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AoA Regional Meetings

The Assistant Secretary for Aging has announced that three regional SMP conferences will be conducted in 2005. Atlanta will host Regions 1-4, August 24-26; Chicago: Regions 5-7 September 13-15; and San Francisco: Regions 8-10 August 10-12.

Westover Consultants, INC will again handle conference logistics and online registration. Information regarding online registration will be provided when the system is activated.

LEAVITT AND MCCLELLAN ADDRESS CMS ADVISORY PANEL ON MEDICARE EDUCATION

The Advisory Panel on Medicare Education, advisors to the Secretary of DHHS and the Administrator of CMS, convened a meeting on March 22nd in Washington, DC. The meeting focused on implementation of the Medicare Modernization Act and the Prescription Drug Benefit. Highlights of the meeting were visits by the new HHS Secretary, Michael Leavitt, and the CMS Administrator, Dr. Mark McClellan. Secretary Leavitt noted that the rollout of the Medicare Modernization Act provisions and the Prescription Drug Benefit are a Herculean task, and congratulated Panel members on the important role they play.

Dr. McClellan cited preventive care as key to reducing the high number of hospitalizations that result from chronic illnesses, and announced that coverage for smoking cessation services is the latest addition to the list of Medicare covered services. Further, nine pilot programs, focused on improvements in care for chronic illness, will be operational within the next few months. He added that the prescription drug benefit is a main component of the prevention effort. This led to the central theme of Dr. McClellan's remarks and the focus of the day's meeting- the challenge of creating and implementing an effective outreach and education strategy for the Prescription Drug Benefit.

According to McClellan, CMS is taking unprecedented steps to assure that all beneficiaries receive information they need

to make informed choices about the Prescription Drug Benefit, and are signed up by the end of the open enrollment period on May 15, 2006. CMS is working closely with the Social Security Administration, HHS Regional Offices, SHIPs, AARP, businesses, unions and a vast array of other organizations that come face to face with beneficiaries and can assist them in understanding and accessing the new services. Dr. McClellan discussed "personalization" of the Medicare program, beyond the effort required for Part D enrollment, and also announced the selection of Dan Schreiner, as CMS' first ombudsman for the Medicare Program.



Michael Leavitt joins Dr. Mark McClellan to focus on the implementation of the MMA.

The Panel heard from representatives of the CMS Office of External Affairs, Medicare Outreach, Division of Beneficiary Analysis and other CMS offices regarding the agency's plans for MMA outreach and education. Speakers emphasized the challenge of "selling" the prescription drug benefit to the public. Describing the prescription drug benefit as a complex product that requires "message discipline" when educating the public- the communication of simple, clear and consistent messages that are heard by an individual at least three times. Speakers

CMS ADVISORY PANEL

emphasized the need to partner with all organizations that interact with beneficiaries in local communities where older Americans “live, work, play and pray”.

Several outreach themes emerged from the presentations and comments from Panel members, including the need to:

- Close the gap in accessibility of services and information for non-English speaking beneficiaries;
- Find and engage non-traditional service providers that regularly influence beneficiary insurance purchasing decisions; and

Make substantial efforts to reach the baby boomer population who provide care and advice to aging parents, and will soon be enrolled in Medicare.

CMS is taking steps to improve its traditional outreach tools. This will include improvements to the 2006 Medicare & You Handbook, creation of additional materials that target low income beneficiaries, a screening tool to help beneficiaries identify types of insurance they already have, and a health plan comparison chart. Although the Handbook will only be printed in English and Spanish, fact sheets and tip sheets will be produced in Chinese, Korean, Vietnamese and Russian. The 1-800 Medicare Call Centers medicare.gov website will also see improvements. This spring CMS will release an online Prescription Drug Benefit Subsidy Eligibility Information tool. By fall 2005, there will be an online Prescription Drug plan finder tool that will include price comparisons and online enrollment.

Additional information about this meeting and other Advisory Panel matters is available at <http://www.cms.hhs.gov/faca/apme/default.asp>.

AoA Update: Funding Opportunities

The Administration on Aging (AoA) announced in the *Federal Register* on March 24, 2005 that it will hold a competition for Senior Medicare Patrol Project cooperative agreement awards for model projects that demonstrate effective ways of utilizing retired persons as volunteer expert resources and educators in community efforts to combat health care error, fraud

and abuse in the Medicare/Medicaid programs.

Project Funding Options

Option 1

The AoA plans to fund up to thirty-two (32) projects, in the following 28 states and jurisdictions through this competition - **Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Idaho, Kentucky, Maine, Massachusetts, Michigan, Montana, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Puerto Rico, Tennessee, Texas, Virginia, Washington, and West Virginia**. Each project will be funded at a federal share of between \$125,000 - \$180,000 per year, for a project period of three years, contingent upon the availability of federal funds.

Option 2

The AoA plans to fund up to two 1-year capacity-building cooperative agreements to applicants from U.S. territories to extend the opportunity to develop the SMP program in these locations. The option is extended at this time based on an assessment of readiness and need, including the Medicare and Medicaid beneficiary population, organizational infrastructure, and program experience in the CMS SHIP program, a partner program to the SMP. Each project will be funded at a federal share of between \$40,000 and \$75,000 for one year, depending on the applicant workplan, organizational capability, proposed intervention, and performance goals, as detailed in the application.

To view the complete program announcement log onto www.AoA.gov. The deadline date for submission of applications is May 13, 2005.

SAVE THE DATE – Two 1-hour informational/Q&A teleconferences will be held at 2:00 PM (ET) on Wednesday, April 13, 2005 (registration deadline Monday, April 10, 2005) and April 20, 2005 (registration deadline Monday, April 18, 2005) for representatives from the 24 states eligible to apply through this Program Announcement. The purpose of these teleconferences is to provide assistance to, and answer questions from, eligible states as they prepare their ALZ grant proposals; other interested members of the Aging Services Network are invited to listen in on the calls. To register for one of the teleconferences, please contact [Chris Lucas](mailto:Chris.Lucas@ALZ.org) @ALZ.org. Be sure to provide your name, agency or affiliation, contact information, and which date (4/13 or 4/20) you wish to participate.

CMS Developing Medicare Prescription Drug Benefit Tool Kit

In response to suggestions and feedback from partner organizations, CMS is in the process of developing a tool kit designed for use by outreach workers (volunteers, staff, etc in community based organizations) to help educate Medicare beneficiaries on the upcoming Medicare Prescription Drug Benefit. A hard copy toolkit, with accompanying CD-ROM resources, will be disseminated throughout the country. The toolkit is designed to facilitate outreach to seniors with clear and accurate information on Medicare prescription drug plans. Their goal is to develop a toolkit with basic, straightforward information that can easily be conveyed to beneficiaries. Proposed resources considered for inclusion in the toolkit includes fact sheets, PowerPoint presentations, draft newsletter articles, PSAs and more. CMS, in partnership with other agencies (including AoA), has convened multiple focus groups consisting of consumers and representatives from various community based organizations to provide feedback on the content and packaging of the toolkit. The anticipated release date for the toolkit is Spring of this year. Stay tuned for more details.

Most Seniors Still Not Using Web

A Kaiser Family Foundation survey shows that less than a third (31%) of seniors (age 65 and older) have ever gone online, but that more than two-thirds (70%) of the next generation of seniors (50-64 year-olds) have done so.

As the Internet becomes an increasingly important resource for informing decisions about health and health care options, the survey points out that the differences among seniors and 50-64 year-olds are striking and indicates that online resources for health information may soon play a much larger role among older Americans.

Twenty-one percent of seniors have gone online to look for health information compared to 53% of 50-64 year-olds; 8% of seniors get “a lot” of health information online compared to 24% of 50-64 year-olds.

“We know that the Internet can be a great health tool for seniors,

but the majority are lower-income, less well educated and not online,” said Drew Altman, President and CEO, Kaiser Family Foundation.

“It’s time for a national discussion on how to get seniors online.”



“It’s time for a national discussion on how to get seniors online.”

The survey also finds that prescription drugs top the list of health care topics researched on line; that among those older Americans who have gone online for health information, a third (34%; 7% of all seniors) say they have talked with a doctor or other provider about information they found online and 23% (5% of all seniors) say they changed their own behavior because of information they found online; and that just 3% of 50-64 year-olds and 1% of seniors say a doctor has ever recommended a particular health or medical Web site to them.

Copies of the report (#7223) are available on the Kaiser Family Foundation's Web site at www.kff.org.

14 Integration Grantees Convene in Washington, D.C.

The Administration on Aging (AoA) hosted representatives from each of the fourteen Integration Grant organizations as well as their project officers and other external experts in early January. Designed as the official kick off for these projects, the meeting included interactive group discussions and brainstorming sessions. Attendees were challenged to identify innovative strategies they could implement as part of their projects, including ways to communicate the insights and lessons learned from these grants with the rest of the Senior Medicare Patrol community. SMP staff were provided the opportunity to share a brief summary of key project activities and outcomes with a panel of experts. Brief highlights of proposed innovative strategies are listed below. One page descriptions for each of these projects is available on the Resource Center website as part of a new section that features details and information from the Integration Grantees.

Innovation Highlights

Arkansas: Sharon.Marcum@arkansas.gov

- Utilizing Geographical Information Systems (GIS) software to map, analyze and track project progress and outcomes.
- Developing a volunteer certification program.

California: agray@cahealthadvocates.org

- Partnering with local chain drug stores to disseminate consumer fraud awareness/ prevention message on drug card leaflets
- Convening a conference on Medi-Cal fraud.

Idaho: ddenney@aging.idaho.gov

- Partnering with local business community to reach 59+ year olds with SMP message.

Illinois: MichaelLee@S3A.com

- Working with the State Attorneys General to develop the “Senior Sleuths” program.
- Partnering with the state Treasurer’s department to develop and disseminate program message and materials.

Indiana: bburcham@iaaaa.org

- Include Medicare drug program fraud & abuse message into existing Medicare Fraud programming, SHIIP training efforts, Hoosier Rx outreach efforts, and case management outreach, assistance, and nutrition programs administered by Area Agencies on Aging.

Iowa: smerner@hvaaa.org

- Partnering with local college criminal justice programs to establish internship programs and develop curriculum on health care fraud as a white collar crime.
- Examining the issue of Medicaid Divestiture as an aspect of consumer fraud.

Missouri: rmcnally@careconnections-services.org

- Partnering with the Medicaid agency to include messages about health care fraud prevention and reporting with the Medicaid Explanation of Benefits.
- Developing videos on pharmacy and home health fraud.

New Jersey

- Partnering with the TRIAD program to develop a joint training video on health care fraud.
- Partnering with Rutgers University extension program to embed health care fraud prevention message in financial

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fraud awareness programs.

Pennsylvania: cory@carie.org

- Developing CD-ROM training for home health professionals on fraud and abuse issues.
- Partnering with Cahaba Safeguard Administrators to identify and develop training resources related to home health fraud issues.

Puerto Rico: jcollazo@ogave.gobierno.pr

- Convening a stakeholder/ steering committee that is comprised of CMS contractor representatives as well as others involved in health care fraud issues.
- Training 92 senior center coordinators to serve as local resources.

Texas (Better Business Bureau):

BMcGinity@bbbhou.org

- Partnering with the Texas USDA cooperative extension on outreach activities.
- Working with local employee assistance programs to target caregivers and working adults.

Texas (National Hispanic Council on Aging):

- Developing and implementing strategies that target Hispanic families e.g. “study circles”.
- Developing a major media campaign on health care fraud prevention that will be implemented through 50 chapter organizations.

Wisconsin (Coalition of Wisconsin Aging Groups)

- Expanding work with professional organizations and outreach to health care providers.
- Developing joint training materials on the Medicare Modernization Act.

Wisconsin (Great Lakes Inter Tribal Council): wholt@glitc.org

- Convening a coalition of partners that will include representatives from Indian Health Services, law enforcement, volunteer organizations, etc.
- Developing a best practices toolkit to share with other projects working with tribal populations.

NCOA Develops Toolkit to Join Physicians and Community-Based Organizations

The National Council on the Aging's (NCOA's) [Center for Healthy Aging](#) and the Merck Institute on Aging and Health (MIAH) have developed a toolkit, [MD Link](#), to help physicians educate other physicians about community-based organizations (CBOs) and the role CBOs can play in helping older adults manage chronic conditions such as depression, diabetes, and physical deconditioning. The toolkit helps primary care physicians learn more about the services CBOs provide to the senior population, and encourages physicians to partner with and increase referrals to CBOs. To create this toolkit, NCOA and MIAH worked with four physician champions, who are viewed as leaders in their health care communities, and four CBOs to investigate how and why doctors and CBOs connect, as well as some of the barriers preventing such connections.

To download the toolkit, visit: <http://www.ncoa.org/content.cfm?sectionID=65&detail=914>

TIPS FOR SUCCESSFUL MEDIA OUTREACH: THE INTERVIEW

*This is the second in a series of articles providing you with useful information to help your program increase visibility through successful media outreach efforts. This article includes excerpts from an online publication written by Jim Cameron, President of Cameron Communications, Inc. (<http://aboutpublicrelations.net/uccameron.htm>) and materials adapted from Berkeley Media Studies Group and *We Interrupt This Message*, by the National PTA.*

Everyone dreams of it- the 60 minutes expose featuring the latest and greatest health care fraud scandal uncovered, of course by your program staff and volunteers, or the front page headline in the Wall Street Journal glorifying the work of your organization.

While these opportunities might not come around as often as you might like, there are numerous chances for you to generate positive press for your program. Being prepared and knowing how to convey your message is critical to the success of your efforts.

Go into every media encounter with your own messages... two or three points that you want to get across regardless of the questions you're asked. What that message is depends a lot on who is reading/viewing/hearing the interview and when.

Not all media were created equal. Print interviews, for example, are much harder than broadcast despite their lack of intimidating cameras and recorders. Print reporters take advantage of this seemingly conversational approach and can keep you chatting for hours... if you let them. Set the guidelines for the interview: who will speak for your organization, on what issues, where and when.

Radio interviews offer an opportunity to narrowly focus your message to a particular demographic or psychographic niche audience reached by the station you're on. On call-in shows you'll have plenty of time to deliver your messages... even from the comfort of your own home, as stations now can have guests by phone as well as callers.

Television is perhaps the most challenging of the media because of its brevity, complexity and reach. Even a lengthy interview may be distilled down to a "sound bite" of a few seconds. But, with training, you'd be surprised at how much information can be conveyed in that limited time... and how well you can control what gets electronically quoted from your interview. Being a visual medium, you'll want to keep viewers focused on your message rather than your flashy attire, ineffective body language or shifty-eyed glances off-camera. (Cameron, 2001)

INTERVIEW PREPARATION

Before you speak to the media, make sure you understand and can concisely convey the answers to the following questions:

- What is the problem?
- What is the solution?
- How will your solution impact seniors, consumers, your community?
- What do you want the media to report?
- Who supports your efforts? Why?

Who opposes your efforts? Why?

MEDIA INTERVIEW TIPS

Plan your points and make them early and often. Remember, an interview is an opportunity to tell your program's story and to make the case against health care fraud. Prepare the points you'd like to make in advance and use every question as an opportunity to address your agenda.



“...there are numerous chances for you to generate positive press for your program.”

SUCCESSFUL MEDIA OUTREACH

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You are a guest and an authority. You have been approached because you are a leader representing health care fraud consumer advocacy organizations. If the reporter asks questions you cannot answer because they are outside your area of expertise, say, "I don't know, but I will get back to you in time for your deadline." In the meantime, consult with others who have the needed expertise.

Speak in a language everyone understands. Jargon, organization lingo or abbreviations that may be familiar to you may have no meaning to the general public.

Be positive, not defensive. Take the trouble to present your point of view in a positive manner. Resist any temptation to attack other organizations. Your accusations or any perception of conflict by the reporter may pre-empt the rest of the interview.

Tell the truth. Factual information is a must. If a statement is made that is not true, refute it immediately and politely. Always correct the information in an informative and helpful manner.

Be brief, especially for broadcast (television or radio). Broadcast news is frequently presented in "sound bites," short, succinct phrases that capture the essence of a program or position on an issue.

Keep your statements or responses to a couple of short sentences. Make your point as often and as logically as possible. You may feel repetitive, but when the interview is edited, the clearest or most emotional statement is likely to be the one that is covered in the news.

SPEAKING IN SOUND BITES

As you develop your answers to the questions above, it is important to keep your messages short and simple in order to attract and sustain the attention of your audience. Whether you are speaking with the media, a potential or current partner or a group of consumers, use **sound bites** to hold your audience's attention.

Here are some tips to help you plan:

Speak to shared values. Stress themes that the majority of people care about.

Talk about what is at stake. Who is affected? What does this mean to people's lives?

Use reasonable language. Don't be afraid to take a strong position, but be sure to use mainstream language. Don't use jargon or acronyms.

Evoke pictures. If you can make people visualize what you are talking about, your point will be more memorable and have more impact.

Take a stand and present a solution. The best messages don't just describe the problem, they also say what should be done about it.

-Adapted from Berkeley Media Studies Group and We Interrupt This Message.

Finally... don't wait for the media to come looking for you. Reach out to them with story ideas, professional commentary and fresh ideas. Call your local papers and radio/TV stations and introduce yourself to the reporter(s) covering your business. Briefly tell them about your work and offer to be "on call" to them should they need your expertise. And follow up with a note, a fact sheet and business card. You'll be amazed at their reaction as very few organizations are so proactive. (Cameron, 2001)

In our next segment, we'll be discussing Media Advisories and Press Releases. If you have story to share, feel free to contact Jolie Crowder at jcrowder@smpresource.org.

FLU CASES RISE IN U.S., PEAK MAY BE AHEAD—CDC

ATLANTA (Reuters) - The number of Americans suffering from influenza has jumped since January, suggesting the worst of the 2004-2005 flu season may be ahead, federal health officials said.

The U.S. flu season, which typically runs from October through March, began slowly despite fears a vaccine shortage would leave millions of unvaccinated Americans vulnerable.

It picked up speed recently, with 33 states reporting widespread flu activity for the week ending Feb. 19, 2005, according to data released by the Centers for Disease Control and Prevention.

A total of 8.5 percent of deaths reported by 122 cities across the nation were attributed to pneumonia and influenza for that week, the highest level in the current flu season and above the weekly epidemic threshold, the CDC said.

Nine children have died from flu in the past two months.

"This may be as bad as it gets, but it could continue to go up," said Lynnette Brammer, an epidemiologist in the CDC's influenza branch.

Influenza, which is marked by respiratory inflammation, fever, muscular pain and intestinal tract irritation, is believed to kill about 36,000 people and hospitalize 114,000 in the United States every year.

Exact figures on flu-related deaths are difficult to get because U.S. doctors are not required to report such deaths.

The rise in flu cases came amid efforts by the federal government to ensure the most needy were vaccinated.

Millions of people were advised last fall to forgo a flu shot due to an anticipated shortage of vaccine following production problems at vaccine manufacturer Chiron Corp., which was supposed to supply about half the needed vaccine.

British regulators on Wednesday cleared Chiron's flu vaccine plant in England to resume production in a move that should ensure supplies for the next flu season.

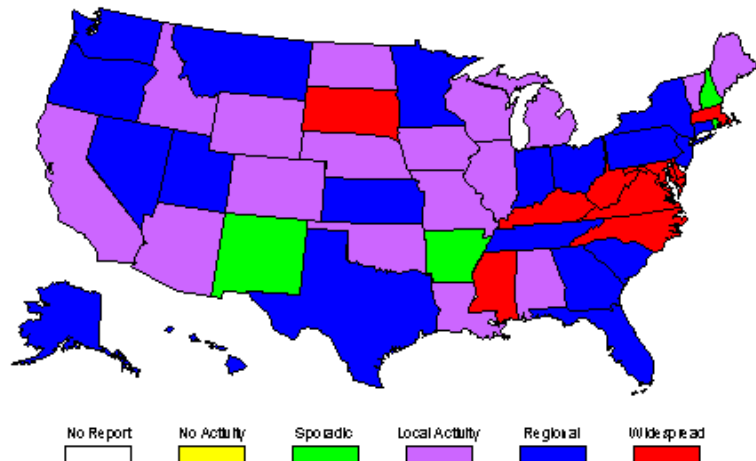
The Atlanta-based CDC, which is spearheading the bid to allocate vaccine, has recommended only high-risk people -- seniors, people with chronic diseases, babies and pregnant women -- get the vaccine.

Those who care for anyone in those groups should also be vaccinated. All others are urged to take alternate steps, such as frequent washing of hands and anti-flu treatments.

Although health experts say it is better to get vaccinated early in the flu season, Brammer noted people could still get protection from a shot at this time of the year.

Weekly Influenza Activity Estimates Reported by State & Territorial Epidemiologists

Week ending March 19, 2005 - Week 11



MEDICAID MANAGED CARE FRAUD

Many SMPs have identified a number of issues that make it difficult to find and report Medicaid fraud and abuse. These issues include a lack of a benefits notice similar to the Medicare Summary Notice, an inability to establish effective, ongoing working relationships with state Medicaid administrators, beneficiaries' perceived reluctance to identify any service improprieties that might reduce benefits, and beneficiaries' low expectations about the amount and quality of Medicaid services that they receive.

CMS Medicaid Managed Care Guidelines

Many states now contract with managed care plans to provide services to their Medicaid population. In August 2000, the Centers for Medicare and Medicaid Services published guidelines to address the growing concern for fraud and abuse in managed care.

State Medicaid programs have traditionally paid providers well below Medicare and private insurance rates. These low rates may provide an incentive for unscrupulous providers to overstate the amount of care provided or to falsify claims to increase Medicaid payments. In addition, most state Medicaid programs that contract for managed care services pay the plans a fixed dollar amount per Medicaid enrollee ("capitation"). The plan and/or its network of providers bear the risk of the enrollee's medical costs exceeding the payment amount. Low capitation rates and shifting the risk of high cost patients to the plan or its network may create additional incentives to commit fraud or abuse.

Below is a summary of these guidelines that you may find helpful. You may download and print the full text of the guidelines at: <http://www.cms.hhs.gov/states/letters/smd80700.asp>.

Falsified or an inadequate provider networks

A managed care provider is expected to have a sufficient number of providers and/or specialists to accept new patients and to cover the needs of enrollees. A managed care organization may demonstrate that it fails to provide an adequate network in any of the following ways:

1. Patients unable to obtain an appointment within a reasonable amount of time.
2. Patients who are unable to see a specialist after repeated requests or who have been unable to receive satisfactory medical treatment from the primary care staff.
3. Patients who need urgent care but are unable to obtain timely care from an urgent care center, or hospital emergency room.
4. Intentional misrepresentation about the size or composition of the provider network.

The CMS Guidelines note that managed care networks are often "very fluid," and temporary provider network deficiencies may not be an indication of fraud. Deficiencies over a period of time, or ongoing complaints by numerous enrollees, or even, "a reputation in the community" for poor service may, however, indicate that the managed care organization is unable to provide an adequate provider network. A sudden increase in the number of unhappy enrollees or complaints about the inability to obtain care, or the quality of care that is provided may be other indicators of fraud or abuse.

Complaints about the Amount or Quality of Care

While some Medicaid beneficiaries may complain about the inability to get care, others may complain that they are required to get care that they don't feel that they need. Although difficult to discern, **overutilization of services** i.e., excessive number of followup appointments or referrals to other providers may indicate that network providers, rather than the managed care organization, may be committing fraud or abuse. Many managed care organizations provide a "stop loss" threshold to protect providers from patients who require more than an average amount of care—providers may, however, try to boost the amount of care to reach the stop loss threshold and receive additional

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payments. Or, providers may make referrals to other entities in which the provider has a financial interest in violation of the Stark Amendment¹,

Underutilization of care allows the managed care organization to collect per capita payments from the state Medicaid office without actually providing any benefit to the enrollee. Examples of these underutilization practices include:

- Delay in assigning a primary care physician at enrollment.
- Delay in reassigning a primary care physician,.
- Delay in making the introductory contact with a new enrollee.
- Delay in scheduling appointments .
- Failure to serve individuals with language or cultural barriers.
- Failure to provide educational services as required by the Medicaid contract and for which the managed care organization is paid, i.e. smoking cessation , diet or weight loss classes.
- Providing less service, or treating Medicaid beneficiaries differently than commercially-enrolled patients.
- Requiring prior authorization for treatment or defining medical necessity, appropriateness of care, or experimental treatment in a manner that discourages beneficiaries from seeking treatment or otherwise denies care.
- Maintaining an ineffective grievance or appeal process.

“Cherry picking” of Managed Care Enrollees

Although most state Medicaid programs require enrollment of all eligible individuals, some managed care plans use techniques to discourage enrollment of individuals with chronic or serious illness. Examples of these enrollment techniques that may indicate fraud or abuse include:

- Use of a health questionnaire, before enrollment
- Providing applications and marketing materials only in areas with healthy individuals,
- Marketing representatives stationed at health fairs or other areas to actively discourage enrollment of individuals with possible high utilization needs,
- Unexplained disenrollment of individuals with high utilization,
- Paying kickbacks to individuals to enroll healthy individuals,
- Creating a referral network that makes it difficult for individuals with certain types of illnesses, e.g. HIV or AIDs, to get adequate care.

Balance Billing of Medicaid Beneficiaries and Nonpayment of Claims

A managed care plan may be committing fraud if it routinely denies providers' claims and providers end up billing beneficiaries for services that the managed care plan should have covered. Beneficiaries are likely to complain to you that they are being asked to pay, or are being sued for, medical bills that they think the managed care plan should pay. Under longstanding federal law², Medicaid providers cannot “balance bill” Medicaid beneficiaries for the difference between the actual bill for service and the Medicaid payment amount for the covered service.

In the managed care context, there are three circumstances in which the plan could ask the beneficiary to pay. First, the beneficiary may be required to pay a small copayment as a member of the plan. Second, the beneficiary may be billed if the service was not a “covered service” under the state’s Medicaid plan. Obviously, a medical service may also not be covered in the managed care context if it is not a service that is either required by the agreement with the State Medicaid program, or a voluntary supplemental benefit that the plan has agreed to cover. Third, if a beneficiary receives medical

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services “out of plan” without authorization or in nonemergency circumstances, the service may legitimately not be covered.

However, a managed care plan may fail to pay a provider, delay paying a provider, or on claim reimbursements from a provider for covered services with little or no explanation. The provider may not understand why payment is not forthcoming, and simply, ask the beneficiary to pay for services. The beneficiary should be advised to appeal to resolve the issue and the managed care plan monitored to determine if the plan is excessively denying or delaying payment and a complaint filed.

Reporting Fraud to Your State Medicaid Office

Many states have made efforts to setup effective fraud prevention and compliance programs. The OIG guidelines suggest several ways that a state can prevent and detect fraud or abuse. These guidelines suggest:

- Operate 24-hour toll-free hotline to respond to complaints.
- Conduct random beneficiary interviews. Medical records should also be reviewed to identify any possible errors or evidence of abuse and/or fraud.
- Require managed care organizations to conduct education programs for their network providers and adopt effective compliance programs.



OIG guidelines suggest that states operate a 24-hour, toll-free hotline.

Despite these suggestions, states are not very far along in their efforts to work with beneficiaries and the SMPs to prevent and detect fraudulent activities. Some SMPs have already developed working relationships with the Medicaid Fraud Control Units (MFCUs) that should be strengthened and further developed. SMPs that have not yet developed these relationships might consider ways to establish positive working relationships.

¹ 42 U.S.C. 1395nn, enacted in 1989 as part of the Omnibus Reconciliation Act. The Stark Amendment initially did not apply to Medicaid-covered health services. However, CMS published a “Phase II” rule, with an effective date of July 26th, 2004 that applies Stark provisions to Medicaid managed care plans. The Stark Amendment, generally, makes it illegal for a physician to refer patients to an “entity” with whom the physician, or his/her family member has a financial relationship. There are, however, exceptions to this rule.

² 42 CFR 447.15, 2005

“Survey Says”

People with no drug coverage are nearly three times more likely than people with drug coverage to forgo needed prescription drugs. People with no drug coverage are also significantly more likely to skip prescription doses or spend less on basic needs to afford their drugs.

Click [here](#) to read the full Health Affairs article, “Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap?”

NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH CARE

The following national standards issued by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed to correct inequities that currently exist in the provision of health services and to make these services more responsive to the needs of all patients/consumers. The standards apply to all cultures and are not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

- CLAS *mandates* are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).
- CLAS *guidelines* are activities recommended by OMH for adoption by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- CLAS *recommendations* are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

The standards are also intended for use by:

- Policymakers, to draft consistent and comprehensive laws, regulations, and contract language. This audience would include Federal,

State and local legislators, administrative and oversight staff, and program managers.

- Accreditation and credentialing agencies, to assess and compare providers who say they offer culturally competent services and to assure quality for diverse populations.

This audience would include the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, professional organizations such as the American Medical Association and American Nurses Association, and quality review organizations such as peer review organizations.

- Purchasers, to advocate for the needs of ethnic consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.
- Patients, to understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them.
- Advocates, to promote quality health care for diverse populations and to assess and monitor care being delivered by providers. The potential audience is wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant, and other community-focused organizations; and local and national nonprofit organizations that address health care issues.
- Educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include educators from health care professions and training institutions, and legal and social services professions.
- The health care community in general, to debate and assess the applicability and adoption of culturally and linguistically appropriate health services into standard health care practice.

CLAS

CLAS standards:

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language

Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Health care organizations must assure the competence of language assistance provided by interpreters and bilingual staff to limited English proficient patients/consumers. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups represented in the service area.

Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement

programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards available to the public and to provide public notice about the availability of this information.

ASA-NCOA Call for Presentations

The American Society on Aging and National Council on the Aging has announced the call for presentations for their 2006 conference, scheduled March 16—19th in Anaheim, California. The 2006 meeting, "Invest in Aging" will bring together professionals working in every sector of the aging society to share their experiences, knowledge and ideas about personal, programmatic and societal issues in aging.

To learn more about how you can showcase the work of your program or organization, visit:

www.agingconference.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.smpresource.org.

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

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HOW MAY I HELP YOU?

Responding to technical assistance inquiries is one of the primary services provided by The Center. we receive dozens of inquiries monthly via our toll free technical assistance line and email-- from the simple: *Do you have brochures in Spanish?*; to the complex: *Can Medicare Advantage plans give gifts for marketing purposes?*.

Below you will find highlights from one of our more recent technical assistance responses submitted by a staff person from a Medicare Carrier. We thought this information might be of particular interest to our readers. 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:

Do you know which month is designated as Fraud Awareness month in 2005?

Response:

According to an internet search, there doesn't appear to be a fraud awareness month in the US, but there is a "National Fraud Awareness Week," which may be what you are thinking of. This has typically been held during the first week in August, but this year is scheduled to be held from July 10-25. This event is sponsored by the National Association of Certified Fraud Examiners. The Association of Certified Fraud Examiners (ACFE) is a 32,000 member-based global association dedicated to providing anti-fraud education and training. Together with its members, the ACFE is "reducing business fraud worldwide and inspiring public confidence in the integrity and objectivity of [their] profession." In past years the week has also been co-sponsored by a number of different private organizations and local chapters of AFCE. I also found an FCC reference from 2 years ago where they acknowledged National Fraud Awareness Week. While National Fraud Awareness Week is not specific to health care it doesn't present a good opportunity for organizations to take advantage of opportunities to promote the health care fraud prevention message as part of a national event. To learn more about this event, visit: <http://www.fraudweek.com/>.

You might also be interested to learn that in October 2004, the Senate passed Resolution 424 that designed October 2004 as "Protecting Older Americans from Fraud Month." The resolution, introduced in September, didn't actually pass until October, so most organizations didn't have time to promote the opportunity-- which was unfortunately only for the year 2004. Again, the resolution was not specific to health care fraud, rather it emphasized the crucial importance of general fraud awareness among seniors. At this time, information is not available about whether Sen. Larry Craig (R-Idaho) has plans to introduce another resolution this year, but be on the look out.