaska alone spends an estimated \$195 million on obesity related diseases.

Please join the **American Heart Association**, **Senator Fred Dyson** and **Representative Peggy Wilson** to begin the discussion of obesity prevention in Alaska.

### **House Committee on Health, Education and Social Services**

Date: **Tuesday, April 25<sup>th</sup>**  
Time: **3 p.m.**  
Location: **Capitol Room 206**

### **Senate Committee on Health, Education and Social Services**

Date: **Wednesday, April 26<sup>th</sup>**  
Time: **1:30 p.m.**  
Location: **Butrovich Room 205**

### Special Guests:

- **Rosey Fletcher**, 2006 Olympic bronze medalist and member of the Municipality of Anchorage Obesity and Health Task Force
- **Dr. Bob Urata**, family physician and President-Elect of the American Heart Association's Pacific/Mountain Affiliate
- **Robb Boyer Ph.D.**, Anchorage School District and member of the Municipality of Anchorage Obesity and Health Task Force



American Heart Association 

American Heart Association 

*Learn and Live*

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**Obesity:**

*An Epidemic for Adults and Children*

**Dr. Bob Urata**

- Family practice physician
- President-Elect, American Heart Association, Pacific Mountain Affiliate

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**Obesity Defined**

- Obesity: having a very high amount of body fat in relation to lean body mass, or Body Mass Index (BMI) of 30 or higher.
- Body Mass Index (BMI): a measure of an adult's weight in relation to his or her height, specifically the adult's weight in kilograms divided by the square of his or her height in meters.

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## Overweight Defined

Due to potential negative connotations associated with the term "obesity," "overweight" is preferred when referring to children and adolescence.

- Overweights BMI between the 85<sup>th</sup> and 95<sup>th</sup> percentiles for ages 2–20 years

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## Trends

- During the past 20 years there has been a dramatic increase in obesity in the United States.
- In 1985 only a few states were participating in CDC's BRFSS and providing obesity data.
- In 1991, four states had obesity prevalence rates of 15–19 percent and no states had rates at or above 20 percent.
- In 2004, seven states had obesity prevalence rates of 15–19 percent, 33 states had rates of 20–24 percent, and 9 states had rates more than 25 percent.

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## Obesity Trends Among U.S. Adults

(BMI = 30 or more = overweight; BMI < 30 = person)

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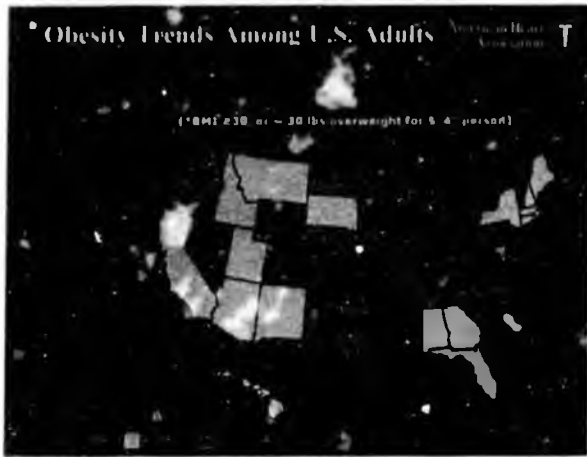
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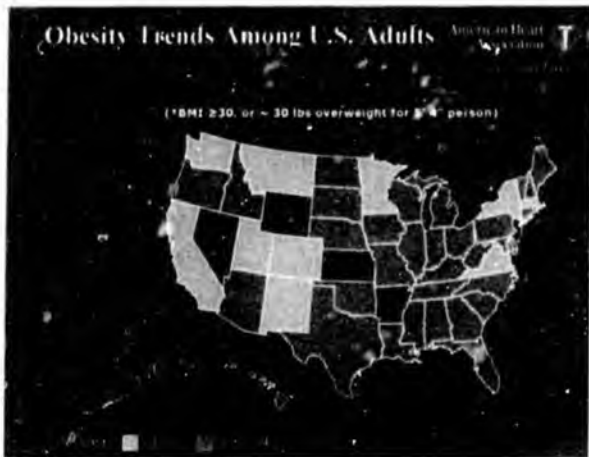
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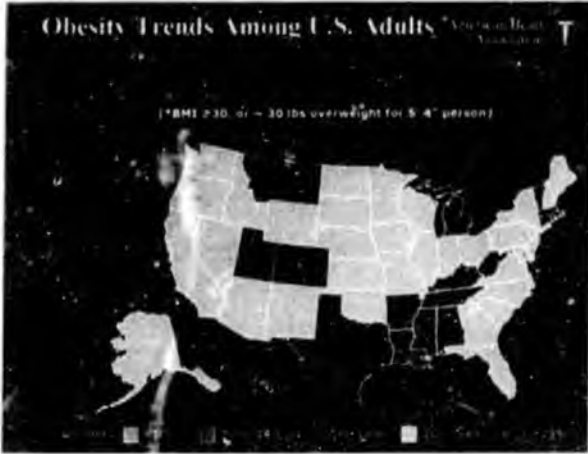
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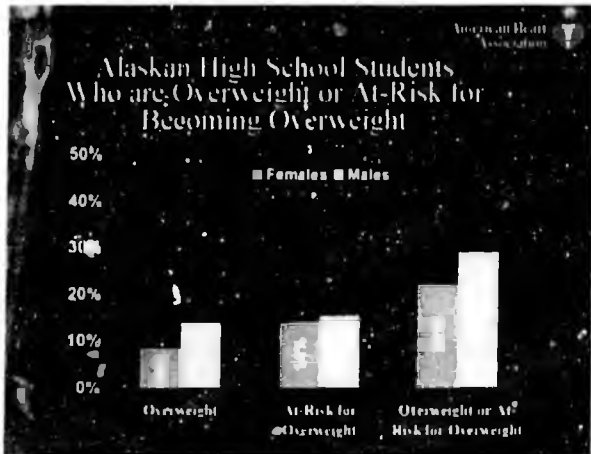
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- Actually 8 million children and adolescents are overweight

- Over the last two decades the rates for overweight adolescents have tripled

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### Overweight and Obesity: Health Consequences

**Youth**

- Increased risk of obesity as an adult
- High blood pressure
- High cholesterol
- Orthopedic disorders
- Type 2 Diabetes
- Psychosocial disorders

**Adults**

- Premature mortality
- Cardiovascular disease
- Type 2 Diabetes
- Musculoskeletal disorders
- Sleep apnea
- Gallbladder disease
- Certain types of cancer (endometrial, colon, kidney, gallbladder, postmenopausal breast)

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### Obesity: Economic Costs

<p><b>United States</b></p> <ul style="list-style-type: none"> <li>• \$75 billion in annual direct medical expenditure*</li> <li>• \$18 billion financed by Medicare</li> <li>• \$21 billion financed by Medicaid</li> </ul>	<p><b>Alaska</b></p> <ul style="list-style-type: none"> <li>• \$198 million in annual direct medical expenditures</li> <li>• \$17 million financed by Medicare</li> <li>• \$30 million financed by Medicaid</li> </ul>
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\*Source: State-Level Estimates of Direct Medical Expenditures: Methodology Report, CPUSA Research, 2004

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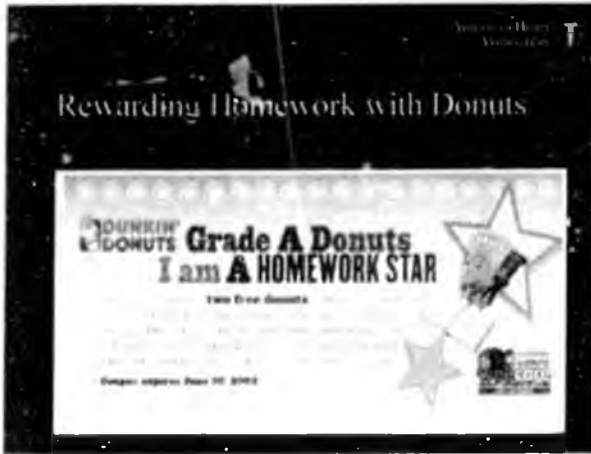
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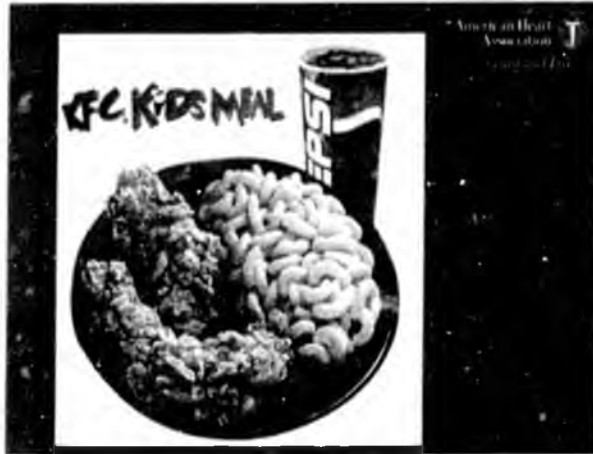
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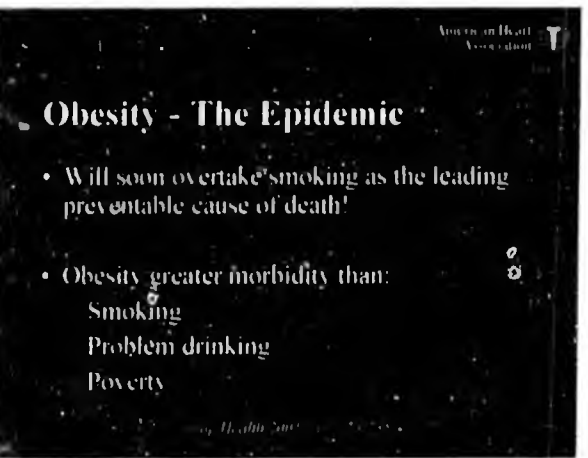
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## Quality of Life

The *National Institute of Health* projects that our next generation of children will be the first in the history of the U.S. whose life expectancy is shorter than their parents due to the impacts of obesity and related health consequences.



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American Heart Association

## American Heart Association

*Learn and Live*

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## Addressing Obesity Through Public Policy:

*Recommendations from the American Heart Association*

**Suzanne Meunier**

*Alaska Director of Advocacy  
American Heart Association*

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## Why Policy is Important to Preventing Obesity in Children

The vast majority of overweight children and adolescents (between 70 and 80%) continue to be overweight in adulthood or will become obese adults.

*Source: American Heart Association, 2007*

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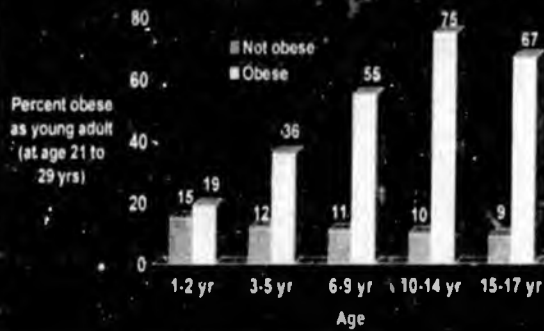
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## Childhood obesity predicts adult obesity




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## Why Policy is Important to Preventing Obesity in Children

- Epidemic childhood obesity rates: *current environment unhealthy*
- Policy change
- Changes in the environment
- Increases in physical activity and improved nutrition
- Improvement in health outcomes

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## The Current Environment Among Alaska Adolescence

- 82% do not attend physical education classes daily
- 32% do not meet the CDC recommendation for physical activity
- Only 16% consume at least 5 daily servings of fruits and vegetables

Source: Behavioral Risk Factor Surveillance System

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## The Opportunity

Schools are ideally suited to give children and adolescents the skills and support they need to adopt daily physical activity and healthy eating behaviors for life.

- More than 95% of all children and adolescents ages 5-17 are enrolled in school.

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## The Opportunity (cont.)

- School-based physical and nutrition education can help students acquire skills, attitudes, and knowledge supportive of healthy behaviors.
- Schools can reinforce positive eating and physical activity habits and offer many opportunities for young people to practice healthy eating and exercise.

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**What is Needed:**  
*Comprehensive School Physical Activity Programs*

The National Association of Sports and Physical Education (NASPE) and the American Heart Association recommend that these specific principles be present in quality physical activity programs.

*School physical activity policy and practices should include:*

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**Principles for Quality Physical Activity in Schools:**

- Quality, daily physical education
- Classroom health education
- Daily recess period (elementary)
- Extracurricular physical activity programs
- Walk/bike to school programs

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**What is Needed:**  
*Promotion of Healthy School Nutrition*

According to AHA scientific guidelines for childhood nutrition, there are eight principles for health school nutrition policy.

*School nutrition policy and practices should:*

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Eight Principles for Quality Nutrition in Schools

- 1. Support increased consumption of fruits and vegetables without excessive fruit juice consumption
- 2. Lead to decreased consumption of saturated and trans-fat
- 3. Encourage reduced consumption of refined grains and sugar-sweetened beverages and foods and encourage the consumption of adequate whole grains
- 4. Encourage consumption of non-fat or low-fat milk

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Eight Principles (cont.)

- 5. Encourage consumption of more non-fried fish, especially oily fish
- 6. Encourage adequate hydration without excess caloric consumption from beverages
- 7. Support healthy behavior environments
- 8. Support nutrition education for all students in all grade levels

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Parents and Teachers

Survey of parents of school-aged children found a significant gap between what parents believe is happening and what is actually happening

77% of parents support requiring daily physical education for all children

62% rate their child's school as "excellent" or "good" on making daily physical education available for all students

In reality only 8.8 to 8.0% of schools nationally (depending on grade level) provide students with daily physical education

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**Parents and Teachers (cont.)**

85% of parents and the vast majority of teachers favor the requirement of students to take physical education every day and at every grade level.

Published in "Physical Education in Schools" (2000) and "Physical Education in Schools" (2001)

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**Parents and Teachers (cont.)**

**Parents want physical education for their kids**

70% of parents think more school PE could help control or prevent childhood obesity.

95% think PE should be a part of school curriculum for all students grade K-12.

54% believe PE is as important or more important than math, science, or English.

AHA's Physical Activity Survey

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**A Complex Problem Requiring a Comprehensive and Collaborative Approach**

- Individuals
- Families
- Industry
- Schools
- Policymakers

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