



SMP Foundations Training Manual

SMP Resource Center

Table of Contents

Acknowledgements	i
About this Edition	i
About the SMP Resource Center	i
Training Overview	i
Chapter 1: SMP Program	
Objectives	3
The SMP Mission	3
SMP is a National Program	5
The Importance of SMP Volunteers	7
How Does the Public Find Their SMP?	9
Chapter 2: Medicare Coverage Basics	
Objectives	13
Medicare Overview	13
Eligibility	13
The Parts of Medicare	14
Original Medicare	15
Medigap	17
Medicare Advantage	19
Original Medicare vs. Medicare Advantage	21
Prescription Drug Coverage	22
Chapter 3: Medicare Enrollment Basics	
Objectives	27
Enrolling in Medicare	27
Medicare Cards and Numbers	27
Medicare Statements	30
Medicare Rights and Protections	31
Chapter 4: Medicare Fraud, Errors, and Abuse	
Objectives	37
Waste in Medicare	37
The Impact of Medicare Fraud, Errors, and Abuse	40
Appendices	
Appendix A: SMP Resources at www.smpresource.org	45
Appendix B: Key Terms	47

Acknowledgments

This manual is a product of the Senior Medicare Patrol (SMP) National Resource Center. It was supported in part by grant number 90MPRC0001, from the U.S. Administration for Community Living (ACL), Department of Health and Human Services (DHHS), Washington, D.C. 20201. Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official ACL or DHHS policy.

About this Edition

This March 2020 edition is updated from the previous versions. Previous editions of this manual were published in 2009, 2011, 2014, and 2017.

About the SMP Resource Center

The Senior Medicare Patrol National Resource Center, more commonly known as “The SMP Resource Center,” is funded by the U.S. Administration for Community Living (ACL), Department of Health and Human Services, and has existed since 2003. The SMP Resource Center serves as a central source of information, expertise, and technical assistance for the Senior Medicare Patrol (SMP) projects.

National SMP Website: www.smpresource.org

This website provides education to the public on health care fraud and how to contact their state SMP. It also contains an “SMP login” portal with resources, training, and technical assistance for the SMP projects nationwide.

Nationwide Toll-free Number: 877-808-2468

Available Monday through Friday, 9:00 a.m. – 5:30 p.m. Eastern Time

Email: info@smpresource.org

Training Overview

Training Goal

The goal of SMP Foundations Training is to provide a foundation of knowledge in three main content areas:

- 1) The SMP Program
- 2) Medicare Basics
- 3) Medicare Fraud, Errors, and Abuse



Tip Box

Throughout the manual, look for “tip” boxes (like this one), which highlight key tips.

About this Manual

This training manual provides information on the following topics:

- **Chapter 1: The SMP Program** describes the SMP mission, the importance of volunteers, and how the public finds their SMP.
- **Chapter 2: Medicare Coverage Basics** describes the parts of Medicare and the coverage provided by each part.
- **Chapter 3: Medicare Enrollment Basics** explains basic information about Medicare related to enrollment, cards and numbers, statements, and beneficiary rights.
- **Chapter 4: Medicare Fraud, Errors, and Abuse** defines and explains the impact of Medicare fraud, errors, and abuse.
- The **Appendices** provide information about related resources and key terms for SMPs.

Additional Training

After completing SMP Foundations Training, additional training may be provided by your SMP depending on your role, as described in Chapter 1. Additional training opportunities may include: SMP Group Education Training, SMP Counselor Training, and/or SMP Complex Interactions Training. Please talk with your local SMP for more information about the training opportunities available in your area.

State and Local Information

Throughout the manual, look for “state and local information” boxes (like this one) to help you track information and resources that may be used locally.



Throughout the manual, look for “caution” boxes (like this one), which highlight areas to watch out for!

State and Local Information #1: Expectations

What can you expect as an SMP team member, and what is expected of you? For more information about expectations in your state, see your SMP’s job description and/or talk with your SMP director or coordinator of volunteers.



SMP Foundations Training Manual

CHAPTER 1: SMP Program

Objectives	3
The SMP Mission	3
Prevent	3
Detect	4
Report	5
SMP is a National Program	6
History	6
Funding Source	6
Program Accountability	7
The Importance of SMP Volunteers	8
What SMP Volunteers Do	8
How Does the Public Find Their SMP?	9

Objectives

This chapter provides an overview of the Senior Medicare Patrol (SMP) program.

Upon completion of Chapter 1: SMP Program, you will be able to:

1. Know the SMP mission
2. Understand that SMP is a national program
3. Understand SMP program accountability
4. Know the importance of volunteers to the SMP program

The SMP Mission

Medicare loses billions of dollars each year due to fraud, errors, and abuse. Estimates place these losses at approximately \$60 billion annually, though the exact figure is impossible to measure.

The SMP program's unique role is to work at the grassroots level with the people directly affected by Medicare fraud, errors, and abuse. SMPs increase public awareness about the resulting economic and health-related consequences. Education and prevention are at the core of the Senior Medicare Patrol program, as demonstrated by its mission:



The SMP mission is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education.

Prevent

SMPs prevent health care fraud through education. They present to groups, exhibit at community events, provide individual counseling, and answer questions from people who call the SMP. SMPs educate Medicare beneficiaries, their families, and caregivers to prevent health care fraud by protecting their medical identification cards and numbers. SMPs caution beneficiaries to:

- Treat their Medicare cards and numbers like they would a credit card. Although Medicare cards and numbers no longer contain Social Security numbers (as of 2019), Medicare numbers are valuable to thieves who want to steal money from Medicare.
- Only share Medicare and other health care identification cards and numbers with trusted sources who need that information to serve them, such as their health care providers.

- This information should not be provided to a stranger who calls, visits, or approaches them in a public setting.
- Medicare already has the person's Medicare number. They will not call to ask for it, and they certainly don't need a bank account number.

Note: When people call 1-800-Medicare for assistance, Medicare **will** ask for the person's Medicare number.

- Treat any offer of free services in exchange for a Medicare or health care identification number with caution.
- Rely on their doctors for medical advice and prescriptions, not advice or offers of medical services from unknown persons who call, visit, or approach them in public. This also means they should not pursue services or advertisements seen on the television, heard on the radio, or received in the mail.
- Never sign a blank medical or insurance form.
 - They should always read and make sure they understand the content before signing.
 - They should request a copy of a form or document they signed for their own records.



Detect

Prevention alone cannot stop all fraud, errors, and abuse. SMPs teach beneficiaries, along with their family members and caregivers, to detect potential problems by taking the following steps:

1. Keep records of health care visits, services or equipment received, test results, etc. The SMP Personal Health Care Journal (PHCJ) is a good health care record-keeping tool.
2. File copies of bills received from doctors, hospitals, pharmacists, suppliers, or other health care providers.

State and Local Information #2: PHCJs

Does your SMP use Personal Healthcare Journals to help Medicare beneficiaries? Talk with your SMP coordinator or volunteers to learn more.

- Save Medicare Summary Notices (MSNs) and Explanations of Benefits (EOBs) and review them for accuracy. Compare the dates, providers, and services received, shown on MSNs and EOBs, to what is documented in personal health care records.
- Beware of charges for services not received, duplicate charges, or services that were not ordered by the person's doctor.

3. Ask questions of the provider, Medicare plan, or 1-800-Medicare when:

- The beneficiary doesn't **understand** the charges billed
- The beneficiary doesn't think they **received the service**
- The beneficiary feels the service was **unnecessary**
- The beneficiary was charged for the same thing **twice**



The Personal Health Care Journal (PHCJ): An Important SMP Tool!

A Personal Health Care Journal is a resource commonly used by SMPs.

This guide helps Medicare beneficiaries, their caregivers, and family document important information about doctor visits, medical diagnoses, equipment received, and more. When kept up to date, the journal can be used later to cross-check services outlined on MSNs and EOBs.

Report

In some cases, SMPs do more than educate. When Medicare beneficiaries are unable to act on their own behalf to address suspected Medicare fraud, errors, or abuse, the SMPs work with them, their family, caregivers, and others to address the problems and, if necessary, make referrals to outside organizations to intervene. SMPs educate beneficiaries to report suspected fraud, errors, or abuse immediately!

Here are steps SMPs recommend beneficiaries take to report their concerns:

1. **Call the health care provider.** Call the provider or supplier first to question the charge. If it was a mistake, ask them to correct it.
2. **Call the company that issued the bill.** If the provider or supplier can't answer the question, contact the company that issued the bill. Their contact information can be found on the MSN (Medicare Summary Notice) or EOB (Explanation of Benefits).
3. **Contact the SMP.** If not satisfied with the response from a provider, supplier, or billing company, contact the local SMP. The SMP helps beneficiaries understand the difference between suspected fraud, errors, or abuse. SMPs also assist beneficiaries in addressing suspected errors. If fraud or abuse is suspected, SMPs refer cases to the proper authorities for further investigation.



SMP is a National Program

The Senior Medicare Patrols (SMPs) are grant-funded projects of the federal U.S. Department of Health and Human Services (HHS), U.S. Administration for Community Living (ACL). All SMP grantees have a shared national identity through a national program name and logo.



History

The seeds of the SMP program we know today can be traced back to 1995, when the U.S. Administration on Aging (AoA) funded five small initiatives to address Medicare fraud. Through the 1997 Omnibus Consolidated Appropriations Act – legislation that formally supported enlisting seniors in the fight against Medicare fraud – the SMP program was born.

Since its inception in 1997, the SMP program has evolved from 12 regional demonstration projects into a nationwide program. The number of grantees increased over time. Since 2003, the SMP program scope has been national. Currently, an SMP grantee serves every state, as well as Puerto Rico, Guam, the U.S. Virgin Islands, and Washington, D.C., for a total of 54 SMP programs nationwide.

Funding Source

The SMP program is funded by ACL, which issues requests for proposals for the SMP program and then competitively awards grants to a selected project in each of the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. As of June 1, 2016, SMP grants are funded by the Health Care Fraud and Abuse Control (HCFAC) Program as discretionary projects. This means funding is provided at the discretion of HHS operating divisions. ACL is an operating division headed by the Administrator and Assistant Secretary for Aging, who is appointed by the President and serves under the U.S. Secretary for Health and Human Services. Through several administration changes, leaders at HHS have continued to use their discretion to fund SMPs.

ACL uses HCFAC funds to support the SMP program nationally. HCFAC funds are used to administer the program, maintain a national SMP data reporting system, and provide supportive services to SMPs nationally. Through HCFAC, ACL funds a national SMP Resource Center and occasionally funds other nationally beneficial initiatives, as funding allows. Some examples include media campaigns, demonstration projects to reach non-English-speaking and other harder-to-reach populations of beneficiaries, and program evaluations.

Program Accountability

As a government-funded program, the SMP program is accountable to the federal government and, ultimately, to taxpayers. SMPs must meet ACL requirements for reporting their activities and outcomes in the SMP Information and Reporting System (SIRS). SMP is unique in that annual SMP program outcomes are analyzed and published by the U.S. Department of Health and Human Services Office of Inspector General (OIG) Office of Evaluation and Inspections, which is responsible for performing audits and inspections of HHS programs. The OIG usually performs this activity for federal agencies, not federal grantees.

The OIG's annual report of SMP performance measures is the result of the 1997 Omnibus Consolidated Appropriations Act and a formal agreement with ACL. Its data is presented to ACL and is made available to the general public through the OIG's website: www.oig.hhs.gov. The report is also posted on the SMP Resource Center website: www.smpresource.org > Resources for SMP > OIG Report. The results may be cited by HHS and the federal agencies within HHS, such as ACL and the Centers for Medicare & Medicaid Services (CMS), by organizations interested in SMP, and also by the media.

The OIG Report includes data about SMP activity in three major areas:

1. **Team member time and effort:** Includes the number of active team members as well as the number of team member work and training hours. Team members include SMP volunteers, partners, and staff.

2. **Outreach and education activities:** Includes such things as the number of group presentations, community events, and individual interactions, as well as the number of people served through these activities.



3. **Complaints of suspected health care fraud, errors, or abuse:** Includes

“complex interactions.” When Medicare beneficiaries, caregivers, and family members bring their complaints to the SMP, the SMP makes a determination about whether or not fraud, errors, or abuse is suspected. This is called a “complex interaction” by SMPs. The SMP helps resolve errors by working with beneficiaries and providers. Suspected fraud and abuse are referred to the appropriate state and federal agencies for further investigation.

The Importance of SMP Volunteers

Engaging volunteers to fulfill the SMP mission is at the core of ACL's request of SMP program grantees. As a grassroots education program, SMP work requires significant face-to-face contact with Medicare beneficiaries, their caregivers, and family members to be effective. The SMP program reaches approximately 2 million beneficiaries each year. This would not be possible without the help of thousands of volunteers.

The SMP program mission is a compelling one and offers volunteers and other team members an opportunity to make an important difference in their communities. Protecting older persons' health, finances, and medical identity while saving precious Medicare dollars is a cause that attracts civic-minded Americans. Many SMP volunteers are also Medicare beneficiaries and thus well-positioned to assist their peers. Even volunteers who aren't Medicare beneficiaries take pride in working to ensure that the Medicare program will be protected for future generations.

What SMP Volunteers Do

SMP programs work with each volunteer to match that volunteer's skills and interests to the needs of the SMP program. As a result, SMP volunteers may serve Medicare beneficiaries, their families, and caregivers in many creative ways. However, there are six types of activities most commonly conducted by SMP volunteers nationwide, called "volunteer roles":

State and Local Information #3: SMP Volunteer Roles

Which role(s) will you perform for your SMP? If you're not sure, talk with your SMP director or coordinator of volunteers.

- **Administrative support:** Help with work such as copying, filing, data entry, and placing outbound phone calls in support of SMP activity.
- **Information distributor:** Help with transporting and disseminating SMP information materials to sites and events; may include presenting prepared copy or performing scripted activities for small groups.
- **Exhibitor:** Help by staffing information kiosks or exhibits at events such as health fairs; also may provide general information about SMP to the public and answer simple questions.
- **Presenter:** Help by giving presentations on SMP topics to small and large groups; may interact with the audience by answering questions and through discussion.
- **Counselor:** Help by having direct conversations with beneficiaries about their individual situations; may include review of personal information such as MSNs, billing statements, and other related financial and health documents.



- **Complex interactions specialist:** Help with in-depth interactions with beneficiaries who are reporting specific instances of health care fraud, errors, and abuse; may act on behalf of a beneficiary to correct an error or refer suspected fraud and abuse to the appropriate authorities.

State and local programs may create other roles not outlined above or they may ask a volunteer to fill more than one of the standard SMP roles. Additionally, at the state and local levels, many SMPs rely on partnerships with other nationwide organizations that also serve the Medicare population, such as Area Agencies on Aging (AAAs) and State Health Insurance Assistance Programs (SHIPs). These key partners help SMPs achieve their mission and may even have an agreement with the SMP to help recruit, train, or house SMP volunteers. Because of this, some SMP volunteers may wear both an SMP hat and an AAA or SHIP hat, depending on their interests.

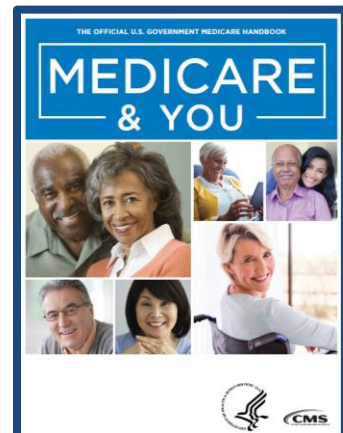
State and Local Information #4: SHIP and SMP

Does your SMP partner with your SHIP (State Health Insurance Assistance Program)? SHIPs provide local, in-depth, and objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers. They are national partners with SMPs. If you're not sure if your SMP is partnering with your SHIP, talk with your SMP director or coordinator of volunteers. More information about SHIP, including contact information in each state, is available at www.shiptacenter.org.

How Does the Public Find Their SMP?

Information about the SMP program is shared with Medicare beneficiaries, their families, caregivers, and the general public in several ways:

- **SMP Outreach:** Most members of the public learn about how to find the SMP in their area through their SMP's outreach and education efforts.
- **The *Medicare & You* Handbook:** The Centers for Medicare & Medicaid Services (CMS) provides information about the SMP program in the *Medicare & You* handbook. This official U.S. government handbook is provided to Medicare beneficiaries by CMS each year and is available online at www.Medicare.gov. The *Medicare & You* handbook directs readers seeking their SMP program to the national SMP Resource Center.



- **SMP Resource Center:** The SMP Resource Center operates a toll-free number (877-808-2468), a national SMP website (www.smpresource.org), and a national Facebook page (www.facebook.com/SMPNationalResourceCenter). The SMP Resource Center's website, toll-free number, and Facebook page provide individuals with contact information for the SMP program serving their geographic area. See Appendix A for a list of SMP resources at www.smpresource.org.
- **ACL's Website:** The Administration for Community Living provides information about the national SMP program on their website: www.acl.gov.

State and Local Information #5: SMP Contact Information

What's the contact information for your local SMP? Who should you contact if you have questions, and what contact information should you provide to beneficiaries who need help? If you're not sure, talk with your SMP director or coordinator of volunteers.



SMP Foundations Training Manual

CHAPTER 2: Medicare Coverage Basics

Objectives	13
Medicare Overview	13
Eligibility	13
The Parts of Medicare	14
Original Medicare	15
Medicare Part A: Hospital Insurance	15
Medicare Part B: Medical Insurance	16
Medigap	17
Medicare Supplement Insurance: Medigap	17
Medicare Advantage	19
Medicare Part C: Medicare Advantage	19
Original Medicare vs. Medicare Advantage	21
Prescription Drug Coverage	22
Medicare Part D: Prescription Drug Coverage	22

Objectives

This chapter provides an overview of the Medicare program. Upon completion of Chapter 2: Medicare Coverage Basics you will be able to:

1. Describe the parts of Medicare and the coverage provided by each part
2. Know the difference between Original Medicare and Medicare Advantage

State and Local Information #6: Medicare Training

Will you work for the SHIP in addition to the SMP? If so, talk with your SMP director or coordinator of volunteers about what training is expected of you.

Medicare Overview

Congress created the Medicare program. It began in 1965. Medicare is the federal health insurance program for:

- ✓ People 65 and older
- ✓ Some people with disabilities under 65
- ✓ Those with End-Stage Renal Disease (ESRD)
- ✓ Certain people with ALS (Lou Gehrig's disease or amyotrophic lateral sclerosis)

How many people are covered by Medicare? In 2018, according to the Medicare Trustees report, Medicare covered almost 60 million people: 51.2 million people age 65 and older and 8.8 million people with disabilities.

The Centers for Medicare & Medicaid Services (CMS) administers Medicare. The program was **NOT designed to pay 100%** of all medical bills, though it now covers the full cost of many prevention and screening services.

Eligibility

In order to be eligible for Medicare, a person must:

1		2
<ul style="list-style-type: none"> Be a U.S. citizen or Be a permanent resident and have lived in the U.S. continuously for five consecutive years 	AND	<ul style="list-style-type: none"> Be 65 or older or Be under 65 but over 18 and receiving Social Security Disability Insurance (SSDI) for at least 24 months or Be under 65 but over 18 and get Social Security Disability Insurance (SSDI) because of a diagnosis of ALS (Lou Gehrig's disease) or Be 18 or older with End-Stage Renal Disease (ESRD)

The Parts of Medicare

Medicare consists of four parts called Part A, Part B, Part C, and Part D.

Option 1: Original Medicare

Medicare Part A and Part B together are known as “Original” or “Traditional” Medicare and provide hospital and medical insurance coverage as outlined in the chart below.

Part A + Part B = Original Medicare

Part A: Hospital Insurance helps cover:

- Inpatient care in hospitals
- Skilled nursing facility (SNF) care
- Hospice care
- Home health care

Part B: Medical Insurance helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (DME)
- Many preventive services

Option 2: Medicare Advantage

Medicare Part C offers an alternate system for delivering the same services as Original Medicare through private insurance plans, called Medicare Advantage plans. Key points about Medicare Advantage are outlined in the chart below.

Part C = Medicare Advantage

Includes all benefits and services covered under Part A and Part B

Is run by private insurance companies that follow rules set by Medicare

Usually includes Medicare prescription drug coverage (Part D) as part of the plan

Usually includes extra benefits and services that aren't covered by Original Medicare

Medicare Part D and Medicare Supplement Insurance

Beneficiaries in Original Medicare also have the option of purchasing additional insurance to cover gaps in coverage.

- Medicare Part D helps cover the cost of prescription drugs and is run by private insurance companies that follow rules set by Medicare.
- Medicare Supplement Insurance, commonly known as Medigap, is not a part of Medicare. It's also offered by private insurance companies.

More information about each of the parts of Medicare is provided throughout the rest of this chapter.

Original Medicare

“Original” or “Traditional” Medicare – Parts A and B together – is one of the health coverage choices that Medicare offers. It is run by the Centers for Medicare & Medicaid Services (CMS), a federal agency. People who are new to Medicare receive their benefits through Original Medicare unless they decide to join a Medicare Advantage plan (Part C). People with Original Medicare can also join a Medicare Prescription Drug Plan (Part D) to add drug coverage and they can buy a Medigap (Medicare Supplement Insurance) policy (sold by private insurance companies) to help fill gaps in Part A and Part B coverage.



Medicare Updates

The Medicare program undergoes changes to benefits, costs, and more every year. See the current version of the *Medicare & You* handbook from CMS for the latest information.

Medicare Part A: Hospital Insurance

Medicare Part A is also known as Hospital Insurance. Part A provides coverage for the following health care benefits:

- Inpatient hospital care
- Skilled nursing facility (SNF) care
- Home health care
- Hospice care



Excluded Services

The following services are NOT covered under Medicare Part A:

- Most long-term care services, such as assisted living or non-SNF nursing home stays
- Custodial care, such as help with bathing, dressing, or eating when the patient is not also receiving skilled nursing or rehabilitation services
- Medically unnecessary stays
- Private hospital rooms unless they are medically necessary
- Private-duty nurses



Key Terms

For definitions of key terms such as premium, coinsurance, and deductible, see Appendix B.

Part A Costs

Most people enrolled in Part A receive Part A benefits without paying a premium. Part A can be purchased if an individual (or their spouse) has not paid enough Medicare taxes to be entitled. This includes, for example, a low-wage seasonal worker or a person who immigrates to the United States late in life.

Beneficiaries with Part A can incur the following out-of-pocket costs:

- \$ **Inpatient Hospital Stays.** Beneficiaries owe an inpatient hospital deductible at the start of each benefit period. The benefit period typically starts with a new hospital admission and ends when they haven't received any inpatient hospital (or skilled care in a SNF) for 60 days in a row. Benefit periods are not tied to a calendar year time frame. Deductibles apply at the start of the benefit period. Daily coinsurance charges may apply for some stays.
- \$ **Skilled Nursing Facility Stays.** Days one to 20 are free. Days 21 to 100 have a daily coinsurance charge.
- \$ **Home Health Care.** No deductibles or coinsurance charges apply.
- \$ **Hospice Care.** No deductibles apply. No coinsurance charges apply, except to inpatient respite services and medications. A 5% coinsurance charge applies for some palliative medications, not to exceed \$5 per prescription.

Medicare Part B: Medical Insurance

Medicare Part B is also known as Medical Insurance. Part B provides health care benefits that help cover the following products and services and more:

- Physician services
- Durable medical equipment
- Home health care
- X-rays, lab services
- Outpatient hospital services
- Mental health services
- Most preventive health care services ("Welcome to Medicare" or yearly wellness visits)



Excluded Services

The following services are **NOT** covered under Medicare Part B:

- Routine foot care
- Hearing aids or examinations for fitting a hearing aid
- Examinations for eyeglasses unless required by cataract surgery
- Routine dental care or false teeth
- Cosmetic surgery (except medically necessary reconstructive surgery)
- Experimental medical procedures
- Custodial care

Part B Costs

Beneficiaries with Part B incur the following out-of-pocket costs:

- \$ **Premium.** This is usually taken out of the monthly Social Security, Railroad Retirement, or federal Civil Service retirement check sent to a beneficiary. If a beneficiary does not receive any of these monthly payments, a bill is sent every three months. For individuals with annual incomes exceeding \$85,000, the Medicare Part B premium is adjusted based on income.
- \$ **Deductible.** Beneficiaries enrolled in Part B are responsible for the Part B deductible each calendar year. This amount is adjusted annually in line with Medicare spending increases.
- \$ **Coinsurance.** After meeting the deductible, in most cases Medicare Part B pays 80% of the Medicare-approved amount. The beneficiary is responsible for 20% of the Medicare-approved amount.
- \$ **Copayment.** This is the amount they may have to pay as their share of the cost for services, after any deductibles. It generally refers to a fixed dollar amount.
- \$ **Excess Charges.** Beneficiaries may incur excess charges over and above Medicare's approved amount for services if they choose a nonparticipating provider who does not accept "assignment" in all cases.
- \$ **Private Pay Agreements.** A small number of providers choose not to enroll in Medicare at all – they "opt out." These providers cannot file a claim with or receive any payment from Medicare, except for emergencies. Providers who opt out of Medicare must ask their patients to sign a "private pay agreement," which explains that beneficiaries must pay the full cost of the services themselves.



Assignment

Assignment means that the provider or supplier agrees to accept the Medicare-approved amount as full payment for covered services.

Before selecting doctors and suppliers, beneficiaries in Original Medicare should ask if they accept payment from Medicare AND if they accept assignment.

Medigap

Medicare Supplement Insurance: Medigap

Original Medicare covers most of the cost for medically necessary health care services and supplies, as mentioned previously. The out-of-pocket costs incurred by Medicare beneficiaries are often called "gaps."

About one-fourth of beneficiaries purchase a Medicare Supplement, or Medigap, insurance policy. State insurance departments regulate Medigap policies, which are sold by private insurance companies and are designed to fill Original Medicare's cost-sharing gaps by helping to pay the coinsurance, copayments, and Part B excess charges. Some policies also offer coverage for services that Original Medicare doesn't cover, such as emergency care during international travel. It's possible to eliminate most out-of-pocket costs for Medicare-covered services with Medigap policies.



Effective in 2020, in most states there are eight types of standardized Medigap policies, identified by the letters A, B, D, G, K, L, M, and N. Medigap insurance companies can decide which of the eight standardized Medigap policies they will sell, but there are conditions:

1. They can only sell these regulated (aka “standardized”) Medigap policies.
2. Every Medigap policy must be clearly identified as Medicare Supplement Insurance.
3. They must offer a Medigap Plan A in order to offer any other Medigap plans.

Note: Anyone who turned 65 before 2020 may have additional plan options. Also, in Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way. For details, contact your SHIP.

Eligibility

To be eligible for Medigap insurance, a beneficiary must be in Original Medicare (enrolled in both Parts A and B) and not in a Medicare Advantage plan or Medicaid.

Beneficiaries who may benefit from a Medigap policy are encouraged to call their SHIP for assistance in choosing a policy that is best for them.

Costs

- \$ Each of the standardized Medigap policies offer the same benefits regardless of the company selling it, enabling “apples to apples” plan comparisons. For example, every policy B will have the same benefits regardless of company.
- \$ Usually the only difference between Medigap policies of the same type, sold by different insurance companies, is the cost of the premium.
- \$ Each insurance company decides which Medigap policies it wants to sell and the price for each policy, though prices may be limited by state law.
- \$ Medicare pays none of the costs for a Medigap policy.



Key Points on Medigap

- A Medigap policy stays in effect as long as the person continues to pay the premium.
- If a person drops a Medigap policy to join a Medicare Advantage plan, they may not be able to get that particular policy back if they return to Original Medicare (unless they are within a 12-month trial period after joining a Medicare Advantage plan for the first time).
- If a person already has a Medicare Advantage plan, it is illegal for anyone to sell them a Medigap policy unless they are switching back to Original Medicare.
- If a person first enrolls in Medicare Part B at age 65 (or if they are over 65 when they drop their employer health coverage), they can generally buy any Medigap policy during a six-month Medigap Open Enrollment Period, regardless of pre-existing conditions; such conditions may affect the availability and price of policies later. Policies available to Medicare beneficiaries under the age of 65, however, vary by state.
- Medigap policies do not cover Part D deductibles or copayments.
- If a person wants to change Medigap policies, they should contact their state SHIP to learn about options.

Medicare Advantage

Medicare Part C: Medicare Advantage

Medicare Part C, more commonly called Medicare Advantage, is an alternative to Original Medicare when elected by a Medicare beneficiary. Medicare Advantage plans are offered by private insurance companies that sign a contract with Medicare. Medicare Advantage plans must provide all Medicare Part A and Part B benefits to plan members. Many offer benefits that Original Medicare doesn't cover, such as routine hearing, vision, and dental care and nonambulance medical transportation services. Most Medicare Advantage plans also include Medicare Part D prescription drug coverage. A plan comparison tool called "Medicare Plan Finder" is available on Medicare's website: www.Medicare.gov.

There are five main types of Medicare Advantage plans:

1. **Health Maintenance Organization Plans (HMOs).** Members must see doctors in the plan's network. In most cases, a primary care doctor coordinates health care.
2. **Medicare Preferred Provider Organization Plans (PPOs).** Members may see any doctor, but it costs less to see health care providers in the plan's network.

3. **Private Fee-for-Service Plans (PFFS).** Members may see any Medicare-approved doctor or hospital if the provider agrees to the plan's terms and conditions of payment before treatment. Not all health care providers accept PFFS plan payment terms. The plan decides how much it will pay providers and how much it will charge beneficiaries. Some PFFS plans have a provider network with doctors who agree to always treat plan members.

4. **Medicare Special Needs Plans.** These plans are not available everywhere. They provide all Medicare health care for beneficiaries with special needs, including those with chronic illness, people in institutions, and people with Medicaid.



5. **Medicare Medical Savings Account Plans.** These plans have two parts – a high-deductible plan and a Medical Savings Account – into which Medicare deposits money that people can use to pay health care costs.

Eligibility

To be eligible to join a Medicare Advantage plan, a person must:

- ✓ Be entitled to Medicare Part A and enrolled in Part B
- ✓ Live in the plan's service area
- ✓ Not have End-Stage Renal Disease (ESRD) at the time of enrollment

Medicare Advantage (Part C) Costs

Out-of-pocket costs vary among Medicare Advantage plans.

- \$ Plan members continue to pay the Part B premium.
- \$ Plans may charge an additional premium, though zero-premium plans are often available.
- \$ Copayments and coinsurance charges may apply.
- \$ Deductibles may apply.
- \$ Plans cannot charge members more than Original Medicare does for certain services such as chemotherapy, dialysis, and skilled nursing facility care.
- \$ Plans have an annual cap on how much a beneficiary pays for Part A and Part B services. This maximum out-of-pocket amount can differ among plans.

Original Medicare vs. Medicare Advantage



The graphics on the following two pages are from the *Medicare & You handbook*, for which the intended audience is Medicare beneficiaries. Within these graphics, please note that “you” refers to beneficiaries, not SMP team members who are reading this manual.



Doctor and hospital choice

Original Medicare	Medicare Advantage
You can go to any doctor that accepts Medicare .	In most cases, you'll need to use doctors who are in the plan's network (for non-emergency or non-urgent care). Ask your doctor if they participate in any Medicare Advantage Plans.
In most cases you don't need a referral to see a specialist.	You may need to get a referral to see a specialist.



Cost

Original Medicare	Medicare Advantage
For Part B-covered services, you usually pay 20% of the Medicare-approved amount after you meet your deductible.	Out-of-pocket costs vary —some plans have low or no out-of-pocket costs.
You pay a premium (monthly payment) for Part B . If you choose to buy prescription drug coverage, you'll pay that premium separately.	You may pay a premium for the plan (most include prescription drug coverage) and a premium for Part B . Some plans have a \$0 premium or will help pay all or part of your Part B premium.
There's no yearly limit on what you pay out-of-pocket.	Plans have a yearly limit on what you pay out-of-pocket for Medicare Part A and B covered services. Once you reach your plan's limit, you'll pay nothing for Part A- and Part B-covered services for the rest of the year.
You can buy supplemental coverage to help pay your out-of-pocket costs (like your deductible and 20% coinsurance).	You can't buy or use separate supplemental coverage—but some plans have lower out-of-pocket costs than Original Medicare.



Coverage

Original Medicare	Medicare Advantage
Original Medicare covers medical services and supplies in hospitals, doctors' offices, and other health care settings.	Plans must cover all of the services that Original Medicare covers. Some plans offer extra benefits that Original Medicare doesn't cover —like vision, hearing, or dental.
You can join a separate Medicare Prescription Drug Plan to get drug coverage.	Prescription drug coverage is included in most plans.
In most cases, you don't have to get a service or supply approved ahead of time for it to be covered.	In some cases, you have to get a service or supply approved ahead of time for it to be covered by the plan.



Travel

Original Medicare	Medicare Advantage
Original Medicare generally doesn't cover care outside the U.S. You may be able to buy supplemental coverage that covers care outside the U.S.	Plans usually don't cover care outside the U.S. Also, plans usually don't cover non-emergency care you get outside of your plan's network.

Prescription Drug Coverage

Medicare Part D: Prescription Drug Coverage

Medicare Part D is also referred to as Medicare prescription drug coverage and helps cover the cost of prescription drugs. CMS contracts with private companies to offer Medicare Prescription Drug Plans to people with Medicare.

Beneficiaries are encouraged to compare plans prior to enrolling because coverage varies. The drugs covered, copayment amounts, deductibles, and gap coverage (see "coverage gap" description below) differ from plan to plan. The Medicare Plan Finder comparison tool is available on the Medicare website: www.Medicare.gov.



Eligibility

Beneficiaries with Original Medicare are eligible to enroll in a stand-alone Medicare Prescription Drug Plan if they live in the plan service area and are not incarcerated. Most, but not all, beneficiaries enrolled in Medicare Advantage plans receive their Part D benefit through the plan. Beneficiaries in some types of Medicare Advantage plans without Part D coverage (e.g., certain private fee-for-service plans) may be eligible to enroll in a stand-alone Medicare Prescription Drug Plan. Eligibility is not based on income or health status.

Costs

The following out-of-pocket costs are associated with Medicare Part D:

- \$ **Premium:** The monthly amount a beneficiary pays varies among plans and the type of coverage each plan offers.
- \$ **Deductible:** This is the amount a beneficiary must pay out of pocket before the plan begins to pay. This amount may increase each year. Not all plans require that a deductible must be met before coverage begins.
- \$ **Copayments or Coinsurance:** Plans generally require the beneficiary to share in the cost of medications. Copayments are lowest for generic drugs.
- \$ **Coverage Gap (“donut hole”):** As of 2019, there no longer is a coverage gap, or “donut hole,” for brand-name drugs as a result of changes made by the Affordable Care Act of 2010 and the Bipartisan Budget Act of 2018. A beneficiary’s share of brand-name drug costs will be no more than 25% from the time the annual deductible is met until they reach the catastrophic coverage limit. The donut hole for generic drugs is to close in 2020, when the donut hole is eliminated entirely.
- \$ **Catastrophic Coverage:** Once beneficiaries reach their plan’s out-of-pocket limit, they automatically get “catastrophic coverage,” which means that they only pay a small coinsurance or copayment amount for covered prescription drugs for the rest of the year.





SMP Foundations Training Manual

CHAPTER 3: Medicare Enrollment Basics

Objectives	27
Enrolling in Medicare.....	27
Medicare Cards and Numbers	28
Medicare Statements	30
Medicare Rights and Protections	31

Objectives

This chapter provides additional information about the Medicare program that goes beyond Medicare coverage basics. Upon completion of Chapter 3: Medicare Enrollment Basics, you will be able to explain basic information about Medicare related to enrollment, cards and numbers, statements, and beneficiary rights.

Enrolling in Medicare

Medicare offers several different time frames for enrolling in the various parts of Medicare. Regardless of whether a beneficiary chooses to enroll in Original Medicare or elects a Medicare Advantage plan, enrollment periods are the time frames in which people become Medicare beneficiaries.

Option 1: Enrolling in Original Medicare

Eligible individuals can enroll in Medicare during one of three types of enrollment periods: Initial Enrollment Period, General Enrollment Period, or Special Enrollment Period.

2018 Beneficiary Enrollment

64% in Original Medicare
36% in Medicare Advantage



Automatic Enrollment into Medicare

Beneficiaries who receive Social Security benefits or Railroad Retirement Board benefits are automatically enrolled in Part A and Part B effective the month they turn 65.

Enrollment in Original Medicare (Parts A & B)

Initial Enrollment Period:

Individuals who are approaching their 65th birthday have an Initial Enrollment Period during which they can sign up for Medicare. The Initial Enrollment Period surrounds their 65th birthday.

General Enrollment Period:

Individuals who don't enroll during the Initial Enrollment Period can sign up during a General Enrollment Period, which runs from January 1 to March 31 each year. Coverage is effective July 1.

Special Enrollment Period:

Individuals who continue to work past age 65 and are covered by employer group health plans generally qualify for the Special Enrollment Period.

Option 2: Enrolling in Medicare Advantage and Prescription Drug Plans

Although the default enrollment is to Original Medicare, there are three types of election periods and two types of enrollment periods during which beneficiaries can instead enroll in or disenroll from a Medicare Advantage plan (Part C) or a Medicare Prescription Drug Plan (Part D), as shown in the chart on the next page.

Enrollment in Medicare Advantage (Part C) and Prescription Drug Plans (Part D)

Initial Coverage Election Period (only for Part C): During this period (which typically aligns with the Initial Enrollment Period for Original Medicare, described above), the beneficiary can contact a Part C plan to enroll.	Initial Enrollment Period for Part D: The Initial Enrollment Period usually surrounds their 65th birthday.	Annual Election Period: This period is also commonly known as “Medicare Open Enrollment” and takes place from October 15 to December 7 each year. Coverage is effective January 1.	Special Election Periods: Beneficiaries usually must remain in their Part C or Part D plans until the end of the calendar year. However, in certain situations, they can join, switch, or drop plans during a Special Election Period.	Medicare Advantage Open Enrollment Period: This period runs from January 1 through March 31 each year.
---	--	--	--	--

Where to Get More Information on Medicare and Enrollment

SMPs are not expected to be experts in all aspects of Medicare, since the SMP focus is on fraud, errors, and abuse.

- SMPs and Medicare beneficiaries can contact their local SHIP (State Health Insurance Assistance Program) to get free, personalized health insurance counseling, including help making health care insurance decisions, finding programs for people with limited income and resources, and learning about claims, billing, and appeals.
- Visit www.shiptacenter.org or call 1-877-839-2675 for the contact information for the SHIP in your state.



Medicare Enrollment for Those Under 65

Beneficiaries who are under 65 and on disability become eligible for Medicare in the 25th month of their disability benefit. Anyone with questions on this can contact their SHIP for more details and assistance.

Medicare Cards and Numbers

When individuals are enrolled in Medicare, they get their original red, white, and blue Medicare card in the mail. If they are automatically enrolled, their card is mailed three months before their 65th birthday or their 25th month of getting disability benefits. The Medicare card shows that a beneficiary has Medicare health insurance. It shows whether they have Part A (Hospital Insurance), Part B (Medical Insurance) or both, and it shows the date their coverage starts.



Medicare Advantage Number and Card

Though all Medicare beneficiaries receive a Medicare card from CMS (as described above), beneficiaries in Medicare Advantage plans also receive a health plan identification (ID) card. This card contains a subscriber or member number that differs from the Medicare number. Plan members must use their health plan ID card and number instead of the Medicare card and number for billing purposes.

The health plan member ID card for Medicare Advantage plans must comply with national standards for medical ID cards.

For example, Medicare Advantage health plan ID cards must include:

- ✓ The beneficiary's subscriber or member number with the plan
- ✓ The plan's website address
- ✓ The plan's customer service number
- ✓ The plan's Health Plan Identification Number (HPID), a CMS-issued number that identifies the plan
- ✓ The phrase "Medicare limiting charges apply" (on PPO and PFFS cards only)

Five Things SMPs and Beneficiaries Should Know about Medicare Cards

1. Each card has a Medicare number that's unique to the beneficiary. This number is used for Medicare transactions like billing, eligibility status, and claim status.
2. The original Medicare card is paper, which is easy for many providers to use and copy.
3. Beneficiaries who sign up for a Prescription Drug Plan and/or a Medigap plan will also receive a health ID card for each of these plans.
4. Beneficiaries who are in a Medicare Advantage plan may have up to three Medicare cards: their Medicare Advantage card, their prescription drug card, and the original Medicare card. Their Medicare Advantage plan ID card is their main card for Medicare – they should use it whenever they need care. Beneficiaries who have a Medicare drug plan should use that card as well. Although these beneficiaries also received an original Medicare card, it is not used as long as they're on an MA plan and should be kept in a safe place.
5. Beneficiaries should only give their Medicare number to doctors, pharmacists, other health care providers, their insurers, and people they trust to work with Medicare on their behalf.

If a Medicare beneficiary needs to replace their card because it's damaged or lost, they can sign in to their [MyMedicare.gov](https://www.mymedicare.gov) account to print an official copy of their original Medicare card. Those who don't have an account can create one. To replace a Medicare Advantage, prescription drug coverage, or Medigap plan card, the beneficiary should contact the plan.

If a beneficiary needs to replace their card because they think that someone else is using their number, the beneficiary should call 1-800-Medicare.

If a beneficiary needs to change their name or address with Medicare, they should set up and access their "my Social Security" account online at www.ssa.gov/myaccount, since Medicare uses the name and address on file with Social Security.



What's in a Number?

Until 2018, Medicare numbers contained Social Security numbers. CMS replaced the old numbers with new, random numbers (made up of a combination of 11 numbers and letters) to protect Medicare beneficiaries from identity theft.

The new numbers are officially called Medicare Beneficiary Identifiers (MBIs), but they're more commonly referred to simply as Medicare numbers.

Medicare Statements

Medicare statements outline coverage decisions and payments made on a beneficiary's behalf for Medicare-covered services. Several types of Medicare statements are sent to beneficiaries depending on whether they are enrolled in Original Medicare, a Medicare Advantage plan (Part C), or a Medicare Prescription Drug Plan (Part D).

MSNs

Original Medicare statements are called Medicare Summary Notices, or MSNs.

MSNs are mailed every three months if there is a Medicare claim filed during that time period.

MSN design is standard, since all MSNs come directly from Medicare.

EOBs

Statements from Medicare Advantage plans and Medicare Prescription Drug Plans are called Explanations of Benefits, or EOBs.

Medicare Advantage and Part D plans may send EOBs for each month in which enrollees received benefits.

EOB design varies from plan to plan; however, CMS issues requirements about the type of information EOBs must include.

MSNs and EOBs explain:

- What the health care provider or pharmacy billed for
- The amount approved by Medicare for payment
- How much Medicare paid
- What the beneficiary may be billed for

MSNs and EOBs are statements, not bills. When these statements are received, it is important for beneficiaries to review them immediately and check for mistakes.

The SMP program encourages beneficiaries to keep a personal record of doctor visits and other health care services or equipment they receive in a calendar or Personal Health Care Journal (described in Chapter 1). Each MSN or EOB should be reconciled with the beneficiary's own records, including any bills from providers or suppliers for out-of-pocket costs. Medicare's website www.MyMedicare.gov allows beneficiaries in Original Medicare to view their most recent MSNs, track claims made on their behalf, and check payment status. MyMedicare.gov can serve as a valuable tool in combating fraud, errors, and abuse, since Original Medicare claim information is available online as soon as claims are processed, so beneficiaries won't have to wait to review their claims.



When mistakes or discrepancies are identified, it's important to address them as soon as possible! SMP counselors are trained to help beneficiaries read their statements, and SMP complex interactions specialists are trained to help beneficiaries address mistakes or discrepancies.

SMP program presentations frequently include instructions on how to read MSNs, which can be complicated and difficult for beneficiaries to understand. Many beneficiary questions are related to how to read MSNs and EOBs. Information about how to read MSNs and EOBs is provided in SMP Counselor Training.

State and Local Information #7: Help with MSNs

Will your role at the SMP require you to be familiar with how to read MSNs and explain them to Medicare beneficiaries?

If so, talk with your SMP director or coordinator of volunteers about what additional training will be needed.

State and Local Information #8: SMP Complex Interactions Specialists

Who handles SMP complex interactions at your SMP? Talk with your SMP coordinator of volunteers to find out.

Medicare Rights and Protections

Medicare has policies and procedures in place to ensure that a person's rights as a Medicare beneficiary and health care consumer are protected. For a full list of these rights and an explanation of additional protections, refer to the most current version of the *Medicare & You* handbook, especially the section "Know Your Rights & How to Protect Yourself from Fraud."

Some of the primary rights and protections explained in the *Medicare & You* handbook include:

- **Medicare Questions Answered.** Many basic rights to quality health care and health care coverage are included, such as the right to have questions about Medicare answered. The SMP program is one of the many available services that can help beneficiaries with this particular right.
- **Rights if a Beneficiary's Plan Stops Participating in Medicare.** Medicare Advantage and Prescription Drug Plans can decide not to participate in Medicare for the coming year. If this happens, the plan will send enrollees a letter about their options. Beneficiaries have the right to join another plan or return to Original Medicare.
- **Appeals.** An appeal is the action a person can take if they disagree with a coverage or payment decision made by Original Medicare or a Medicare health or drug plan. The handbook covers details on what qualifies for an appeal and how to file an appeal.
- **Advance Beneficiary Notice of Noncoverage (ABN).** In Original Medicare, a health care provider or supplier may give a person a notice called an "Advance Beneficiary Notice" (ABN). This notice says Medicare probably (or certainly) won't pay for some services in certain situations. It allows the beneficiary to choose whether or not to get the services listed on the ABN. If the person accepts the items or services listed on the ABN, they might have to pay out of pocket. There are specific rules that govern how and when providers use ABNs, further described in the handbook. If a provider was required to issue an ABN but didn't, the beneficiary usually must be reimbursed.
- **Privacy of Personal Information.** By law, Medicare is required to protect the privacy of personal medical information. Medicare is also required to notify beneficiaries how Medicare may use and give out ("disclose") their personal medical information held by Medicare.



Patient Rights

If a patient feels that a provider is discharging them too soon, it is important to get that discharge decision in writing so that they can appeal the decision through the Beneficiary & Family Centered Care Quality Improvement Organization (BFCC-QIO) for their state.

Protections for Low-income Beneficiaries

Additional protections apply for low-income beneficiaries who qualified for Medicaid and/or the Qualified Medicare Beneficiary (QMB) program. Federal law prohibits providers from billing beneficiaries for the Medicare deductibles and coinsurance charges that Medicaid and QMB cover.

- ✓ Report violations to 1-800-Medicare.
- ✓ Medicare payment contractors issue compliance letters.
- ✓ Providers who violate the law repeatedly are subject to fines.

Insurance companies cannot issue Medigap policies to those enrolled in Medicaid and/or a QMB. For more information on applying for Medicaid or a QMB, SMPs and Medicare beneficiaries can contact their local SHIP. Visit www.shiptacenter.org or call 1-877-839-2675 to find contact information for the SHIP in every state.

SMP Counselor Training

See the SMP Counselor Training for more information about the QMB program and other Medicare assistance programs.



LOCAL HELP FOR PEOPLE WITH MEDICARE



SMP Foundations Training Manual

CHAPTER 4: Medicare Fraud, Errors, and Abuse

Objectives	37
Waste in Medicare	37
Medicare Fraud and Abuse	37
Medicare Errors and Other Situations That May Not Be Fraud	39
The Impact of Medicare Fraud, Errors, and Abuse	40
Medicare Trust Fund Losses	40
Consequences to Beneficiaries	41
How SMPs Help	42

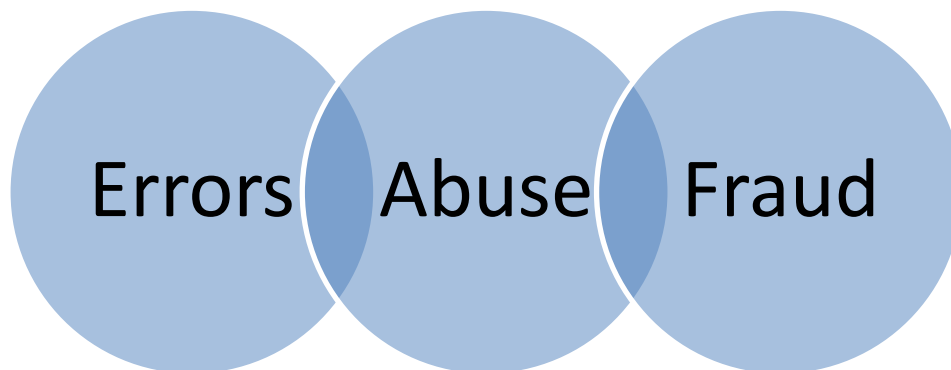
Objectives

This chapter defines and explains the impact of Medicare fraud, errors, and abuse. Upon completion of Chapter 4: Medicare Fraud, Errors, and Abuse, you will be able to:

1. Identify the differences between Medicare fraud, errors, and abuse
2. Describe the impact of Medicare fraud, errors, and abuse to both the Medicare program and Medicare beneficiaries

Waste in Medicare

Waste in the Medicare program involves the entire continuum of fraud, errors, and abuse.



First on the continuum is the possibility of a billing **error**. As explained throughout this manual, Medicare is complex. This complexity lends itself to innocent human errors that, if not caught, create losses to the Medicare program and to beneficiaries' own personal finances.

Next on the continuum is suspected **abuse**. Errors that become institutionally entrenched are one form of abuse in the Medicare program.

At the end of the continuum is Medicare **fraud**. Fraud is intentional and the types of fraud schemes are complex, sometimes even including the involvement of organized crime.

Medicare Fraud and Abuse

The main difference between Medicare fraud and abuse is **intent**. Was the improper behavior intentional and conducted knowingly? Only the authorities will be able to make a final determination, not SMPs. It is still important to know the differences in the definitions of fraud and abuse. Both terms are commonly used. The actions authorities will take depend upon whether they suspect abuse or whether they suspect fraud.

Definition of Abuse

Medicare 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.

Medicare abuse is further defined as incidents or practices by 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. CMS includes in this definition “billing Medicare for services that are not covered or are not correctly coded.”

Definition of Fraud

Fraud assumes “criminal intent.” Medicare fraud is defined as **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.

CMS further defines fraud as “the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true” and that is made “knowing that the deception could result in some unauthorized benefit to himself or herself or some other person.”



Fraud vs. Abuse: Intent is Key

Inappropriate practices that start as abuse can evolve into fraud. A final determination can only be made after an investigation by the authorities.

Common Examples of Suspected Medicare Fraud or Abuse

- Billing for services or supplies that were not provided
- Providing unsolicited supplies to beneficiaries
- Misrepresenting a diagnosis, a beneficiary’s identity, the service provided, or other facts to justify payment
- Prescribing or providing excessive or unnecessary tests and services
- Violating the participating provider agreement with Medicare by refusing to bill Medicare for covered services or items and billing the beneficiary instead
- Offering or receiving a kickback (bribe) in exchange for a beneficiary’s Medicare number



- Requesting Medicare numbers at an educational presentation or in an unsolicited phone call
- *Routinely* waiving coinsurance or deductibles
 - Waivers are only allowed on a case-by-case basis where there is financial hardship, not as an incentive to attract business

See Appendix A for information about how to find examples of current fraud schemes at www.smpresource.org.

State and Local Information #9: Local Examples of Scams

Are there any current examples of scams in your local area? Talk with your SMP coordinator of volunteers to find out.

Medicare Errors and Other Situations That May Not Be Fraud

The majority of health care providers are ethical, striving to provide quality care and to submit proper claims for payment. Billing Medicare for health care services involves following complicated rules and procedures, however, which can lead to human error in the billing process. It is important to not immediately jump to the conclusion of fraud if something doesn't look right on an MSN or EOB.



Because of Medicare's complexity, beneficiaries may have trouble understanding their Medicare statements and bills from providers or they may be suspicious of a charge or service that is actually legitimate. That's why SMPs encourage beneficiaries to contact their providers with questions as a typical first step in addressing suspected fraud, errors, and abuse.

Below are some common examples of suspected errors or misunderstandings:

Beneficiary claims to have not received a service or does not recognize a provider name

- A billing or processing error may have occurred. For example:
 - There may be two beneficiaries with the same name and the charge was assigned to the wrong person.
 - A coding mistake could have occurred, resulting in a charge for a different service than the one actually performed.
- The service could legitimately have been provided by a provider the beneficiary did not see in person or while conscious, such as an independent laboratory, pathologist, anesthesiologist, or radiologist.

High or duplicate charges on a hospital inpatient bill

- Medicare rules may allow for different charges in different settings. The hospital setting is a common example. What may seem like high charges on a hospital bill compared to charges for a similar service in an outpatient setting may actually be legitimate due to Medicare rules.
- Duplicate charges are often a billing or processing error.

Medicare didn't pay for skilled nursing care

- The beneficiary may have entered the hospital as an outpatient under what's called "Observation Status" and was then transferred to a skilled nursing facility without meeting Medicare's requirement for a three-day inpatient hospital admission. Though this is an area of concern for beneficiaries and their advocates, it is not fraud, error, or abuse.

If contacting the provider doesn't clarify whether or not an error occurred or whether the billing practice was consistent with Medicare rules, then Medicare fraud or abuse may be suspected. A pattern of error by a particular provider increases the likelihood of fraud or abuse and is considered a red flag.

The Impact of Medicare Fraud, Errors, and Abuse

Reasons for addressing the problem of waste in Medicare include the economic impact on taxpayers and the solvency of the Medicare Trust Fund as well as the economic and health impacts to individual Medicare beneficiaries who are victims of Medicare fraud, errors, and abuse.

Medicare Trust Fund Losses

Medicare loses billions of dollars each year due to fraud, errors, and abuse. In 2014 testimony before the Senate Special Committee on Aging, the National Health Care Anti-Fraud Association placed these losses at approximately \$60 billion annually, though the exact figure is impossible to measure. The most commonly cited range for all health care fraud estimates is 3 to 10% of annual health care expenditures. 2018 Medicare expenditures were over \$740 billion and are expected to rise as the baby boomer population ages.



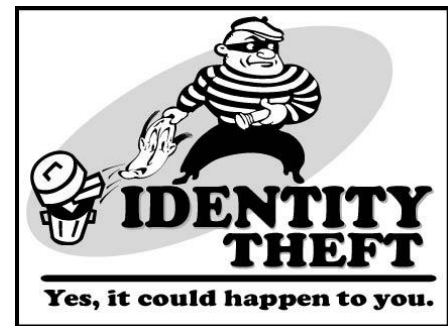
Although the exact amount of Medicare funds lost due to fraud each year is not known, the more the U.S. Department of Health and Human Services spends to prevent and detect fraud the more it finds. What is clear is that the problem exists and efforts to address it through beneficiary and provider education, as well as law enforcement actions, produce results. With legitimate Medicare costs expected to rise, reducing loss due to fraud, errors, and abuse remains vital.

Consequences to Beneficiaries

In addition to harming the Medicare program, Medicare fraud, errors, and abuse can result in serious personal consequences for Medicare beneficiaries, such as medical identity theft, negative health impacts, and personal financial losses.

Medical Identity Theft

Medical identity theft can disrupt a Medicare beneficiary's medical care and waste taxpayer dollars. Medical identity theft occurs when a beneficiary's personal information (such as their name, Social Security number, or Medicare number) is misused or stolen – by a provider, a supplier, or by someone posing as the real beneficiary. Scam artists solicit Medicare numbers because they can be used to submit false claims to Medicare.



When Medicare beneficiaries fall prey to scams aimed at obtaining Medicare numbers, their Medicare number is considered to be “compromised” as a result of medical identity theft. The beneficiary will need to contact their local SMP for assistance! They will also need to contact 1-800-Medicare to report a compromised Medicare number and/or request a new Medicare number. If given a new number, the beneficiary will then need to provide the new number to all of their providers. If the beneficiary's Social Security number is also stolen, the beneficiary will also need to report the issue to local law enforcement and the Federal Trade Commission. SMP complex interactions specialists work directly with beneficiaries to help guide them through this process.

Health Impact

Receiving health care from a fraudulent provider can mean the quality of the care is poor, the intervention is not medically necessary, or, worse, the intervention is actually harmful. A beneficiary may later receive improper medical treatment from legitimate providers as a result of inaccurate medical records that contain:

- False diagnoses
- Records showing treatments that never occurred
- Misinformation about allergies
- Incorrect lab results

Additionally, because of inaccurate or fraudulent claims to Medicare, beneficiaries may be denied needed Medicare benefits. For example, some products and services have limits. If Medicare thinks such products or services were already provided, they will deny payment.

Personal Financial Losses

Medicare fraud, errors, and abuse can all result in higher out-of-pocket costs for beneficiaries, such as copayments for health care services that were never provided, were excessive, or were medically unnecessary. Beneficiaries may also find themselves stuck with bills for services from providers who should have billed Medicare but instead billed them for the entire cost of that service.

How SMPs Help

SMPs play a unique role in the fight against fraud and abuse. SMP volunteers and staff serve as “eyes and ears” in their communities, educating beneficiaries to be the first line of defense against Medicare fraud and abuse.

SMPs educate beneficiaries on how to prevent, detect, and report health care fraud. Prevention and detection efforts include educating beneficiaries, their family members, and caregivers on the importance of protecting personal information, safeguarding Medicare numbers, and reviewing MSNs and EOBs for accuracy. When suspicious behaviors or charges are detected, SMPs educate beneficiaries about how to report their complaints.



Current Scams and Government Action

To find out about scams related to the SMP mission and actions taken by federal agencies to crack down on Medicare fraud, errors and abuse, visit the national SMP website: www.smpresource.org (described in Appendix A).

See the Medicare Fraud > Fraud Schemes page for information about common scams. See the News page for links to news articles related to the SMP mission, including scams and government takedowns.

Beneficiaries have many avenues to choose from when they wish to report potential health care fraud, errors, or abuse: their health care provider, 1-800-Medicare, their private Medicare plan, the OIG Hotline, or the SMP. Many beneficiaries choose to first turn to the SMP program for assistance because the SMP is a trusted and expert source of information about Medicare fraud, errors, and abuse. After all, part of the SMP mission is to report health care fraud, errors, and abuse. When errors are suspected, SMPs guide beneficiaries in the process of correcting them. When fraud or abuse is suspected, SMPs refer complaints to the proper authority; SMPs do not investigate suspected fraud and abuse. That is the role of CMS, the OIG, and law enforcement.

Are You Ready?

Now that you have learned about the SMP program, Medicare basics, and Medicare fraud, errors, and abuse, talk with your SMP director or coordinator of volunteers about additional training that you may need or what you need to do to make sure you are ready to begin your SMP work.





SMP Foundations Training Manual

APPENDICES

Appendix A: SMP Resources at www.smpresource.org	45
Appendix B: Key Terms	47

Appendix A: SMP Resources at www.smpresource.org

Information about the SMP program and Medicare fraud, errors, and abuse is available on the SMP Resource Center's national website: www.smpresource.org.

SMP Resource Center homepage: www.smpresource.org

The website homepage gives information about the SMP program to the general public and SMPs.

- ❑ **Find Help in Your State button:** This button provides SMP contact information for each state and territory.
- ❑ **SMP Resource Center Facebook feed:** This shows recent posts on the Center's national Facebook page: <https://www.facebook.com/SMPNationalResourceCenter/>
- ❑ **News page:** This page is packed with news articles, including fraud schemes.
- ❑ **Contact Us page:** This page provides contact information for the SMP National Resource Center, which operates a toll-free number: (877) 808-2468. The Center connects people to their local SMP program.
- ❑ **Medicare Fraud menu > Fraud Schemes page:** This page links to scams that people encounter and gives health-related resources.
- ❑ **Medicare Fraud menu > FAQs page:** This page provides answers to frequently asked questions. For example, for help with questions about Medicare that aren't related to fraud or abuse, individuals are directed to contact their SHIP (State Health Insurance Assistance Program) by visiting www.shiptacenter.org or by calling 1-877-839-2675.
- ❑ **SMP Login (www.smpresource.org/Login.aspx):** The SMP Login area provides access to the SMP Resource Library and/or TRAX: Training Tracker, depending on each SMP team member's access level.
 - The SMP Resource Library is a searchable database of materials produced by SMPs or for SMPs.
 - TRAX: Training Tracker is the training tracking system for the SMP network. It allows SMPs to take, assign, and track training and assessments.

State and Local Information #10: SMP Website

Does your SMP also have a website? Click the "Find Help in Your State" button to find out!



News

See the News page for links to news articles related to the SMP mission, including scams and government takedowns.

See the Fraud Schemes page for information about common scams.

State and Local Information #11: The SMP Resource Library and TRAX: Training Tracker

Will you have access to the SMP Resource Library and/or TRAX: Training Tracker? Ask your SMP director or coordinator of volunteers. If you have access to the library, you can search for resources yourself. If you only have access to TRAX, someone at your SMP will need to assign resources to you.

Resources for SMPs at www.smpresource.org

The Resources for SMPs section of the website, which is accessed by clicking the “Resources for SMPs” button on the homepage, provides information intended primarily for SMPs.

- **Center Publications page:** This page includes information about how to access the SMP Resource Center’s national Facebook page and sign up for national newsletters related to SMP.
- **OIG Report page:** This page provides information about performance measures and the OIG as well as access to the annual SMP OIG Report.
- **SMP Information and Reporting System (SIRS) page:** This page provides information about how to access the SMP data system and related resources.
- **Training:** This page provides resource lists for SMP team members to help look for key resources in the SMP Resource Library based on specific topics.
 - **Tip:** If you have access to the SMP Resource Library, see the Getting Started with SMP Resource List for suggested resources in the library.

State and Local Information #12: SIRS

Will you enter your own data in the SMP Information and Reporting System (SIRS) or will someone at your SMP enter your data for you? Ask your SMP director or coordinator of volunteers.

Appendix B: Key Terms

This appendix is both a glossary and an index of key terms for SMPs. It provides definitions and lists page numbers within this manual for more information about each term.

Abuse: Medicare 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..... 37, 38

Advance Beneficiary Notice of Noncoverage (ABN): This notice is given to a beneficiary by a provider when Medicare probably (or certainly) won't pay for some services in certain situations. It allows the beneficiary to choose whether or not to get the services listed on the ABN..... 32

Annual Election Period: Used to enroll in Medicare Advantage and Prescription Drug Plans. This period is also commonly known as "Medicare Open Enrollment" and takes place from October 15 to December 7 each year..... 27, 28

Appeal: The action a person can take if they disagree with a coverage or payment decision made by Original Medicare or a Medicare health or drug plan..... 32

Assignment: The provider or supplier agrees to accept the Medicare-approved amount as full payment for covered services..... 17

Detect: SMPs teach beneficiaries, their family members, and their caregivers to detect potential problems..... 4, 5

Donut Hole: See Part D Costs - Coverage Gap

Explanation of Benefits (EOB): Mailed each month in which enrollees of a Medicare Advantage and/or Medicare Prescription Drug Plan received benefits. The EOB design and mailing schedule vary from plan to plan... 4, 5, 30, 31, 39

Fraud: Fraud assumes "criminal intent." Medicare fraud is defined as **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..... 37, 38

General Enrollment Period: Used for enrollment in Original Medicare. Individuals who don't enroll in Medicare during the Initial Enrollment Period can sign up during a General Enrollment Period, which runs from January 1 to March 31 each year. .. 27

Health Care Fraud and Abuse Control (HCFAC) Program: Provides funding to administer the SMP programs, maintain a national SMP data reporting system, and provides supportive services to SMPs nationally. 6

Health Impact: Because of inaccurate or fraudulent claims to Medicare due to medical identity theft, beneficiaries may be denied needed Medicare benefits, receive improper medical treatment, or have inaccurate medical records..... 41

Health Plan Identification Card: See Medicare Advantage Card

Initial Coverage Election Period: Used to enroll in Medicare Advantage plans. During this period, the beneficiary can contact a Part C plan to enroll. 27, 28

Initial Enrollment Period for Part D: Used to enroll in Medicare Prescription Drug Plans. During this period, the beneficiary can contact a Part D plan to enroll. It includes the three months before, the month of, and the three months after their birthday. 28

Initial Enrollment Period: Used for enrollment in Original Medicare. Individuals who are approaching their 65th birthday have an Initial Enrollment Period during which they can sign up for Medicare. The Initial Enrollment Period surrounds their 65th birthday. 27

Medical Identity Theft: Occurs when a beneficiary's personal information (such as their name, Social Security number, or Medicare number) is misused or stolen – by a provider, a supplier, or someone posing as the real beneficiary. Scam artists solicit Medicare numbers because they can be used to submit false claims to Medicare. 41

Medicare & You Handbook: The Centers for Medicare & Medicaid Services (CMS) provides information about the SMP program in the *Medicare & You* handbook. This official U.S. government handbook is provided to Medicare beneficiaries by CMS each year and is available online at www.Medicare.gov. 9, 21, 31

Medicare Advantage Card: This card contains a subscriber or member number that differs from the Medicare number. Plan members must use their health plan ID cards and numbers instead of Medicare cards and numbers for billing purposes. 3, 29

Medicare Advantage Open Enrollment Period (MA OEP): Used by those already enrolled in a Medicare Advantage plan to enroll in Medicare Advantage and Prescription Drug Plans. This period runs from January 1 through March 31 each year. Beneficiaries must be in an MA plan on January 1 to use the MA OEP. 27, 28

Medicare Card: Red, white, and blue card that shows that a beneficiary has Medicare health insurance. It shows whether they have Part A, Part B, or both, and it shows the date their coverage starts. 3, 28, 29, 30

Medicare Eligibility: There are certain requirements a person must meet to be eligible for Medicare. 13

Medicare Number: The number is made up of a combination of 11 numbers and letters. It is officially called a Medicare Beneficiary Identifier (MBI) but is more commonly referred to simply as a Medicare number. 3, 28, 29, 30, 38, 41, 42

Medicare Open Enrollment: See Annual Election Period. 28

Medicare Statement: Outlines payments made on a beneficiary's behalf for Medicare-covered services. See *also* Medicare Summary Notice (MSN) or Explanation of Benefits (EOB). 30, 31, 39

Medicare Summary Notice (MSN): Mailed every three months to

beneficiaries on Original Medicare. It outlines payments made on a beneficiary's behalf for Medicare-covered services..... 4, 5, 8, 30, 31, 39

Medigap: Medicare Supplement Insurance policies sold by private insurance companies that are designed to fill Original Medicare's cost-sharing gaps by helping to pay the coinsurance, copayments, and Part B excess charges. 14, 17, 18, 19, 33

OIG Report: The Office of Inspector General (OIG) annual report of SMP performance outcomes in three major areas - team member time and effort, outreach and education activities, and complaints of suspected health care fraud, errors, or abuse. 7, 46

Original Medicare: Medicare Part A and Part B together provide hospital and medical insurance coverage. ... 14, 15, 18, 19, 21, 22, 27

Part A – Hospital Insurance: Part A provides coverage for the following health care benefits: inpatient hospital care, skilled nursing facility (SNF) care, home health care, and hospice care..... 14, 15

Part A Costs – Home Health Care: No deductibles or coinsurance charges apply. 16

Part A Costs – Hospice Care: No deductibles apply. No coinsurance charges apply, except to inpatient respite services and medications. A 5% coinsurance charge applies for some palliative medications, not to exceed \$5 per prescription. 16

Part A Costs – Inpatient Hospital Stays: Beneficiaries owe an inpatient hospital deductible at the start of each benefit period. The benefit period

typically starts with a new hospital admission and ends when they haven't received any inpatient hospital (or skilled care in a SNF) for 60 days in a row. Benefit periods are not tied to a calendar year timeframe. Deductibles apply at the start of the benefit period. Daily coinsurance charges may apply for some stays. 16

Part A Costs – Skilled Nursing Facility Stays: Days one to 20 are free. Days 21 to 100 have a daily coinsurance charge. 16

Part B – Medical Insurance: Part B provides health care benefits that help cover the following products and services - physician services, durable medical equipment, home health care, X-rays, lab services, outpatient hospital services, and mental health services. 14, 15, 16, 17

Part B Costs – Coinsurance: After meeting the deductible, in most cases Medicare Part B pays 80% of the Medicare-approved amount. The beneficiary is responsible for 20% of the Medicare-approved amount. Coinsurance is the term most often used to describe beneficiary cost-sharing in Original Medicare. 17

Part B Costs – Copayment: This is the amount they may have to pay as their share of the cost for services, after any deductibles. It generally refers to a fixed dollar amount. 17

Part B Costs – Deductible: A yearly fixed amount beneficiaries owe before Original Medicare, their Prescription Drug Plan, or other insurance begins to pay. Original Medicare has separate deductibles for Parts A and B. This amount is adjusted annually in line with Medicare spending increases. 17

Part B Costs – Excess Charges:

Beneficiaries may incur excess charges over and above Medicare's approved amount for services if they choose a non-participating provider who does not accept "assignment" in all cases..... 17

Part B Costs – Premium: A

beneficiary's periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. The payment is usually taken out of the monthly Social Security, Railroad Retirement, or federal Civil Service retirement check sent to a beneficiary. If a beneficiary does not receive any of these monthly payments, a bill is sent every three months. 17

Part B Costs – Private Pay

Agreements: A small number of providers choose not to enroll in Medicare at all – they opt out. These providers cannot file a claim with or receive any payment from Medicare, except for emergencies. Providers who opt out of Medicare must ask their patients to sign a private pay agreement, which explains that beneficiaries must pay the full cost of the services themselves. 17

Part C – Medicare Advantage: An alternative to Original Medicare when elected by a Medicare beneficiary. Medicare Advantage plans are offered by private insurance companies that sign a contract with Medicare. Medicare Advantage plans must provide all Medicare Part A and Part B benefits to plan members. Many offer benefits that Original Medicare doesn't cover, such as routine hearing, vision, and dental care and nonambulance medical transportation services. Most Medicare Advantage

plans also include Medicare Part D prescription drug coverage. 14, 19, 20, 21, 27, 29

Part D – Prescription Coverage: CMS contracts with private companies to offer Medicare Prescription Drug Plans to people with Medicare. 14, 22, 23

Part D Costs – Catastrophic

Coverage: Once beneficiaries reach their plan's out-of-pocket limit, they automatically get "catastrophic coverage," which means that they only pay a small coinsurance or copayment amount for covered prescription drugs for the rest of the year..... 23

Part D Costs – Coinsurance: Plans generally require the beneficiary to share in the cost of each medication. Coinsurance is a percentage of the cost. 23

Part D Costs – Copayments: Plans generally require the beneficiary to share in the monthly cost of medications. Copayment is a fixed amount of the cost. Copayments are lowest for generic drugs..... 23

Part D Costs – Coverage Gap: As of 2019, there no longer is a coverage gap, or 23

Part D Costs – Deductible: The amount a beneficiary must pay out of pocket before the plan begins to pay. This amount may increase each year. Not all plans require that a deductible be met before coverage begins. 23

Part D Costs – Premium: The monthly amount a beneficiary pays varies among plans and the type of coverage each plan offers. 23

Personal Financial Losses: Medicare fraud, errors, and abuse can all result

in higher out-of-pocket costs for beneficiaries, such as copayments for health care services that were never provided, were excessive, or were medically unnecessary. Beneficiaries may also find themselves stuck with bills for services from providers who should have billed Medicare but instead billed the beneficiary for the entire cost of that service..... 42

Personal Health Care Journal (PHCJ) :

A guide to help Medicare beneficiaries, their caregivers, and family members document important information about a beneficiary's doctor visits, medical diagnoses, equipment received, and more. ... 4, 5, 31

Prevent: SMPs prevent health care fraud through education..... 3, 4

Report: When Medicare beneficiaries are unable to act on their own behalf to address suspected Medicare fraud, errors, or abuse, the SMPs work with them, their family, caregivers, and others to address the problems and, if necessary, make referrals to outside organizations to intervene..... 5

Senior Medicare Patrol (SMP): Grant-funded projects of the federal U.S. Department of Health and Human Services (DHHS), U.S. Administration for Community Living (ACL)..... 6, 7

SMP Mission: Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. 3, 8, 42

SMP Volunteer Roles: There are six types of activities most commonly conducted by SMP volunteers nationwide: administrative support, information distributor, exhibitor, presenter, counselor, and complex interactions specialist..... 8, 9

Special Election Periods : Used to enroll in Medicare Advantage and Prescription Drug Plans. Beneficiaries usually must remain in their Part C and Part D plans until the end of the calendar year. However, in certain situations, they can join, switch, or drop plans during a Special Election Period. 27, 28

Special Enrollment Period: Used for enrollment in Original Medicare. Individuals who continue to work past age 65 and are covered by employer-provided group health plans generally qualify for the Special Enrollment Period. 27

State Health Insurance Assistance

Program (SHIP): Grant funded projects of the federal U.S. Department of Health and Human Services (DHHS), U.S. Administration for Community Living (ACL) that provide local, in-depth, and objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers. . 9, 18, 28, 33

Traditional Medicare: See Original Medicare.

Waste: In the Medicare program, waste involves the entire continuum of fraud, errors, and abuse..... 37

