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INSIDE THIS ISSUE:

'SENIOR PATROL' PROJECTS CONTINUE TO RECOVER MONEY FOR FEDERAL HEALTH PROGRAMS, IG SAYS

In the first six months of 2004, Senior Medicare Patrol Projects recouped more than $42,000 for the Medicare program and reported $200,000 in savings for both the Medicaid program and beneficiaries, the Department of Health and Human Services Office of Inspector General said in a report released Dec. 2.

The senior patrol projects have recovered or saved nearly $4 million for federal health programs since the program's inception in 1999 (HHS OIG).

Between January and June 2004, the senior patrol projects educated nearly 250,000 beneficiaries in more than 82,000 group training sessions and one-on-one sessions, the IG reported. Training and education efforts resulted in nearly 3,000 complaints, of which more than 500 were reported to Medicare contractors for follow-up, the report stated.

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The recent data were reported in *Performance Data for the Senior Medicare Patrol Projects: October 2004 Performance Report* (OEI-02-04-00360).

"We continue to emphasize that the number of beneficiaries who have learned to detect fraud, waste, and abuse from the Senior Medicare Patrol Projects, and who subsequently call the OIG fraud hotline or other contacts, cannot be tracked. Therefore, the projects may not be receiving full credit for savings attributable to their work," the IG said in the report. "In addition, substantial savings, which cannot be tracked, may be derived from a sentinel effect whereby fraud and errors are reduced in light of Medicare beneficiaries' scrutiny of their bills."

The report is available at http://www.oig.hhs.gov/oei/reports/oei-02-04-00360.pdf.

As reported in the BNA Health Care Daily Report (Vol. 9, No. 232)

Congratulations to Fran Wersells, the winner of the "You've Read It, Now Name It!" Contest

Thank you to everyone who submitted a name for the Center's newsletter. There were many great suggestions, unfortunately we could only choose one. For submitting the winning name, Fran, of AoA (Region V), will receive a $25 Visa Gift Card!

AOA UPDATE

In January 1998, the Administration announced unprecedented steps to involve Medicare beneficiaries in identifying and combating fraud and abuse. The following, month beneficiaries were provided with new information on how to report fraud and a toll-free number to report fraud was printed on every statement, bill, and claim.

* OIG Performance data for the Senior Medicare Patrol projects for the period January - June 30, 2004 shows about 248,000 beneficiaries were educated and about 3,000 complaints were received. In total the projects recouped $449,090 in Medicare, Medicaid and other savings to beneficiaries. Speaking of tracking SMP complaints, AoA is working to develop a new complaints management, tracking and reporting system in collaboration with the Center, CMS, OIG and other partners. Many of you have provided feedback to assist AoA in developing system requirements: Please continue to let us know how SMP complaints tracking and reporting processes may be improved.

A look ahead at 2005:

* In January 2005, the SMP Integration grantees will meet in DC to discuss vision, strategies, and plans to embed their programs into state and local health care fraud control and aging services networks.
* We expect to develop and disseminate updated and translated program materials as identified as a priority need in the 2004 Needs Assessment Survey conducted by the Center.
* Mark your calendars: Regional meetings will be held to provide technical assistance, fraud alerts and listening sessions during the summer.
* AoA expects to publish SMP project grant announcements in the Federal Register in January of 2005, which is earlier than in past years.
* Finally, AoA and the Center we will lead two panels on the SMP program during the ASA/NCOA National Conference in Philadelphia, March 2005.

We look forward to the New Year with energy and optimism that the SMP program will remain in the forefront of health care education, detection, and reporting.

NO VIOLATION OF ANTI-KICKBACK STATUTE IF MUNICIPALITY EMS WAIVES COST-SHARING FOR MEDICARE BENEFICIARIES

On October 5, 2004, the Office of Inspector General (OIG) issued Advisory Opinion 04-13 that allows municipal governments that operate emergency ambulance services to waive cost sharing for people with Medicare. A municipal emergency medical services (EMS) system requested the OIG opinion to resolve a question about whether a waiver of Medicare cost sharing for municipal residents violates the Anti-Kickback provisions.

The Advisory Opinion maintained that municipal residents had previously paid real estate taxes supporting the municipal EMS service and, therefore, waiver of cost-sharing was not prohibited under the Anti-Kickback law, Section 1128(B)b of the Social Security Act. This decision allows municipalities to bill Medicare or other insurance to pay for emergency transportation provided to Medicare beneficiaries or other municipal residents, but does not require them to bill residents for cost-sharing amounts.

This opinion only applies to EMS services that are performed directly by a municipality for its residents; it does not apply to local governments who contract privately for EMS. This reverses an earlier Advisory Opinion, where the OIG held that a municipality cannot require an EMS contractor to waive Medicare consumer cost sharing. Municipalities can pay cost sharing for residents, and the contracted company may waive cost sharing if it determines that a beneficiary has financial hardship. (OIG Advisory Opinion, No. 01-12, issued July 20, 2001).

> "Municipal governments that operate emergency ambulance services can waive cost shares for people with Medicare."

CMS ANNOUNCES IMPROVED EFFORTS TO REDUCE MEDICARE PAYMENT

The Centers for Medicare & Medicaid Services (CMS) today announced new steps to measure error rates in Medicare payments more accurately and comprehensively at the contractor level, and to further reduce improper payments through targeted error improvement initiatives.

We have made significant strides in how we measure the error rate in Medicare payments, and that will enable us to do even more to bring it down," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "We have much better data that will help us pinpoint problems and allow us to work with the Medicare contractors and providers to make sure claims are submitted and paid properly."

In addition, independent auditors for CMS issued an unqualified opinion on the agency's fiscal year 2004 financial statements, which are required by the Government Management Reform Act. This year's opinion marks the sixth consecutive year that CMS has received an unqualified opinion, demonstrating CMS' stewardship, discipline and accountability in the implementation of its fiscal responsibilities

Under the new measurement process for the Medicare error rate, the net national rate for fiscal year 2004 was 9.3 percent. The enhanced information comes from the first full year of data for an expanded program run by CMS to collect more detailed and contractor-specific information to help prevent future errors. CMS also announced new initiatives to reduce the error rate by more than half to 4 percent in four years, by building on recent reforms in payment oversight and new authorities in the Medicare law.

Medicare pays more than 1 billion claims each year. In fiscal year 2004, CMS reviewed approximately 160,000 Medicare claims from the preceding year to learn, more precisely, where errors were being made.

This review was the most extensive ever, providing CMS with more accurate information about contractor-specific error rates, error rates by provider type, and error rates by service type. This level of detail and accuracy is critical for CMS to identify where problems exist and target improvement efforts more effectively, and it reflects the agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments.

"We have developed the best data ever on contractor specific error rates," said Dr. McClellan. "With this new and detailed information, we are now able to develop specific steps for the Medicare contractors to take more effective actions in reducing the error rates. Using this report and the new, comprehensive data, we can better manage our contractors, making them more accountable to the taxpayers, beneficiaries, and providers, and laying a foundation for the further contractor reforms that we intend to implement in the next few years."

The 2003 analysis identified a large and unexpected increase in the rate of non-responses. CMS adjusted the non-response rate based on past experience with non-responders and other error categories, reporting the

2003 adjusted error rate as 5.8 percent. Without adjusting for the non-response, the 2003 payment error rate would have been 9.8 percent.

The 2004 data for error rate analysis was larger and more detailed than the 2003 data, just as the 2003 data was more extensive than data from previous years.

Since 1996, the Department of Health and Human Services (HHS) has annually determined the error rate for fee-for-service (FFS) claims paid by Medicare contractors, the insurance organizations that process and pay Medicare claims. From 1996 until 2002, the HHS Office of Inspector General (OIG) using a sample size of about 6,000 claims conducted the process used to measure Medicare payment error rates. The measured error rate declined from 13.8 percent in 1996 to 6.3 percent in 2002.

In fiscal year 2003, and as part of the agency's enhanced efforts to improve payment accuracy, CMS began calculating the Medicare FFS error rate and estimate of improper claim payments using a methodology approved by the OIG for the past two years. Since 2003, the OIG has assisted CMS in developing, reviewing, and formulating further actions based on the more extensive data collection.

"The assistance provided by the Office of Inspector General is helping us improve our accuracy and effectiveness in identifying and responding to problems in paying claims," said Dr. McClellan. "The majority of providers are honest and want to make sure they file their claims correctly so they can be paid timely, and we're taking new steps to work with our contractors to make sure that happens, as we move forward with fundamental contractor reform over the next few years."

CMS' more extensive survey, involving a more comprehensive analysis of a larger number and variety of claims, was accompanied by well-coordinated outreach to health care providers to improve claims submissions. CMS established two programs to monitor the accuracy of Medicare FFS payments: The Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). The main objective of the CERT program and HPMP is to measure the degree to which CMS and its contractors are meeting the goal of "Paying it Right."

The 2004 analysis does not adjust the non-response rate, and also includes other data improvements that reflect input from Congress and other oversight partners. In particular, the sample of claims for fiscal intermediaries, who process and pay Medicare Part A claims, was doubled from the prior year so that intermediary-specific

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error rates could be calculated at the same levels as the Medicare carriers (Part B contractors) and durable medical equipment regional carriers. The data now permits accounting for appeals involving all types of benefits (not just hospital benefits). Thus, the more comprehensive error rates of the last 2 years are illustrative of CMS' new measurement process.

Of the total payments sampled in 2004, results of the new measurement program indicate the following payment error traits:

* 4.1 percent of payments had errors due to insufficient documentation being submitted (2.6 percent was reported in the 2003 analysis, which included much less information on fiscal intermediaries in 2003);

* 2.8 percent had errors due to non-responses to request for medical records (an unadjusted 5.0 percent rate was found in 2003);

* 1.6 percent had errors due to medically unnecessary services (1.3 percent in 2003);

* 0.7 percent had errors due to incorrect coding (0.7 percent in2003); and the remaining

* 0.1 percent had other errors (0.2 percent in 2003).

The claims included in this analysis were submitted before many of the agency's recently-implemented initiatives to reduce error rates took effect. The more comprehensive data provides CMS with the opportunity to enhance and expand its efforts to monitor the impact of these initiatives. As part of its general efforts to further reduce the Medicare error rate, the CMS contractors will be required to:

* Develop corrective action plans that include efforts to educate providers about the importance of submitting thorough and complete medical records;

* Identify where additional review of claims and education on submitting claims is needed, based on information that shows where the highest percentage of errors on overused billing codes are occurring; and

* Use the performance results to develop local efforts to lower their error rates by addressing the cause of the errors and outlining corrective steps.

"We've taken major steps in recent years to get much better data on payment accuracy for each and every one of our contractors, and in every case, better measures mean an ability to reduce error rate for those contractors," said Dr. McClellan. "We've taken a major step this year to improve data on the fiscal intermediaries, and we are now using this information to drive down their error rates in the same way."

In addition, CMS is continually developing educational material and information for healthcare providers as part as of "The Medicare Learning Network." CMS has developed over 250 national provider education articles annually that outline, on a flow basis and in plain language, the coverage, billing and coding rules associated with Medicare program changes. These articles can be found at www.cms.hhs.gov/medlearn/matters.

The 2004 error rate short report can be found at www.cms.hhs.gov/CERT.

BUSH NOMINATES EPA ADMINISTRATOR MIKE LEAVITT AS NEW HHS SECRETARY

Michael Leavitt, nominated as secretary of HHS.

President Bush on Monday nominated Michael Leavitt, administrator of the Environmental Protection Agency and former Republican governor of Utah, to replace Tommy Thompson as secretary of HHS, Reuters reports (*Reuters*, 12/13). Bush said Leavitt is a "fine executive" and a "man of great compassion," adding, "He's an ideal choice to lead one of the largest [agencies] of the United States government." Leavitt said, "I feel a real sense of understandable regret" about leaving EPA and noted that HHS plays a vital role in the lives of all U.S. residents (Sherman, *AP/San Francisco Chronicle*, 12/13). Leavitt added that he was "looking forward to implementing [Bush's] vision" at HHS, including the launch of the new Medicare prescription drug benefit in 2006.

Leavitt is a nationally recognized leader in the areas of health care and welfare reform. During his three terms as Utah governor, he was chosen by the nation's governors to represent states in working with Congress on welfare reform, Medicaid and children's' health insurance. Utah initiatives during Leavitt's administration were featured as models for or adopted as national programs by Congress. The Children's Health Insurance Program (CHIP) helped reduce the uninsured rates for children in Utah to its lowest point ever and was adopted by Congress as a national program. His administration worked to increase the number of Utahans with health insurance by 400,000, improve immunization rates by nearly 75%, increase collection of child support and dramatically improve the child welfare system.

FLU SEASON UPDATE

After a chaotic prelude to flu season, stimulated by restrictions on one of the major flu vaccine suppliers for the US, the flu season fortunately seems to be off to a slow start. According to the CDC's Influenza Summary Update, flu activity through the middle of November was low across the country. Only two states, Delaware and Alaska, are reporting widespread outbreaks, and New York state is reporting a regional outbreak.

So, was it much ado about nothing? Hardly! The media frenzy earlier this fall, while creating a great deal of needless anxiety, also prompted great demand for the flu vaccine from the people who need it the most. And those good general hygiene tips your mom used to tell you– like washing your hands and covering your mouth when you cough and sneeze– received much attention in the press. The flu season isn't over, and unfortunately will come around again before you know it. Included in this article is useful information for the remainder of this season and for seasons to come.

Influenza Billing Guidelines

CMS has created the publication: Medicare Preventive Services - Adult Immunizations: A Guide to Billing Influenza and Pneumococcal Vaccinations. You can find the full document on the CMS website at http://www.cms.hhs.gov/medlearn/refimmu.asp. Here are some generic guidelines you should be familiar with when it comes to billing for flu shots:

1.If someone has Medicare Part B and is vaccinated by a provider that accepts assignment, it is illegal for that provider to collect money from him or her. Medicare will not pay the costs of vaccination for an individual with Medicare Part A only.

2.Medicare pays a provider for the vaccine itself, and for the administration of the vaccine. A physician or supplier who accepts assignment must not bill a beneficiary for any cost—people with Medicare do not pay deductibles and co-payments for flu vaccinations.

3.If your client has Part B AND is vaccinated by a provider that does NOT accept assignment, the provider may collect their usual charges (i.e., the amount charged a patient who is not a Medicare beneficiary) for the flu and PPV at the time of administration. Your client is responsible for paying the difference between what the physician or supplier charges and the amount Medicare allows for administration. The physician or supplier must submit an unassigned claim on the beneficiary's behalf. However, all physicians and suppliers, regardless of participation status, must accept assignment of the Medicare vaccine payment rate.

If you receive a complaint from a Medicare beneficiary about being charged for a flu or pneumococcal vaccination, we recommend you review the billing guidelines or contact the Center for assistance in determining the appropriateness of the complaint.

Reporting Process

If someone calls to report a complaint of any kind (price gouging, providers that accept assignment charging beneficiaries, unlicensed/unauthorized individuals offering immunizations, etc.), the CDC requests you collect as much of the following information as possible. *Numbers 4 and 8 are essential.*

1. Name of person calling in report;

2. Affiliation of person calling in report;

3. Phone number of person calling in report;

4. Name of entity complaint is based on (company, individual, etc.);

5. Phone number of entity or any other identifying information (email address, license number, etc.);

6. Name of a contact person at entity;

7.Vaccine presentation (10-dose vials, individual vaccine, etc.); and

8. Price

Your standard complaint reporting form in all likelihood will assess these as well as other points of information.

Price Gouging

The Medicare website currently states that Medicare will pay about $18/shot. Because "price gouging" regulations vary from state to state, there is no standard dollar figure or amount that applies nationally. For instance, the Kansas Attorney General's office considers price gouging as any charge that is more than 2 ½ times the "average" price. Florida legislation simply states that it is price gouging if the price "grossly" exceeds the average price in the 30 day preceding days.

If you receive a complaint that you believe is valid, it is important that you forward the information ASAP to the following entities for investigation:

1. **CDC:** They have set up a special contact email for complaints for use by providers. They have also indicated that SMPs can submit their complaints to the CDC to this email address as well. Once reported to this email address, the CDC will forward complaints to your State Attorney General's Office for follow-up. Do NOT call the CDC's immunization hotline to report your complaint, or you will be re-routed. Do NOT distribute this email address to other organizations. Submit your complaints to: Jim Harrison at jrh3@cdc.gov.

2. **Local law enforcement:** Only call local law enforcement if you determine there is an immediate threat to health and safety.

3. **OIG and CMS Carrier or Intermediary:** If the complaint involves issues related to Medicare reimbursement, you should also contact the OIG hotline and submit the complaint to the contact at your CMS Carrier or Intermediary.

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FLU SEASON UPDATE

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According to the CDC/ HHS protocol for managing complaints, consumers should be advised that their complaints will be forwarded to the National Association of Attorneys General, the Attorney General in their state, and the Attorney General in the state where the vendor is located (if in a different location).

<u>Consumer Protection</u>

There have been multiple reports across the country of inappropriate activities aimed at both consumers and providers--corporate price gouging directed at health systems and physician's offices has received the most widespread attention.

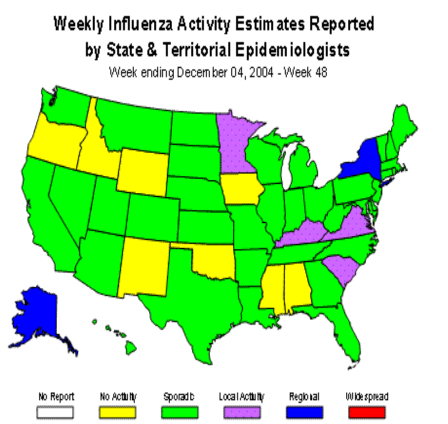
There have been several other reports of potential fraudulent or illegal activities generally targeting seniors and those other groups that are part of the federal Centers for Disease Control and Prevention's (CDC's) high risk population.

* The Denver Post reports that nearly 800 doses of flu vaccine were stolen from a pediatric clinic in Aurora, Colorado.

* The Virginia Department of Health has turned a case over to the CDC involving a group of seniors who received shots from unmarked vans parked in parking lots.

* The Senior Medicare Patrol (SMP) Project in Texas received a report from a senior who received a telephone call from a person offering to come to their home and administer a flu shot. The caller indicated that they worked for a home health agency and had a surplus of this year's flu vaccines. You had to have a Medicare number to qualify.

* In an online article, experts warned of spammers taking advantage of the shortage by offering vaccines through e-mails and on websites. Spammers are using a variety of methods, such as pinging and hijacking servers, to profile and target people most susceptible to the scams. Vircom, an IT security firm, calculates approximately one in 20,000 people targeted by spammers falls for the schemes. Since the flu scams may number in the "high millions," according to Francois Bourdeau with Vircom "sixty percent will be downright frauds, where the only goal was to get people's credit card information," Bourdeau says. The other 40 percent, according to Bourdeau, lead to Web sites that may actually offer something--possibly the real flu vaccine, possibly another substance. Bourdeau says that most of the sites offering vaccines are "hit-and-run" operations. "They set up a Web site for about 48 (or) 96 hours," Bourdeau says. The culprits then shut down the sites and set up others at different addresses. According to Bourdeau, the brief life span of these Web sites explains why they can't be found by simple Google searches.



Beyond economic concerns, these scenarios present potentially serious health concerns. Inappropriate management of the vaccine can cause serious health problems. According to Ryan Stice, pharmacy director for Porter Adventist Hospital, quoted in the Denver Post article, the vaccine must be kept refrigerated between 36 and 46 degrees Fahrenheit or it will become inactive. He added that any sterile product not stored properly also can develop bacterial growth

While we do not wish to cause alarm among consumers or deter them from seeking vaccination from appropriate, trusted health care personnel and sources, it is essential to point out general steps they should take to protect themselves. Consider these consumer protection tips:

1. Do not accept offers for the flu vaccine over the phone or from people who approach you.
2. Do no purchase vaccines being sold over the Internet.
3. If you have Part B Medicare **and** a provider says they accept Medicare, they can NOT charge you for the vaccine- it is against the law!
4. In most states it is illegal to over charge people for shots. The average price of a flu shot is around $20.
5. Read your Medicare Summary Notice (MSN) or explanation of insurance benefits when you receive them to make sure you were not charged for services, vaccines or equipment you did not receive.
6. Report:

* Anyone <u>you don't know</u> who offers you the shot.

* Anyone who asks for your Medicare or Medicaid number and also asks you to pay for the shot if you have Medicare Part B.

* If you think you have been charged too much for your shot.

* Errors or questions about charges on your MSN or explanation of insurance benefits.

DEVELOPING CULTURAL COMPENTENCY

A recent Federal Trade Commission report revealed that members of racial and ethnic minorities were more likely to be victims of fraud than non-Hispanic whites. Those who are American Indians or Alaska Natives were at greatest risk, and Hispanics and African Americans were more than twice as likely to be victims of fraud as non-Hispanic whites. With health care fraud disproportionately occurring in minority populations, SMPs are faced with the challenge of effectively communicating with individuals from racially, ethnically, culturally and linguistically diverse groups. To overcome this barrier to effective outreach to underserved populations, projects have committed to developing a fundamental understanding of cultural competency and its importance in fighting health care fraud and abuse.

Cultural Competence Defined

Culture: The thoughts, ideas, behavior patterns, customs, values, skills, language, arts, and faith or religion of a particular people at a given point in time.

* Culture defines us as individuals; it makes us who we are.
* Everyone has a culture, which influence how each of us sees others.
* Communities have different cultures influenced by their members, the environments, and socioeconomic conditions.

Cultural Competence: The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, and faiths or religions in a manner that recognizes, affirms and values the worth of individuals, families, tribes and communities, and protect and preserves the dignity of each.

* Cultural competence is a continuous process of learning about the culture strengths of others and integrating their unique abilities and perspectives into our work.
* Cultural competence is a vehicle to broaden our knowledge and understanding of individuals and communities.
* Cultural competence, or lack of it, will be reflected in how beneficiaries and communities relate to and interact with staff and volunteers.

Twelve Things You Should Do To Promote Cultural Competence

1. Make a commitment to expand your knowledge about culture and cultural competence.

2. Make a commitment to develop an understanding of various cultural groups within communities served by your project.

3. Include culture and cultural competence principles in your strategic planning, policy development, program design and service delivery processes. Increase organizational understanding of how the various dimensions of culture impact the beneficiaries that you serve and the staff and volunteers who work with them.

4. Be committed to promoting cultural competence. Develop this commitment through staff and volunteer development and training, performance evaluations, and policies that support cultural competence.

5. Create a safe, secure and supportive environment where staff and volunteers can explore and develop an understanding for all cultures. Create formal partnerships with community organizations that work with different cultural groups and encourage staff and volunteers to actively engage communities and families in the development of policy, program designs and service delivery models.

6. Be active in local minority communities. Engage these communities by recruiting local citizens for volunteer positions and on advisory teams and task forces. Encourage and support staff and volunteers to become involved in community boards and cultural activities.

7. Be an example to tribes, communities and families that work with your project by making hiring decisions that are reflective of the diversity of those populations. More importantly, make sure that staff and volunteers develop an understanding and respect for the richness, strength and diversity of different cultures.

8. Advocate for the development of cultural principles in other groups to which your agency belongs or partners.

9. Become more proactive about recognizing and resolving conflicts that can occur when different cultures interact.

10. If your agency provides educational and/or recreational opportunities for your community, make sure that they include experiences that are reflective of all cultural groups. Many tribes and communities have museums or cultural centers that host a variety of event throughout the year and on holidays. Also, during the summer many communities have various festivals that celebrate the culture and traditions of different racial and ethnic groups; actively participate and make your presence known at these events.

11. Share! If your project has developed resources aimed at these special populations, *please* share them. Projects are in need of foreign language materials as well as materials with pictures of diverse populations. Submit your resources to Candice Griffin at cgriffin@smpresource.org or upload them into the Center resource library.

12. Contact Andrea Fehring at afehring@smpresource.org for information on The Center's archived MShow cultural diversity seminars featuring Dr. Michelle Yehieli and Dr. Mark Gray.

For questions or comments contact Candice Griffin at cgriffin@smpresource.org.

NO OVERPAYMENT COLLECTION FOR TERMINATED ESRD BENEFICIARIES

On October 29, 2004 the Centers for Medicare and Medicaid Services (CMS) issued a directive to carriers and intermediaries not to collect overpayments for benefits paid on behalf of a subset of Medicare beneficiaries whose Medicare benefits ended in November 2003. Some beneficiaries with End Stage Renal Disease (ESRD) were no longer Medicare-eligible in 1999 but were not terminated from Medicare at that time. In November 2003 CMS and the Social Security Administration retroactively terminated coverage for these beneficiaries and provided written notice of the termination. In October 2004, CMS directed carriers and intermediaries not to collect overpayments to medical providers that were due to the retroactive termination.

If any medical providers in your area are sending bills to former beneficiaries who were eligible for Medicare benefits due to ESRD, advise the provider that these beneficiary are not liable for the bills, and any overpayments assessed against the provider for this population should be dropped by the carrier or intermediary. For more information, please go to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp and scroll down to Transmittal File No. R13GI, date 10/29/04.

PRODUCTS AND PRACTICES OF DISTINCTION

The Center is pleased to offer the Products and Practices of Distinction program to all participating Senior Medicare Patrol projects. The Products and Practices of Distinction recognition program was created this past year to honor imaginative, effective, and cost efficient products and practices to address Medicare/Medicaid errors, fraud, and abuse developed by Senior Medicare Patrol projects across the country. The purpose of this opportunity is to enhance national dissemination of quality products created by SMPs that help them reach their goals and to encourage collaboration. Additionally, this provides an opportunity for The Center and AoA to better understand relevant issues and practices in the SMP community. The program both recognizes and facilitates sharing of these innovations within the SMP community.

Click here if you are interested in submitting a Product or Practice of Distinction to be considered during the next review process or contact Andrea Fehring at afehring@smpresource.org.

NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION (NHCAA) INSTITUTE FOR HEALTH CARE FRAUD PREVENTION ANNUAL TRAINING CONFERECNE (2004)

Center staff attended NHCAA's conference in November. The conference was sponsored by NHCAA, whose mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud. The Annual Training Conference is recognized as the single-most important national venue to spotlight emerging schemes, current issues, and best practices on the health care and disability fraud forefront.

Educational sessions included: Top Ten "Problem" Billing Codes; Working With State Fraud Bureaus/NAIC to Combat Health Care Fraud; Future Issues Confronting SIU Managers; and Wheelchairs and Scooters among others. If you are interested in any of the conference materials, please contact the Center at info@smpresource.org. (Because of copyright restrictions we are unable to distribute to all projects.) Center staff will be working to convene a briefing with NHCAA staff in the coming months to discuss partnership opportunities.

MEDICARE PREVENTIVE HEALTH BENEFITS SCHEDULED TO TAKE EFFECT JANUARY 1ST

What better way to ring in the new year than with a preventive health check-up! Final rules published by the Centers for Medicare and Medicaid Services (CMS) on November 15, 2004 implement a number of new changes, including the new "Welcome to Medicare Physical" (WMP), and screening tests for diabetes and heart disease. The final rule also increases payments for vaccinations and other types of injections. For example, payments for administering the influenza vaccine will rise from $8 to $18. Physicians can also be paid for injections and vaccinations, even when performed on the same day as other Medicare-covered services. (Medicare currently does not allow payment for injections provided on the same day as other Medicare services.)

Welcome to Medicare Physical

Section 611 of the Medicare Modernization Act (MMA) defines an "initial preventive physical examination" (referred to as the WMP) to mean physicians' and certain qualified nonphysician practitioners' services consisting of all of the following:

(1) Review of the individual's comprehensive medical and social history.

(2) Review of the individual's potential (risk factors) for depression (including past experiences with depression or other mood disorders) based on the use of an appropriate screening instrument.

(3) Review of the individual's functional ability and level of safety that is, at a minimum, a review of the following areas: hearing impairment, activities of daily living, falls risk, and home safety.

(4) An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified nonphysician practitioner, based on the individual's comprehensive medical and social history and current clinical standards.

(5) Performance and interpretation of an electrocardiogram.

(6) Education, counseling, and referral, as appropriate, based on the results of the previous five elements of the initial preventive physical examination.

(7) Education, counseling, and referral, including a written plan provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits; that is, pneumococcal, influenza, and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic exams, prostate cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, screening for glaucoma, medical nutrition therapy services, cardiovascular screening blood tests, and diabetes screening tests.

Coverage of initial preventive physical examinations is provided under Medicare Part B only. The MMA permits payment for one initial preventive physical examination within the first 6 months after the effective date of someone's Part B coverage, but only if that coverage begins on or after January 1, 2005. Payment for this service would be applied to the required deductible, which is $110 for 2005, if the deductible has not been met, and the usual coinsurance provisions would apply.

In the final rule, CMS made two changes to the proposed payment to ensure that beneficiaries get the maximum value from this service. Physicians can bill and be paid separately for the screening electrocardiogram, in addition to the payment for the physical. The rule also lets a physician bill for a more extensive office visit when performed at the same time as the physical, as long as the services are medically necessary.

What better way to ring in the new year than with a preventive health check-up!

Comments published in the Federal Register reflect provider group concerns that reimbursement levels for the WMP are inadequate to cover the complexity of the services required by the statute. However, CMS responded that they believe the coverage is adequate, and will make every effort to track utilization and monitor the payment situation. Assuming providers accept assignment, even at the full rate of $110 to cover the deductible, the WMP appears to be an excellent value for consumers.

Diabetes Screening Tests

Section 613 of the MMA mandates coverage of diabetes screening tests for certain people with Medicare who are *at risk* for diabetes, starting January 1, 2005. There is no cost to beneficiaries for these testing services.

Certain tests for persons with symptoms of uncontrolled diabetes, such as excessive thirst or frequent urination are already covered as a diagnostic service. An individual "at risk" for diabetes is defined as having any of the following:

- High blood pressure (Hypertension)
- Abnormal cholesterol (Dyslipidemia)
- Obesity, defined as a body mass index
- (BMI) greater than or equal to 30 kg/ m2.

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MEDICARE PREVENTIVE HEALTH BENEFITS

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- Previous identification of an elevated impaired fasting glucose (high blood sugar level after not eating for a pre-defined period of time)
- Previous identification of impaired glucose tolerance (difficulty regulating glucose levels in the blood stream)
- A risk factor consisting of at least two of the following characteristics:
    - Overweight, defined as a body mass index greater than 25 kg/m2, but less than 30.
    - A family history of diabetes.
    - A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.
    - 65 years of age or older.

Medicare beneficiaries diagnosed with prediabetes are eligible for up to 2 screening tests per 12 month period. "Pre-diabetes" diabetes is defined as a previous fasting glucose level of 100–125 mg/dL, or a 2-hour post-glucose challenge of 140–199 mg/dL. For individuals not meeting the prediabetes criteria, one diabetes screening test is covered per individual per year.

Heart Disease Screening Tests

Section 612 of the MMA established coverage for screening of cardiovascular diseases. The new benefit includes use of three clinical laboratory tests (total cholesterol, HDL-cholesterol, and triglycerides), ordered as a panel no more frequently than every five years. There is no cost to beneficiaries for these testing services.

General Reimbursement Notes

Medicare rules require that laboratory tests for screening or other diagnoses must be ordered by licensed health care practitioners, specifically physicians, physicians' assistants, nurse practitioners, or CNSs .

It is important to note that the new rules specifically state that clinicians, include laboratories must issue an advance beneficiary notice (ABN) if there is doubt about any of the statutory periods (e.g. 6 month window for WMP, 5 year window for heart disease screening, etc.), otherwise the provider can be held financially liable. This should be translated to mean that the patient is responsible for tracking the timing of benefits they utilize, or they will be financially liable if they receive an ABN from the provider. CMS established a number of new billing codes in an effort to track utilization of these benefits and screening tests.

TIPS FOR SUCCESSFUL MEDIA OUTREACH

A key element of working well with the media is understanding the unique logistical challenges faced by professionals in the media. For instance, the needs of a reporter at a major metropolitan daily newspaper differ markedly from those of a cable news program producer.

The first step to effectively reach the media in your community is to create a list of media outlets and key reporters who may be interested in your efforts. Creating your list is as easy as watching the news or reading the newspaper. Keep a record of the reporters covering health care, senior issues, fraud, and Medicare or Medicaid in your area. This research will make your job easier when you are looking for coverage. The Internet, is an excellent source for contact info, as media websites often include beats, bios and contact information.

CREATING NEWS

News doesn't just happen, it is created. Here are five tips that may increase your chances for getting news coverage.

1. Make your story visually compelling -- give your story a "human face.". A picture is worth a thousand words. When planning an event for the media, identify visuals that illustrate your topic. Schedule a visit with volunteers or consumers who have particularly interesting stories to share. Point out the problems, and demonstrate how your program has helped.

2. Piggyback on breaking news. Medicare Modernization Act changes are a hot prime time subject. Be prepared to be one of the experts on the issues being debated. Take advantage of opportunities that can increase the profile of your program.

3. Tie-in your events and trainings to anniversaries and annual events. There is a holiday or recognition for just about everything. The US Census Bureau provides great resource materials for different populations around different heritage or cultural days/weeks/months. Find a way to tie programs or media advisories to those dates.

4. Keep reporters and editors informed about special events. Announce speakers' forums, health fairs, trainings or other activities that may be of interest to a large audience. Invite local VIPs and let the media know who will be coming.

5. Give them a hook. To attract an editor to your story, you need a "hook" or "angle." Tell the story in a new way. It is not news to just say that Medicare fraud costs a lot of money. However, you can make it news if you can provide them the story of a victim of health care fraud

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MEDIA OUTREACH

(Continued from page 10)

in your community. A hook takes a story that has been told a hundred times and provides a new angle for telling it.

How you present your story will determine whether the editor will assign your article to a reporter, or throw it away. Always ask if a reporter is on deadline, and if so, ask when would be a good time to call back. Nothing is more irritating to a reporter than an out-of-the-blue pitch when they're trying to file stories or waiting for someone else to call them back.

There are a host of resources on the internet to assist you in your media outreach efforts. One suggested favorite site that identifies tips for pitching stories: http://aboutpublicrelations.net/ucgranat2a.htm

This is the first in a series of articles providing you with useful information to help your program increase visibility through successful media outreach efforts. In our next article, we'll discuss interview tips. If you have an interesting story about your media outreach efforts to share, feel free to contact Jolie Crowder at jcrowder@smpresource.org.

Content adapted from Berkeley Media Studies Group and We Interrupt This Message. Technical assistance provided by Jeannie Baumann, Communications Associate for The American Health Quality Association.

HOW MAY I HELP YOU?

Responding to technical assistance inquiries is one of the primary services provided by The Center. From the simple—do you have brochures in Chinese?—to the complex—what are the rules regarding reimbursement for home health services following hospitalization?—we've received several hundred inquiries via our toll free technical assistance line and email since we opened our doors. Below you will find highlights from one of our more recent and interesting technical assistance responses. Between The Center's staff and program consultants, the SMP projects have access to a wealth of expertise in Medicare, Medicaid and aging services. If we don't know the answer, we'll do our best to find it!

Question:

Can a company promote their "Medicare+Choice" aka HMO (new Medicare Advantage Plans) by giving out gifts? I have been contacted by a senior that was offered a cell phone if they signed up. I am not sure where to look to get this answer.

Thanks for any help you can provide.

Response:

CMS rules allow Medicare Advantage plans to give gifts of "nominal value"--that is, gifts worth $15 or less--for marketing purposes. A stripped down cell phone might be worth $15 or less these days since many of the phone companies give away basic phones when you sign up with them. Frankly, I can't imagine why someone would want a phone without a cell service contract but who knows, it might work!

As with any offer, we all know "free" gifts never really are free. Consumers would be well advised to ask questions before accepting gifts, and more importantly before signing any type of contract. In this case, cell phone service contracts can be quite costly to maintain or cancel.

You can read the section below taken from the Medicare Managed Care Policy Manual, Chapter 3.

> 50.1.1 - Nominal Gifts (Rev. 5, 01-02-02) Many health plans/M+C organizations offer gifts to potential enrollees if they attend a marketing presentation. This is permitted as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the health plan/ M+C organization. Nominal value is defined as an item worth $15 or less, based upon the retail purchase price of the item. Local Medicare fee-for-service fiscal intermediary and/or carrier charge listings can be used to determine the value of medical services, examinations, laboratory tests, etc., associated with nominal value determinations in marketing scenarios. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount. The dollar amount associated with the definition will be periodically reassessed by CMS. An organization may offer a prize of over $15 to the general public (for example, a $1,000 sweepstakes on its corporate Web site) as long as the prize is offered to the general public and not just to Medicare beneficiaries. When the whole company is offering a prize to individuals well beyond only Medicare individuals, and that prize does not relate to a specific inducement to enroll in company products, the company should not exclude anyone with Medicare from being able to win the prize.

VOLUNTEER PROGRAMS—STEPS FOR ENSURING SUCCESS PART 1

Understanding that volunteers are vital part of the SMP program, it is important to recognize that a successful volunteer program doesn't just happen. It takes planning to develop and maintain a solid program. Planning gives you the opportunity to work out the purpose of the program, the role of volunteers in the organization, and how the volunteer program fits into the structure and the mission of the organization. Planning is best done with input from those who will be affected by the volunteer program, particularly the leaders, the paid staff, and the clients of the organization. A thorough planning process will include the following elements:

Mission Statement: Why does the volunteer program exist?

A mission statement is a sentence or short paragraph that states the purpose of the volunteer program and the needs the program addresses. A volunteer program's mission statement should impart a sense of purpose among paid and volunteer staff, helping each to understand the importance of the work they do, and how each complements the other.

Vision Statement: What will the future be like because of the volunteer program?

A vision statement provides a description of what the world will look like when the mission is accomplished. It should address everything the program strives to change, for example: Medicare and Medicaid education; the reduction of errors; fraud and abuse; and the well-being of the beneficiaries.

Needs Assessment: What needs will the volunteer program address?

Formal and informal input from paid staff, the volunteers and even beneficiaries will help focus the talents of volunteers where they can be of most assistance. Input from paid staff will also help put to rest any concerns they may have about effectively working with the volunteer program to meet unmet needs.

Goals and Objectives: What will be the impact of the volunteer program?

Defining measurable goals and objectives gives your volunteers a clear picture of what needs to be accomplished and provides the Projects with a way to evaluate the program. Measurable goals incorporate what will be accomplished, by whom, how often, and to what extent.

Budget: What is the budget for the volunteer program?

"Volunteer" does not mean "free." Be sure to determine the financial, in-kind, and human resource support necessary to develop and sustain the volunteer program. Include in the budget expenses for developing policies and procedures, producing and disseminating recruitment materials, conducting background checks, obtaining training supplies, and hosting recognition events.

Building Investment Among Staff: How will you prepare paid staff to work with and manage volunteers?

After obtaining input from paid staff on the design of the volunteer program, keep them informed as the program develops; report successes. Ask for help in resolving problems. Provide training for staff on the workings of the volunteer program. If they buy in to the volunteer program, paid staff will create a welcoming environment for volunteers. If not, they may give volunteers the impression that they aren't valued. Make clear to paid staff that volunteers are brought in to support and enhance their work, not to replace them.

Position Descriptions: What will volunteers do?

Position descriptions are critical to the success of your volunteer program. Your agency is most likely to be able to recruit and retain volunteers if you offer clearly defined positions that take into account a volunteer's needs as well as yours. Every volunteer should receive a written position description that includes: his/her title, the purpose of the assignment, the results to be achieved, suggested activities, evaluation criteria, qualifications, time frame, the site where the volunteer will work, supervision, and benefits.

After the planning and organization of the volunteer program has occurred, the next step should be developing policies and procedures to give the program direction.

Policies and procedures are the nuts and bolts of the volunteer program. A policy is a principle, plan, or course of action. Policies tell people what to do. A procedure is a series of steps that direct people how to do what they must do.

VOLUNTEER PROGRAMS

Reasons to define policies

- Connects the volunteer program to the larger organization and its mission.
- Provides structure for sound management.
- Formalizes decisions that have already been made.
- Ensures continuity over time and promotes equity and standardization.
- Articulates the importance of volunteers and provides an ongoing element of volunteer recognition.
- Contributes to increased volunteer satisfaction, productiveness, and retention.

Types of written policies that should be developed

- Statements of belief/position/value of organization.
- Rules to specify expectations, regulations, and guides to action (e.g., confidentiality, time and training commitments, customer service).
- Aids to program effectiveness (e.g., personnel policies) modified for the volunteer program.

Specific levels of policies

- Organizational - broad, general statements (e.g., beliefs, values, mission of organization as a whole).
- General - policies about the volunteer program (e.g., why it exists, what constitutes a volunteer, etc.).
- Specific - policies within the volunteer program (e.g., specify what to do).

Seven steps in policy development for volunteer programs

1. Recognize that volunteer involvement already exists within the organization.
2. Acknowledge that volunteers are important within the organization.
3. Acknowledge that volunteer involvement warrants the attention of senior management.
4. Begin to give consideration to the volunteer program -- develop a philosophy of why volunteers should be involved in programs and services the project provides.
5. Develop policies about volunteer involvement.
6. Develop operational guidelines, standards, and procedures for volunteer involvement.
7. Ensure volunteer program evaluation, compliance with established policies and standards, and regular policy review.

Clarifying your need for volunteers, developing goals and objectives, and writing position/task descriptions are preliminary tasks to ensure the start of a successful program. If your volunteer program already contains these elements of success, then you are off to a great start. If you have an established volunteer recruitment and management program, you likely already have these components in place, but should consider periodically auditing your volunteer program activities, and checking in with your peers to identify new successful practices.

In our next article, we will be discussing volunteer recruitment and how to determine if a volunteer is a good fit for your project. Content adapted from *By Definition: Policies for Volunteer Programs*. For questions or comments contact Candice Griffin at cgriffin@smpresource.org.

Visit us on the web at www.smpresource.org

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For more information about the National Consumer Protection Technical Resource Center, please visit us at www.smpreource.org.

All newsletter submissions and inquires should be directed to Candice Griffin at cgriffin@smpresource.org.

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FROM THE CENTER

- In 2003, the Center conducted its baseline needs assessment to gauge the needs of the SMP community. Thanks to the enthusiastic and open participation of the projects, the Center was able to ascertain the most immediate needs and work to serve in those areas. This year the Center will be conducting its second round needs assessment. Through your continued feedback and candor we hope to make year two a bigger success!
- Join over 4,000 of your colleagues at the 2005 ASA-NCOA Joint Conference, the most comprehensive education and networking event in the field of aging. Join participants from across the nation in Philadelphia, March 10—13, 2005. For more information visit the conference web site at www.agingconference.org.
- If your project has developed foreign materials, we invite you to share them with other projects by posting them in the Center's resource library at www.smpresource.org or forward your submission to Candice Griffin at cgriffin@smpresource.org!