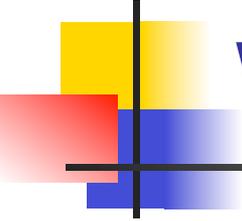


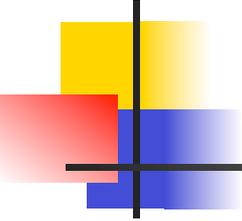
Medicare 101

Presented by
Area Agency on Aging 1-A



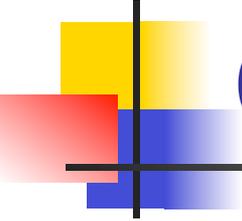
What is Medicare?

- Federal Health Insurance for:
 - People 65 years of age or older
 - Some persons with disabilities, after a 24 month waiting period
 - People with End-Stage Renal Disease
 - People with Amyotrophic Lateral Sclerosis (ALS)



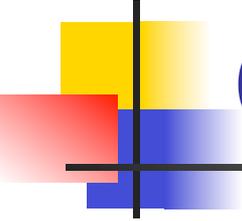
Medicare Plan Choices

- Original Medicare
 - Part A- Hospital Insurance
 - Part B- Medical Insurance
 - Part D- optional Prescription Insurance
- Medicare Advantage
 - Health Plan (HMO, PPO, PSO) offered by private health plans



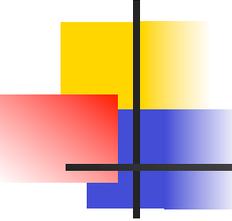
Original Medicare

- Part A- Hospital Insurance
 - Covers
 - Hospital stays
 - Skilled nursing facility care
 - Hospice care
 - Costs
 - \$1,216 deductible a hospital stay of 1-60
 - \$304 per day for days 61-90- hospitalization



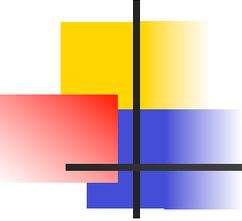
Original Medicare- Part A cont.

- Also covers skilled nursing facility after a 3 day hospital stay for care relating to hospital treatment
- Covered in full for first 20 days.



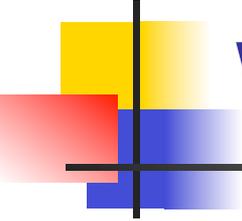
Original Medicare

- Part B- Medical Insurance
 - Covers
 - Outpatient services, such as doctor's visits, ambulance, lab, x-rays, medical equipment
 - Costs
 - Monthly premium of \$104.90 for most people
 - Annual deductible of \$147
 - 20% co-pay for most services



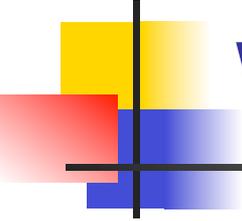
Part D- Prescription Coverage

- Medicare Prescription Drug Coverage is part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)
- First time Medicare provided prescription coverage for outpatient prescription drugs



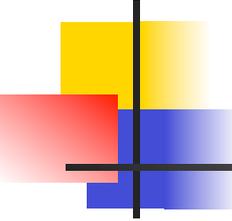
Who is Eligible for Part D?

- Anyone who has Medicare Part A and/or Part B
- Enrollment is voluntary
- In most cases, beneficiary must choose and join a Medicare drug plan to get coverage



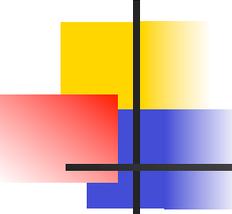
When to Enroll in Part D

- New to Medicare
 - 7 Month period
- Annual Enrollment Period will change to
 - October 15th – December 7th
- Special Enrollment Period
 - Low income, involuntary loss of credible coverage, moved outside of plan's service area, etc.



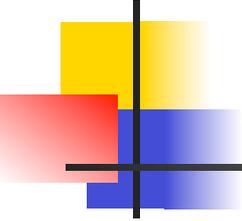
Creditable Coverage

- People who have other drug coverage that is at least as good as Medicare's drug coverage may keep their coverage and incur no penalty
- If someone involuntarily loses creditable coverage, there is a 60 day Special Enrollment Period.



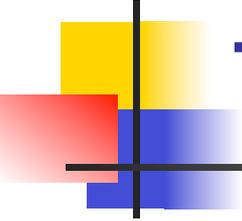
Penalty

- If a beneficiary does not enroll in Medicare Part D when they are first eligible and does not have creditable coverage, he/she is subject to a penalty
- Penalty is in the form of higher premiums should he/she elect to join a Medicare Part D plan later
- 1% of the National Average Premium (**\$32.42 in 2014**) **applied monthly**



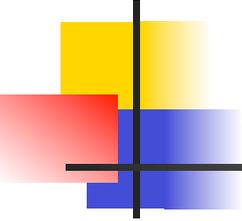
Medicare Part D Costs

- For coverage in 2014, beneficiaries will generally pay...
 - A monthly premium
 - **\$310** deductible
 - 47.5% of drug costs brand name drugs & 72% for generic drugs from **\$2,850 to \$4,550 of True –out-of-pocket cost.**



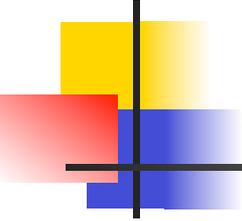
Types of Part D Plans

- Offered by private companies
- Approved by Medicare
- Two Types
 - Prescription Drug Plans
 - Medicare Advantage



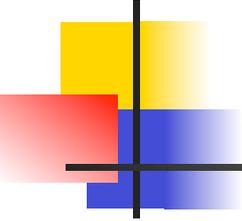
Stand Alone Prescription Drug Plans

- Adds drug coverage to Original Medicare
- Formulary- list of drugs a plan will cover
 - Vary from Plan to Plan



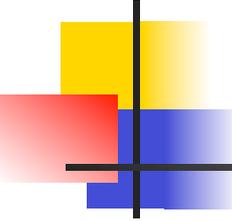
Extra Help with Part D for Low-Income Beneficiaries

- People with lowest income/assets can get help in paying for Part D 2014 rates
- Single **\$17,235** income/ **\$13,440** assets
- Married **\$23,265** income/**\$26,860** assets
- Apply through Social Security Administration



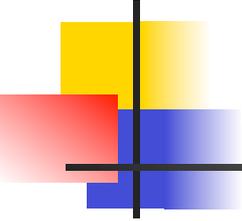
Medicare Advantage + Prescription Drug Coverage

- Offers comprehensive coverage for medical care, plus prescription drug coverage
- Replaces Original Medicare with a managed care plan
- Drug coverage structured the same as Part D



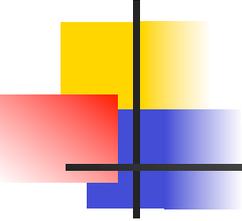
Medicare Advantage

- Changes the structure of Medicare benefits
- Plan is primary
- Subject to co-pays
- Plans can be HMO, PPO, PSO
- Medicare Advantage wraps Medicare, supplement and prescription drugs into one policy



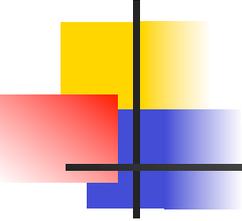
Medicare Advantage Costs

- Still Pay Part B premium
- Pay Medicare Advantage Premium
- Pay associated co-pays for medical care



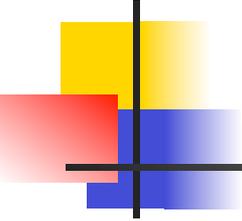
Enrollment

- New to Medicare
 - 7 month window
- Annual Election Period starting in 2011
 - October 15th to December 7th



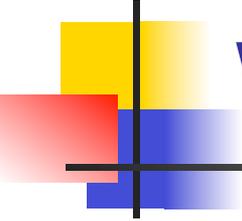
Medigap

- Sold by private insurance companies
- Fills the gaps of Original Medicare
- Currently 11 standard plans "A, B,C,D, F, F (high deductible), G,K, L, M & N."
- Set core benefits for each standard plan
- Costs vary



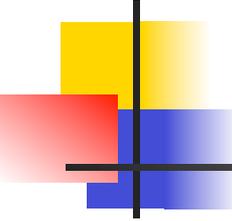
Medigap

- Helps pay the costs with Original Medicare
- Don't need Medigap if you are
 - In a Medicare Advantage plan
 - Have retiree coverage
 - Have Medicaid



What Medigap Pays

- Co-insurance amounts for Part B (20%)
- Some policies cover deductibles for Part A and/or Part B
- Some policies offer additional benefits, like Foreign Travel Emergency or Routine Checkups

The logo graphic consists of a vertical black line on the left, a horizontal black line below the text, and three overlapping squares: a yellow one at the top left, a red one at the bottom left, and a blue one at the bottom right. The text 'MMAP' is in a blue, sans-serif font to the right of the vertical line.

MMAP

- Medicare/Medicaid Assistance Program
- 800-803-7174
- Provides individual insurance counseling for people with Medicare
- We're here to help!



Navigating
Medicare

MMAP, Inc.
Michigan Medicare/Medicaid Assistance Program

Medicare Fraud and Abuse



Tamara Perrin

MMAP Inc.

MMAP, Inc.

- ▶ MMAP is Michigan's SHIP – a State Health Insurance Assistance Program
- ▶ MMAP's funding comes from the Michigan Office of Services to the Aging through a grant provided by the Centers for Medicare & Medicaid Services, the Federal Medicare agency and the Administration on Aging

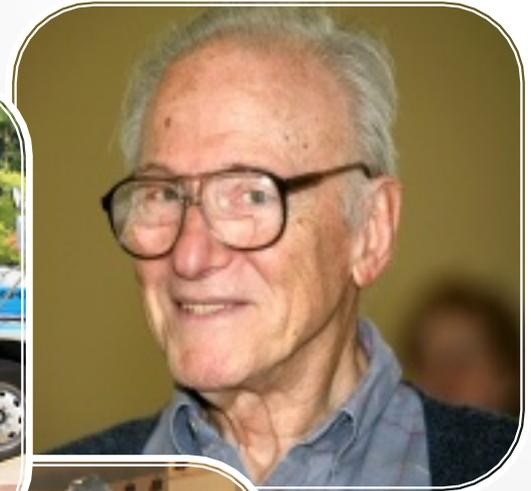
MMAP's Mission

To educate, counsel and empower Michigan's older adults and individuals with disabilities, and those who serve them, so that they can make informed health benefit decisions

Agenda

- ▶ Welcome, Introductions, Objectives of Training
- ▶ Understanding Fraud and Abuse
 - ▶ Definitions
 - ▶ Who Perpetrates Medicare Fraud and Abuse?
 - ▶ Examples of Fraud and Abuse
 - ▶ Errors and Other Situations that may NOT be Fraud
 - ▶ Managing Complaints of Fraud and Abuse
 - ▶ Consequences for Perpetrators of Fraud and Abuse
 - ▶ Consequences to Beneficiaries who are Victims in Fraud Schemes
- ▶ Fraud Schemes
 - ▶ Scams for Obtaining Medicare Numbers
 - ▶ Common Medicare Fraud Schemes
- ▶ How SMPs Combat Fraud, Errors and Abuse
- ▶ Evaluation and Wrap-Up

Understanding Fraud and Abuse



Definition: Fraud

- ➔ Knowingly and willfully executing, or attempting to execute, a scheme or ploy to defraud the Medicare program,
- OR
- ➔ Obtaining information by means of false pretenses, deception, or misrepresentation in order to receive inappropriate payment from the Medicare program

Fraud

Occurs when an Individual or organization deliberately deceives others to gain unauthorized benefit.

Fraud may be discovered when

- ➔ Beneficiaries report complaints to companies that process Medicare claims; or
- ➔ Medicare contractors review medical claims for inappropriate billing

Definition: Abuse

Incidents or practices of providers that are inconsistent with accepted sound medical, business, or fiscal practices.

These practices may directly or indirectly result in

- ➔ Unnecessary costs to the program,
- ➔ Improper payment, or
- ➔ Payment for services that fail to meet professionally recognized standards of care or that are medically unnecessary.

Abuse Involves

- ▶ Payment for items or services when there is no legal entitlement to that payment,
- ▶ And the provider has not knowingly and intentionally misrepresented the facts to obtain payment.

Note

The difference between fraud and abuse is intentionality!

Who Perpetrates Medicare Fraud and Abuse?

Fraud can be committed by any person or business in a position to bill the Medicare program or to benefit from Medicare's being billed.

For example:

- Doctors and health care practitioners
- Suppliers of durable medical equipment (DME)
- Employees of physicians or suppliers
- Employees of companies that manage Medicare billing
- Beneficiaries

Examples of Fraud

- ▶ **Billing for services or supplies not provided**
- ▶ **Altering claim forms to obtain a higher payment amount**
- ▶ **Billing twice for the same service or item**
- ▶ **Billing separately for services that should be included in a single service fee**

Examples of Abuse

- ➔ Excessive charges for services or supplies
- ➔ Routinely submitting duplicate claims
- ➔ Improper billing practices, such as
 - ✓ Billing Medicare at a higher fee schedule rate than for non-Medicare patients
 - ✓ Routinely submitting bills to Medicare when Medicare is not the beneficiary's primary insurer
- ➔ Breach of the Medicare participation or assignment agreements
 - ✓ Collecting more than 20% coinsurance or the deductible on claims filed with Medicare
- ➔ Exceeding the limiting charge
- ➔ Claims for services not medically necessary

Remember...



Inappropriate practices
that start as abuse
can evolve into fraud.

Errors and Other Situations That May Not be Fraud

- **Beneficiary Claims He/She Did Not Receive Service —**
 - ☑ Claim shows service provided by physician, but beneficiary saw nurse practitioner, physician's assistant, physical therapist
 - ☑ Bill lists a provider the beneficiary did not “see” e.g., laboratory, pathologist, anesthesiologist, radiologist
 - ☑ Possible billing or processing error (e.g., mis-keyed Medicare number);
- **Hospital Inpatient Bill—High or Duplicate Charges**
 - ☑ Billing or charging error by the hospital

Managing Fraud Complaints

When you identify a potential fraud issue you may contact:

- ➔ MMAP (Michigan SMP) 1-800-803-7174
- ➔ OIG (The Office of the Inspector General) may involve state or other federal agencies (e.g., the FBI) in investigation and prosecution
- ➔ Michigan Attorney General's office (Medicaid issues)



Results of FBI Investigations

2,423 cases through 2006

- 588 indictments**
- 534 convictions**
- Recovery of \$1.6 billion**
- Assessment of \$173 million in fines**
- Restitution of \$373 million.**

Consequences for Perpetrators of Fraud

- ➔ A federal crime to defraud the U.S. Government or any of its programs; convictions can be criminal and/or civil
- ➔ Convicted persons may be sent to prison, fined, or both
- ➔ Criminal convictions usually include restitution (repayment of the stolen funds) and steep fines; penalties up to \$2,000 for each false or improper claim plus up to twice the amount falsely claimed.
- ➔ Convictions also result in mandatory exclusion from the Medicare program for a specific length of time
- ➔ In some states, individuals and healthcare organizations may lose their licenses.

Consequences for Perpetrators of Fraud (Cont.)

➔ For false claims

- \$10,000 per claim
- Triples damages
- Jail time

➔ For kickbacks

- Up to \$25,000 in fines
- Up to five years in prison

➔ Potential for civil monetary penalties at \$10,000 per claim



Consequences of Abuse

- ➔ Recovery of amounts overpaid with interest and penalties—for first-time offense
- ➔ Education and/or warnings
- ➔ Referral to the Medical Review Unit
- ➔ Referral to the Office of Inspector General if all else fails and abuse continues
- ➔ Possible sanctions or exclusion from the Medicare program
- ➔ Possible Civil Money Penalties (CMPs) up to \$10,000 for repeated limiting charge violations

Consequences to Beneficiaries

- ➔ Theft of Medicare/Medicaid numbers leads to false claims
- ➔ Beneficiary's file may be notated as a problem
- ➔ Benefits may be affected— file may be flagged
DO NOT PAY
- ➔ May result in higher Medicare premiums
- ➔ Theft of SSN often leads to identify theft and theft of banking information

Common Fraud Schemes

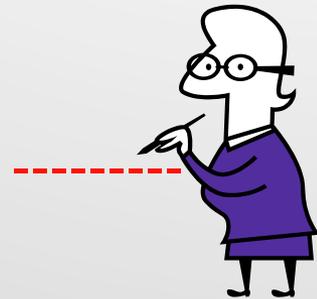


False Claims

False Claims Act of 1986: states that entity is liable if it knowingly makes or uses a false record or statement to have a false claim paid. May be pursued under federal and state criminal laws.

Examples:

- ▶ **Durable Medical Equipment – Scooters for motorized wheelchairs**
- ▶ **Infusion drug services – billing and providing unnecessary services**



Kickbacks

The Anti-Kickback Statute: It is a criminal offense to knowingly and willfully offer, pay, solicit, or receive any payments to induce or reward referrals of items or services that can be reimbursed by a federal health care program.

Examples:

- **Infusion Drug Scheme – Pay beneficiaries to use Medicare number to bill**
- **Durable Medical Equipment – paying kickbacks to physician to falsify prescriptions and beneficiaries for using Medicare information**
- **Sales pitch deliberately confuses people into believing the caller represents the government or private insurers.**

Scams for Obtaining Medicare and ID Numbers

Note: The Medicare/Medicaid ID number is key for parties planning to defraud Medicare or Medicaid.



“Free” Medical Evaluations Testing

- Companies use phone solicitation, newspaper ads, and coupons mailed to consumer’s home to advertise free testing or services;
- Consumer is asked to complete a form to receive free tests; The form asks for Medicare, Medicaid, Social Security, or insurance numbers.

Stealing Medicare ID from Provider

- ▶ Example: Texas DME owner admitted to stealing Medicare numbers from hospital she worked at

Up Coding

Up Coding: Billing for one service while providing a separate, less expensive service

Examples:

- ▶ **“Outlier” cases in Home Health Care**
- ▶ **Using inappropriate location-specific codes**

Medicare Advantage/ Part D

▶ Medicare rules state:

◦ Plans

- Cannot Market before the Marketing Period which begins October 1st
- Cannot conduct sales activities at “educational” events (such as health fairs)
- Cannot make unsolicited contact with beneficiaries
- Cannot provide subsidized meals at marketing events

◦ Agents

- Cannot go door to door
- Must be licensed in the state



Combat Fraud, Error and Abuse



Three Important Steps in Preventing Health Care Fraud

Protect

Detect

Report

Medicare, Medicaid, and Social Security Numbers

- ✓ Treat the same as credit cards
- ✓ Don't carry with you until you need them for visits to doctor, clinic, or pharmacy
- ✓ Never give to a stranger

- ✓ Record doctor visits, tests, and procedures in personal healthcare journal or calendar
- ✓ Save MSNs and Part D Explanation of Benefits; shred when no longer useful.

Remember: Medicare does not call or visit to sell anything.

Three Important Steps in Preventing Health Care Fraud (Cont.)

Protect

- ✓ Review MSNs and Part D Explanation of Benefits (EOB) for possible mistakes.
- ✓ Access Medicare account at www.MyMedicare.gov –available 24/7.

Detect

- ✓ Compare MSNs and EOBs to personal health care journal and prescription drug receipts to ensure they are correct.
- ✓ Look for three things on billing statement:
 - Charges for item or service not received
 - Billing for same thing twice
 - Services not ordered by doctor

Report

Three Important Steps in Preventing Health Care Fraud (Cont.)

Protect

Detect

Report

✓ Call health care provider or plan with questions about information on MSNs or Part D Explanation of Benefits

✓ If not satisfied with response, call local SMP (1-800-803-7174).

Final Thoughts

- ▶ You are in a position to make a significant contribution to the prevention of health care fraud and abuse.
- ▶ For your interest in and your commitment to this work, we thank you sincerely.





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