SHIBA

Senior Health Insurance Benefits Assistance

Section 7

Medicaid *and* Fraud and Abuse

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Section 7, Medicaid *and* Fraud and Abuse

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Introduction to Medicaid, Fraud/Abuse

Goal

Participants will acquire basic knowledge about eligibility, benefits, and the application procedure for Oregon's Medicaid program and learn about how to detect fraud and abuse in the Medicare and Medicaid programs.

Learning objectives

On completion of this module, the SHIBA volunteer trainee will be able to:

- Provide information about the distinctions between the Medicaid and Medicare programs and how the two programs work together.
- Provide information about Medicaid eligibility, financing, benefits, and application processes.
- Detect potential fraud and abuse in the Medicare and Medicaid systems and assist beneficiaries in reporting this information.

Medicaid introduction

Medicaid, also called Medical Assistance (M.A.) or Title 19, is a medical assistance program for certain low-income people. It is the health program supplement for three major financial assistance programs.

- Supplemental Security Income (SSI).
- Temporary Assistance to Needy Families (TANF) (Medicaid's ties with TANF are not detailed here).
- Oregon Health Plan — Health care for low-income individuals & families.

Medicaid is a *needs-based* program for which applicants must prove that their income and resources are below certain levels that indicate their financial need.

Differences between Medicaid and Medicare

Medicaid and Medicare differ in who is served, as well as their funding, operations, and administration.

Beneficiaries:

- **Medicaid** primarily serves low-income people and complements SSI and TANF programs. It is also a major source of payment for long-term care costs.
- **Medicare** is primarily for people older than 65 and complements regular Social Security benefits/retiree health program. Also applies to those who are disabled and receive cash benefits for 24 continuous months.

Funding:

- **Medicaid** is funded by federal and state taxes.
- **Medicare** is funded by Medicare Trust Funds (strictly federal) and premiums.

Operations and Administration:

- **Medicaid** operates as an assistance program. **Medicaid** is a federal-state partnership. States administer the program under broad Centers for Medicare & Medicaid Services (CMS) guidelines. Therefore, programs vary from state to state.
- **Medicare** operates as an insurance program. Medicare beneficiaries pay premiums and deductibles. **Medicare** is solely a federal program. It is administered by federal agencies including CMS and the Social Security Administration (SSA). Therefore, the program is uniform among the states.

Services and coverage

Medicaid covers:

- Basic hospital, physician, and therapy services.
- Physical exams and immunizations.
- Prescription drugs, eyeglasses, and medical transportation (eyeglasses every two years, more often if due to cataracts).
- A range of long-term care services, including:
  - Nursing home care.
  - Adult foster care.
  - Residential facility care.
  - Assisted living facility care.
  - Adult day care.
  - In-home services for disabled and elderly clients.

Medicare covers:

- Basic hospital, physician, therapy.
- Limited skilled nursing facility services and home health care.
- Limited preventive health services.

Eligibility

Medicaid

- Depends on financial need; i.e., low income and low financial resources and varies by state.
- Age 65 and older, or blind, or disabled or TANF recipient.
  Note: There are no residency requirements as to the length of time the applicant needs to reside in Oregon prior to Medicaid application.

Medicare

- Depends on contributions to the Social Security system while employed.
- Must be 65 or older.
- Also covers certain disabled people under age 65.

Medicaid Supplemental Security Income (SSI) Eligibility

SSI is a federally funded, nationwide income assistance program for the aged (65 or older), blind or disabled (any age), administered by the Social Security Administration.

SSI's purpose is to ensure a minimum level of income for eligible people who do not have enough income or resources to maintain a minimum standard of living.

Clients should apply for SSI at their local Social Security Administration office. While individuals who are eligible for SSI are also eligible for Medicaid, Oregon requires a separate Medicaid application. **Clients should apply for Medicaid at their local Seniors and People with Disabilities Office.**

Applicants for SSI must be:

- 65 or older, blind, or disabled.
- A citizen or resident of the United States. Legal aliens or other permanent residents as defined by law are eligible.

Income requirements, 2008

SSI applicants also must have limited income. Income eligibility standards vary among the states but the SSA applies the same method for reviewing an applicant's income in all the states. In Oregon, SSI recipients are assumed eligible for Medicaid.

Federal	**Individuals**	**Couples**
SSI Income Limit	$638/month	$956/month

Income is defined as anything received in cash or in kind that is food, clothing, or shelter, or anything that can be converted to cash and used to purchase food, clothing, and/or shelter, except food stamps. Included in income, therefore, are such items as wages, Social Security, pension or retirement benefits, gifts, inheritances, dividends, interest, and royalties.

Types of income include:

- Earned Income (e.g., wages).
- Unearned income (e.g., Social Security benefits, pension benefits, gifts, inheritances, bank interest, etc.).
- Different exclusions apply to gross income to reach monthly countable income for SSI purposes.

Allowed income exclusions

- A $20 general exclusion is applied against unearned income first, then against earned income.
- A couple is entitled to only one $20 exclusion. Needs Based Payments recipients like VA pension and TANF do not get this exclusion.
- Individuals with earned income may exclude the first $65 plus one-half of the remainder, as demonstrated by this formula:

Gross Wages (minus) $65= countable earned income

EXAMPLE: An individual who has monthly wages of $465 would have $200 in countable earned income to add to any countable **unearned** income.

$$\frac{\$465 - \$65}{2} = \frac{\$400}{2} = \$200$$

Note: If an individual or couple receives $20 or less of unearned income (e.g., bank interest) on an irregular or unpredictable basis (defined as less often than monthly), the income can be excluded. Both conditions must be met — the income must be received less often than monthly and the amount received must be less than $20. If more than $20 is received, the entire exclusion is lost.

Resources

Those with resources or assets above certain levels are not eligible for SSI. In order to be considered a resource, the item in question must be *available* to the SSI applicant.

Countable resources:

- Include savings accounts, checking accounts, cash on hand, non-home real estate, etc.
- Individuals: maximum of $2,000 in countable resources.
- Couples: maximum of $3,000 in countable resources.

Resource exclusions

- **The homestead**, including adjoining land, is excluded as long as the individual or spouse is disabled or a dependent minor child is living in it, or if the individual or couple is receiving long-term care and plans on returning to it. This is a case-by-case decision.
- **Life insurance.** Cash values of all life insurance policies owned by the applicant are excluded if the total face value of the policies does not exceed $1,500. If face value is greater than $1,500, the policy's entire cash value is included as a liquid resource. Term life insurance is excluded entirely.
- **Automobile.** The value of one automobile is excluded up to $4,550. Under SSI, however, the total value of an automobile may be excluded if needed for health or self-support reasons.
- **Funeral service.** Up to $1,500 may be excluded for self and spouse. Interest earned on these funds is not counted. Burial space, burial plots, crypts or mausoleums and merchandise, such as, casket, and liner of any value may be excluded. Oregon further allows exclusion of merchandise in the amount of $1,500 for the client's minor and adult children, client's siblings, client's parents (except stepparents) and spouse of any of these relatives.

Transferring resources

- **60-month restriction on transfers.** To qualify and remain eligible for SSI, you can't transfer assets within 60 months of applying for SSI or Medicaid, except for exempt assets and transfers for fair market value.
- **Presumption of improper transfer.** When a person or spouse gives away non-exempt property within 60 months of applying for Medicaid for long-term care anytime after application, the law presumes that the transfer was made in order for the person to become eligible for assistance. If you do this, you will be ineligible for benefits for a period that is based on the amount of assets transferred.
- Transfer of a homestead does not bar eligibility if the transfer was made to any of the following:
  - the spouse of the person.
  - a child of the person under age 21 or a child who is blind or disabled.
  - a brother or sister of the person who has an equity interest in the home and who resided with the person for at least one-year immediately before the person was admitted for long-term care.
  - a son or daughter of the person who provided care and resided in the home for at least two years immediately before the person was admitted for long-term care.
- Before transferring assets the person should obtain advice from an attorney or legal assistance program familiar with both federal and state Medicaid laws.

Medicaid Eligibility (not based on SSI)

Applicants should apply for Medicaid at **Seniors and People with Disabilities** office or the **Area Agency on Aging.** States must provide Medicaid services for these persons:

- the aged (65 or older).
- the blind.
- the disabled.
- SSI recipients.
- Legal aliens or other permanent residents as defined by law who are aged or disabled.
- TANF clients must apply at local Adult and Family Service (AFS) offices.

Income requirements

Similar to SSI, the Medicaid applicant must meet income limitations, resource limitations, and income eligibility standards. Some states provide categorical eligibility for aged, blind, and disabled people using income standards that are the same as, or close to, SSI standards.

- People in Oregon with income at or below the following categorical income standards may qualify for Medicaid or the Oregon Health Plan (OHP):

Medicaid		**OHP**	
Individuals	$638/month	Individuals	$867/month
Couples	$956/month	Couple	$1,167/month

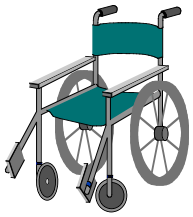
Note: Persons with income at or below $1,911/month qualify for long-term care based on service needs. If income is more than this amount, the applicant can consult an attorney regarding a trust. There is a $2,000 resource limit.

Nursing home residents and spousal impoverishment rules

Nursing home residents and other people receiving long-term care services may qualify for Medicaid if their income is less than their cost of care minus certain allowable deductions.

Long-term care services include in-home services, housekeeper/homemaker care, adult foster care, residential care, assisted living, and specialized living care.

People who qualify for Medicaid are required to contribute most of their monthly income to pay part of the long-term care costs. Nursing home residents may deduct from their monthly income a minimum personal needs allowance of $30. They are also allowed an allocation to maintain the home where it can be established that the individual can realistically expect to return home in some circumstances.



Note: Foster home and assisted living residents are allocated a needs allowance of $110 per month.

Income standards

After a person in a nursing home has established eligibility for Medicaid, the state must allow that person's spouse living in the community to receive a sufficient amount of the institutionalized spouse's income each month to raise the community spouse's income to at least 150% ($1,750 in 2008) of the federal poverty level for a couple.

- In determining Medicaid eligibility for a person receiving LTC who has a community spouse, states must allow the community spouse to keep a share of the couple's resources.
  - Medicaid assesses the resources the client had when he or she began receiving care.
  - In Oregon, the community spouse is allowed to keep a portion of their joint resources.

Medicaid benefits

States must make certain services available to all recipients to qualify for federal funding. The Basic Health Care Package includes the following:

- Physician, lab, and x-ray services.
- Pharmacy services.
- Hospital services (inpatient and outpatient).
- Physical therapy/occupational therapy.
- Diagnosis for all lines on the prioritized list.
- Durable medical equipment (DME).
- Vision, glasses.
- Hearing, speech services.
- Dental services.
- Preventive care exams.
- Over-the-counter drugs.
- Chemical dependency services.
- Limited mental health services (through local mental health programs).

The state Medicaid program may cover additional benefits not included in the federal requirements.

Dual entitlements – Medicaid and Medicare

Dual entitlement beneficiaries are those beneficiaries who are eligible for both Medicare and Medicaid.

For those who are eligible for both Medicaid and Medicare, Medicaid pays the following:

- The deductibles for Medicare Parts A and B.
- Coinsurance payments for Medicare Parts A and B.
- Other services that Medicare does not cover (varies from state to state).
- The Part B monthly premium.

Note: Physicians and other service providers are not required to serve Medicaid recipients unless they are Medicaid contractors. Recipients should determine whether or not a provider accepts Medicaid before receiving services.

How do Medicaid and Medicare work together?

- The provider submits claims directly to Medicare and Medicaid. The patient is not responsible for any paperwork. Medicare and Medicaid pay the provider directly. The patient handles no checks.
- Mandatory assignment: Medicaid pays no more than the Medicare Part B approved charges, i.e., only the 20% coinsurance***. The patient is not responsible for paying any excess over the Medicare approved amount.***
- The provider may not bill or collect charges from the Medicaid beneficiary unless the beneficiary agreed to pay for services not covered by Medicaid.

Medicare Buy-In Programs

Qualified Medicare Beneficiary (QMB)

Sometimes called the Medicare *Buy-in-Program,* QMB provides benefits to Medicare beneficiaries living **below specific federal poverty level guidelines**. There are three benefit packages in Oregon. To receive benefits from the QMB program you must be receiving Medicare Part A. To receive these benefits, participants in QMB must go to a doctor who treats Medicare patients and is also a Medicaid provider.

1. QMB-Basic

For those eligible for QMB-BAS, state Medicaid programs pay for the following:

- Medicare premiums.
- Medicare deductibles.
- Coinsurance for covered Medicare Part A and B expenses.

Income and resource levels for QMB-BAS are:

	Income	Resources
• Individuals	$867	$4,000
• Couples	$1,167	$6,000

2. Specified Low-Income Medicare Beneficiaries (SLMB) (SLMB-Basic & SLMB-Full)

Under the Specified Low-Income Medicare Beneficiaries there are two categories — Basic (QMB-SLMB) and Full (QMB-SLMF). Under the SLMB program, the state pays only the Part B premium. Under SLMF (also called ***Qualified Individual (QI)***), the federal government allots the states a limited amount of funds to provide the benefits. Beneficiaries must apply each year for benefits in this category; it's first come, first served. Beneficiaries are still responsible for deductibles and coinsurance payments.

Income and resource levels for the two categories are:

	FLP level	Income	Resources
• **Individuals:**			
SLMB	120% FPL	$1,040	$4,000
SLMF	135% FPL	$1,170	$4,000
• **Couples:**			
SLMB	120% FPL	$1,400	$6,000
SLMF	135% FPL	$1,575	$6,000

3. Qualified Disabled & Working Individual (QMB-DW)

This program pays for Medicare Part A for some disabled workers who lost eligibility for Social Security because they are working.

	FLP level	Income	Resources
• Individuals	200% FPL	$1,734	$4,000
• Couples	200% FPL	$2,334	$6,000

Applying for Medicaid Programs

To apply for QMB programs, beneficiaries must contact their local Department of Human Services office of Seniors and People with Disabilities or Area Agency on Aging office. The agency will make a decision within 45 days of the date of the application.

The applicant will have to verify income, resources, age and disability. Encourage clients to take information concerning:

- ♦ Proof of all income, age, and citizenship/legal residency.
- ♦ Liquid assets including checking and savings account statements.
- ♦ Real property assets (buildings and land other than the homestead).
- ♦ Life and health insurance policies.
- ♦ Medicare and Social Security cards.

Fraud and Abuse

The majority of doctors, labs, nursing homes, home health agencies, hospitals and other health care providers are honest. Unfortunately, there are providers who intentionally deceive or misrepresent services that are provided to people with Medicare or bill Medicare for services that were never provided. Billions of dollars are lost to Medicare fraud and abuse every year. That could mean higher premiums, deductibles, and co-payments.

Medicaid, which pays for health care for low-income people of all ages, is vulnerable to the same fraud schemes as Medicare.

Fraud occurs when someone intentionally deceives or misrepresents himself or herself in a way that could result in unauthorized payments being made. Examples of fraud include:

- Billing for services or supplies that were not provided or altering claim forms to obtain a higher payment amount.
- Paying for a referral (offering a kickback).
- DME providers giving a beneficiary one item and charging Medicare for another.
- Rolling labs billing for tests that have never been received.
- Ambulance services billing for more miles than traveled.
- Providing physical, speech or occupational therapy to a group and charging for each individual.
- Billing for psychotherapy when it was a recreational activity.

Abuse occurs when unintentional incidents or practices of providers are inconsistent with accepted, sound medical business or fiscal practices. Examples of abuse include:

- Exceeding the limiting charge.
- Claims for services that are not medically necessary.
- Excessive charges for services or supplies.

Tips to prevent fraud

Medicare is improving its capability to crack down on those who take advantage of the program. They are using four methods to fight fraud and abuse: prevention, early detection, coordination with other government agencies and prosecution of wrong doers.

People can help protect Medicare and themselves by taking these simple steps:

- Carefully review the Medicare Summary Notices. Ask questions if:
  - You don't understand the charged billed to Medicare.
  - You don't think you received the service.
  - You feel the service was unnecessary or misrepresented.
- Never loan your ID card to anyone or give your Medicare or Medicaid number over the telephone to people you do not know.
- Beware of health care providers who say they represent Medicare or a branch of the federal government.
- Beware of providers who use pressure tactics to get you to accept a service or product.
- Be suspicious of companies or advertising that offers free medical equipment and asks for your Medicare number.
- Beware of providers and suppliers that use phone calls and door-to-door selling as a way to sell you goods or services.
- Never sign a blank form. Always read and keep a copy of any document or agreement you sign.
- If you rent medical equipment, return the item to the medical equipment dealer when you are finished and always get a receipt for the return.
- Beware of experimental therapies and high-priced medical services or diagnostic tests. Rely on your own doctor's advice to prescribe appropriate treatment for you.

Examples/fraud schemes

- In a 60-day period, a clinical laboratory submitted to Medicare 717 claims for 416 beneficiaries (many of whom were deceased) and received $330,000. One of the referring physicians listed on the claims had been deceased for two years.
- A national independent physiological lab billed Medicare for over $5.9 million for Medical Resonance Imaging (MRI) services that were not provided. The provider used several different business names; none of which were viable businesses; the addresses were merely mail drops.
- Durable Medical Equipment (DME) suppliers have billed adult diapers as Female Urinary Collection Devices (FUCD). Suppliers misrepresented the item and patients' conditions in billing. Medicare paid nearly $9 per FUCD; the diapers cost the suppliers 26 cents. Charges to Medicare have been as high as $5,200 per month.

How to report fraud

If there are questionable charges on a bill, and/or fraud or abuse is suspected the beneficiary should call:

- The provider for an explanation.
- The fiscal intermediary for Part A bills.
- The Medicare carrier for Part B bills.

Before making the call, carefully review the facts as shown on the Explanation of Medicare Benefits or Medicare Summary Notice (MSN). You should review the following items very carefully:

- The provider's name and any identifying number.
- The item or service in question.
- The date on which the item or service was supposedly furnished.
- The amount approved and paid by Medicare.
- The date of the EOMB or MSN.

- The name and Medicare number of the person who supposedly received the item or services.
- The reason you believe Medicare should not have paid.
- Any other information the person with Medicare may have showing that the claim for the item or service should not have been paid by Medicare.

If the reporting of possible fraud is done in writing rather than by telephone, state at the beginning of the letter that it is a fraud complaint. This will help ensure that the complaint is forwarded to the Medicare contractor's fraud unit, or you may call:

- **Oregon's Medicare/Medicaid statewide fraud reporting number: 1-800-232-3020, or:**
- **Office of Inspector General: 1-800-HHS-TIPS (1-800-447-8477)**

How complaints are handled

The complaint will be acknowledged within 30 days. This notice will give a date by which the fraud unit expects to complete the investigation. The investigator will reach one of three conclusions:

- The claim may have appeared to be wrong, but was correctly filed.
- The provider made a billing error that appears to have been an honest mistake.
- The provider appears to have filed a false claim.

If the amount at issue is small, and there isn't a pattern of fraud, Medicare will recover the overpayment and issue a warning to the provider. If the review discloses a pattern of fraud, the case will be referred to the Office of Inspector General for civil, criminal, and/or administrative action.

Penalties for fraud

The Office of Inspector General coordinates its investigation with several other federal and state law enforcement agencies. Depending upon the outcome of the investigation, one of the following penalties may apply:

- **Criminal Prosecution** – It's a felony to steal from Medicare. Some providers are sent to prison and/or required to pay back the amount they have stolen, plus fines. Providers are also barred from doing business with Medicare for at least five years.
- **Civil Proceeding** – The U.S. Attorney may file a civil suit, or the case could be settled. The amount stolen, plus penalties and fines are paid to the government. The provider may also be barred from doing business with Medicare and Medicaid for a number of years.
- **Administrative** – Even when the U.S. Attorney's Office declines to prosecute the case, the Office of Inspector General may take action to exclude the provider from billing Medicare or Medicaid.