Alleviating Confusion and Preventing Fraud in the Medicare Part D Program

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INTRODUCTION

ow that the Medicare Part D program has begun, attention is being focused on maintaining the integrity of this complex program. Because the Medicare Modernization Act (MMA) of 2003 represents the largest expansion of Medicare since the program’s inception approximately 40 years ago, it is inevitable that not everyone involved with Medicare Part D will have a positive experience adapting to the changes.

The Centers for Medicare and Medicaid Services (CMS) and the public are now primarily concerned about how Medicare beneficiaries will select a Prescription Drug Plan (PDP) while coping with ambiguous or incorrect information and about the possibility of fraud involving Medicare Part D.

CONFUSION OVER PLAN ENROLLMENT

Medicare beneficiaries have stated that their confusion is largely the result of a seemingly limitless number of plan options, each with variations regarding not only premiums but also formulary designs, services, and pharmacy networks. Beneficiaries have, on average, 40 different prescription plans to consider, and comparing these plans is not a simple task.

Even though competition is intended to improve choices and to allow beneficiaries to select a plan that best meets their individual needs, this ability to choose appropriately is dependent on a knowledgeable consumer. Unfortunately, most Americans—particularly older people with some level of dementia—will be unable to make the necessary evaluation without assistance.

Those health care providers who are most ready and able to assist older patients are confused about the extent of involvement that the CMS will allow. The CMS marketing guidelines have caused confusion among health care providers because they seem to imply that these clinicians should not be steering patients to a specific plan. As a result, health care providers are under the impression that the only role they may play is to direct their patients to the CMS (OIG).2 The survey found that most beneficiaries relied on news media or direct mail for information; only 20% of them contacted an information source directly. It was concluded that promotion of Medicare Part D should make more use of the media and the mail.

Despite these deficiencies, the focus thus far has been on the Medicare Web site and a toll-free call-in telephone line. A test by the Government Accountability Office (GAO) on the accuracy of Medicare’s toll-free hotline found that 29% of callers obtained inaccurate answers and 10% received no answer at all.3 Although the goal of the CMS is to bring about continued improvement and increased participation in the program, it may actually have a limited effect, because more than 75% of beneficiaries have never gone online and only 8% have ever used the toll-free phone number.

FRAUD

Unfortunately, Medicare beneficiaries and the PDPs that serve them are not the only ones who might be benefiting from the $740 billion expansion of the Medicare program. Medicare fraud involves cheating either the federal government or the beneficiaries. Perhaps the worst form of fraud affects these frail elders, who can hardly afford to be cheated. This dishonesty is appearing in the form of identity theft, selling products that people do not need, or changing the product after people have selected the plan. The manner in which the CMS chose to implement the Medicare Part D program is partly to blame for the relative ease with which the unscrupulous can cheat senior citizens.

Identity Theft

By far, the largest number of complaints to the federal government has involved seniors who have become victims of identity theft, according to the Federal Trade Commission.
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(FTC). Historically, telemarketing scams have been a major problem, resulting in a cost of more than $40 billion per year; these scams most often affect those over the age of 65. The incidence of identity theft may become even more prevalent as a result of the CMS’s desire to make marketing of the Medicare PDP program by health plans as open as possible. To that end, the CMS is allowing telemarketers to contact Medicare beneficiaries at home from 8 a.m. to 9 p.m.

This approach may only serve to confuse people and is likely to lead to the unintended consequence of opening the door for new telemarketing scams involving identity theft. The beneficiaries may be encouraged to reveal personal information over the phone, and they will undoubtedly have difficulty distinguishing authentic telemarketers from scammers.

Beneficiaries can eliminate these calls if they add their phone number to the FTC’s “Do Not Call” registry (888-382-1222); they can also do so electronically by using the Web site www.donotcall.gov.

Although telemarketing “cold calls” are permitted, CMS marketing guidelines prohibit Medicare Advantage plans, PDPs, or their representatives from making door-to-door sales calls or sending unsolicited mail. Therefore, beneficiaries should be instructed that most, if not all, of the mail they receive regarding the Medicare PDP coverage is probably of some value.

Identity theft is especially easy with Medicare recipients because a person’s Medicare number and Social Security number are the same. Instead of providing personal information over the telephone, Medicare beneficiaries should give information only to the CMS or to representatives whose identity they can verify. The CMS has enlisted the help of law enforcement officials to investigate two possible scams in which Medicare beneficiaries were asked for their bank card numbers and other personal information.

PHARMACEUTICAL MARKETING STRATEGY

Now that the federal government is paying a significant portion of prescription drug expenses for the elderly, it is considered fraudulent for pharmaceutical companies to use incentives to encourage the use of expensive branded products. Attention is being focused on pharmaceutical patient assistance programs (PAPs) and pharmacy rebates.

Patient Assistance Programs

Recently, the OIG issued a Special Advisory Bulletin. The message informed drug manufacturers that the OIG had determined that allowing the companies’ PAPs to subsidize a patient’s cost-sharing for their prescription drugs could violate the federal anti-kickback statute. As a result of the OIG’s concern about fraud, PAPs will need to be eliminated or reconfigured to be in compliance with the statute.

Rebates

Another potential type of fraud involves rebates from pharmaceutical companies to pharmacy providers, especially long-term-care pharmacy providers. The CMS has stated that when a long-term-care pharmacy that is part of a Part D plan’s network continues to receive access or performance rebates from a manufacturer for drugs dispensed under Part D, these benefits must go to the Medicare beneficiaries who purchase those drugs.

The basis of this concern is the extent to which a long-term-care pharmacy is being paid by a manufacturer to move market share in the context of a Part D plan without the knowledge or approval of a plan. Such a situation raises the same concerns about increased program and beneficiary costs; if a manufacturer is paying price concessions to long-term-care pharmacies in exchange for formulary access or moving market share, these pharmacies may be inducing a demand for higher-tiered or nonformulary drugs, thus actually increasing the costs to the plan and the government.

The CMS believes that the clear intent of Congress, as demonstrated in the framework of the MMA provisions, is that the benefits of discounts, rebates, and other price concessions on covered Part D drugs provided by Part D plans should accrue to beneficiaries. When discounts, rebates, or other price concessions related to Part D drugs purchased for enrolled beneficiaries are diverted to entities other than Part D plans, the costs to the Medicare Trust Fund and to Medicare beneficiaries are increased.

Given that Medicare will pay nearly 100% of the costs of the drug benefit for institutionalized individuals, the CMS believes that only one policy is consistent with the MMA’s position on long-term-care pharmacies that are part of a Part D plan’s network—that rebates or other price concessions paid based on covered Part D drugs purchased with these dollars should accrue to the government. This philosophy could easily evolve to influence the CMS’s position on direct-to-consumer advertising and product sampling.

BILLING MEDICARE

Fraud may also occur when health care providers and suppliers bill Medicare for services that were never provided or received. Under Medicare Part D, PDPs receive 80% reinsurance for individual beneficiaries who spend more than $3,600 out of pocket; this is the point at which a beneficiary has received more than $5,100 in total medications. This has created a situation in which Medicare Advantage plans benefit financially from shifting coverage of medications from Medicare Part B to Medicare Part D. Although some of this maneuvering is legal, there is a concern that companies might shift expenses or might document claims that are not legitimate. In such an event, the federal government would be paying for products and services that were never purchased.

Of course, this type of fraud is not new. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which authorized the start of the Medicare Integrity Program, the government was able to collect nearly a half-billion dollars in connection with health care fraud cases in the program’s first year. Most of this initial focus involved billing fraud.

PREVENTING FRAUD

Responsibility for fraud prevention belongs to everyone, especially health care professionals who care for the frail elderly. These professionals are the first people to whom their older patients turn for advice. For this reason, health care providers need to recognize fraud and should advise their patients appropriately.

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Besides answering their patients’ questions about fraud, these professionals can play a major role in educating older patients so that they do not become victims. Education should consist of taking steps to prevent identity theft and encouraging patients to join a plan that provides access to needed medications. The CMS can also work to reduce the level of confusion surrounding the number and variety of PDP designs.

In 1999, Medicare launched a major campaign to combat fraud under the banner “Who Pays? You Pay.” Medicare offered classroom training to 10,000 of its beneficiaries and volunteers from the American Association of Retired Persons (AARP). The sessions were intended to show them how to question their health care bills in order to reduce unnecessary spending, for example, making sure that they received the services or products that were paid for, and that the doctor ordered, and determining whether the products or services were appropriate for their diagnosis and treatment.

Even before that program was unveiled, the Clinton administration had focused unprecedented attention on the fight against fraud, abuse, and waste in a Medicare program called “Operation Restore Trust,” also known as the Senior Medicare Control Project. This model has been successful in recovering funds. Regional centers in various communities provide outreach opportunities for citizens to learn more about Medicare and Medicaid programs.

Today, the MMA plans to accomplish fraud prevention by having the CMS work with eight new Medicare Drug Integrity Contractors (MEDICs) that possess specialized skills enabling them to detect fraud, waste, and abuse in the new PDP program. The eight MEDICs include the Delmarva Foundation; Electronic Data Systems, Inc. (EDS); IntegriGuard; Livanta; Maximus Federal Services; NDCHealth; Perot Systems Government Services; and Science Applications International Corporation. Their responsibilities are as follows:

• analyzing claims data to discover areas in which fraud or abuse could be occurring
• investigating potential fraudulent activities involving enrollment, eligibility determination, or distribution of the prescription drug benefit
• scrutinizing unusual activities that might be considered fraudulent, as reported by the CMS, contractors, or Medicare beneficiaries
• conducting investigations about complaints of fraud
• referring cases to the appropriate law enforcement agency as needed

In addition to using MEDICs to investigate fraud, the CMS has recommended these precautions for Medicare beneficiaries to avoid scams:

• not giving personal information to PDP marketing representatives.
• adding their phone numbers to the Do Not Call registry.
• arranging for their Medicare Part D premiums to be deducted directly from their Social Security checks. By doing this, they do not have to write a personal bank account check, use a credit card, or reveal personal financial information to a third party, and they can easily keep track of their monthly premium payments.
• contacting the CMS by calling 1-800-Medicare if they suspect a problem.

CONCLUSION

The strategies outlined in this article are meant to protect elderly patients against fraud and to help them make more informed decisions. Without question, health care professionals will play a major role in this process; otherwise, they will find it necessary to deal with procedural difficulties as the federal government works to improve the integrity of this complex program.

REFERENCES