Coordination of Benefits

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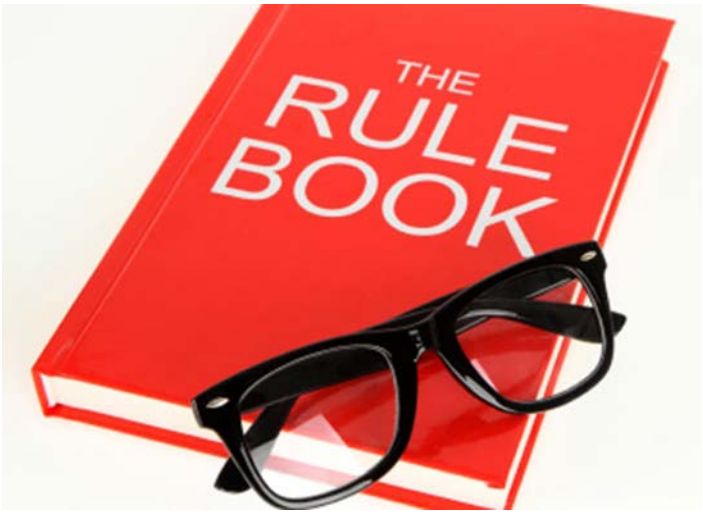
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Presentation Overview

- Overview of Part D COB Requirements
- Common Questions and Concerns
  - Explanation of Benefits (EOB) Requirement
  - Order of Payment Rules

Part D Coordination of Benefits (COB) Requirements



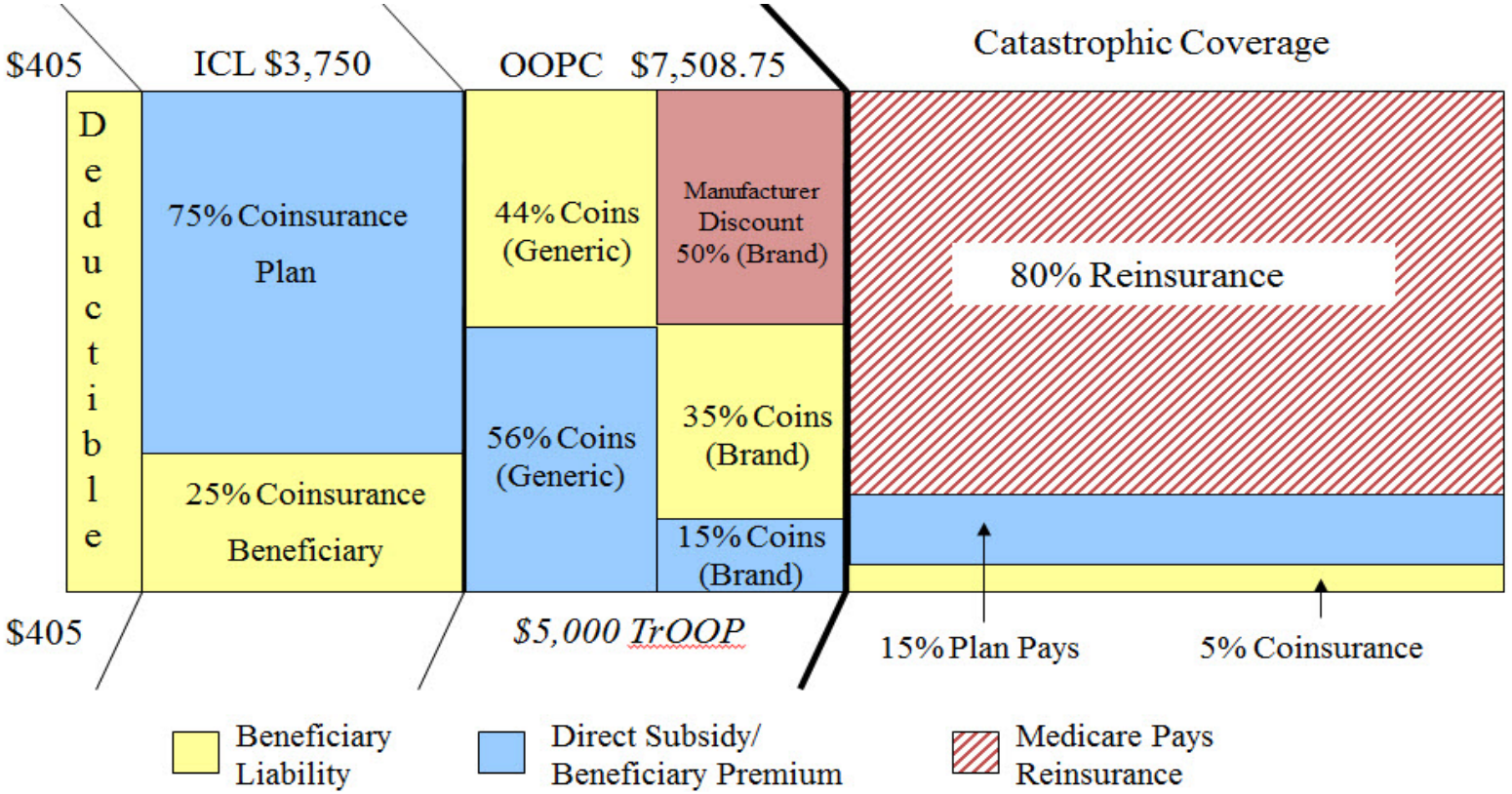
All Part D plans, including PACE Organizations are required to coordinate with other payers of prescription drug coverage.

1860D-24(a) of the Social Security Act

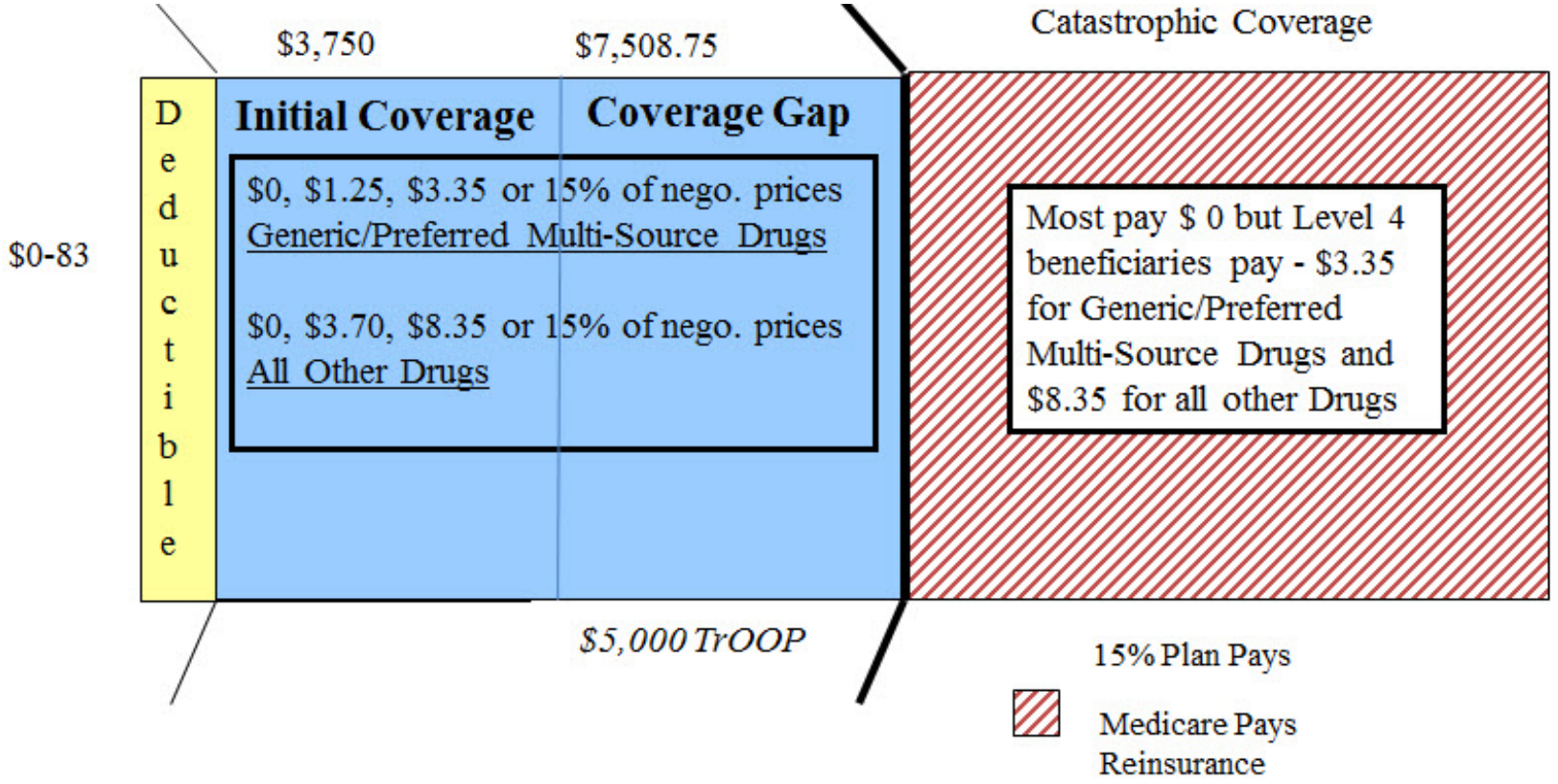
Requirements Include…

- Sponsors must transfer TrOOP (True out-of-Pocket) and gross covered drug cost balances whenever a beneficiary changes Part D sponsors during the coverage year.
  - This data is required for the new sponsor to correctly position the beneficiary in the benefit.
  - Therefore, PACE Organizations need to make sure that TrOOP from their plans or if prior plans do not use ATBT gross covered drug costs are conveyed to beneficiaries leaving their organizations.

Standard Benefit 2018



2018 Low Income Subsidy Beneficiary Coinsurance (Non Pace)



Part D Requirements – Retroactivity

50.15.3 – Retroactive Claims Adjustments and Resolution Directly with Other Payers

"Compliance with COB requirements includes not only coordinating benefits with other payers at the Point of Sale (POS), but also the need to work with beneficiaries and other payers to resolve post-adjudicative payment issues arising from retroactive claims changes."

PACE organizations may encounter retroactive adjustments of claims from non-PACE plans.

COB Timeframes (42 CFR 423.466)

- Retroactive Adjustments
  - Sponsors are required to make retroactive claims adjustments and issue refunds or recovery notices within 45 days of the sponsor's receipt of complete information regarding claims adjustment.
- COB Time Limit
  - Sponsors are required to coordinate benefits with other entities providing drug coverage, and non-network payers (such as beneficiaries and others paying on the beneficiaries' behalf) for a period not to exceed 36 months from the date of fill for a covered Part D drug.

Which Payments Count Towards TrOOP

Payments for covered prescription drugs paid for by:

TrOOP eligible:

- Beneficiary, family, friends
- SPAPs/ADAPs
- Medicare Extra Help (LIS)-Subsidy paid in addition to beneficiary copay
- Indian Health services
- Most charities
- Manufacturer payments under Coverage Gap Discount Program
- Beneficiary payments from HSAs, FSAs, MSAs

Non-TrOOP eligible:

- What Part D plan pays
- Premiums
- Drugs purchased abroad
- Over the counter drugs
- Payments reimbursed by other insurance companies

Basic TrOOP Requirements for Pace Organizations (POs)

- When a beneficiary enters a PACE plan, the plan receives the TrOOP
  - Through Automated TrOOP balance transfer (ATBT) or
  - From a beneficiary notice from a PO that doesn't participate in the automated TrOOP balance process.
- When a beneficiary leaves PACE, TrOOP must be calculated.
  - Supplemental payments
  - Costs for beneficiary before entering PO

Basic TrOOP Requirements for Pace Organizations (POs) (cont.)

- Report values to beneficiary and new Part D plan (ATBT) preferred method
- Non-qualified supplemental payments must reduce TrOOP
- If supplemental payer has paid part of the copay (such as SPAP/ADAP) and the copay amount changes retroactively (due to LICS level change), the PACE must reimburse the supplemental payer.

Explanation of Benefits (EOB)

- Part D plans must distribute EOBs to beneficiaries who have used their Part D benefits in the past month.
- PACE plans are exempt from that requirement.
- However, PACE must still communicate utilization to beneficiaries.

Communicating PACE Information to Beneficiaries leaving PACE

- “Participant Notice of Benefit Information for Your New Medicare Prescription Drug (Part D) Plan”
- Provide letter to the beneficiary and the new plan within 7 days of the date of the TRR notifying the PACE organization of the member’s disenrollment

What is Medicare Secondary Payer (MSP)?

- MSP rules prohibit Medicare plans, including POs from making payment if a payer is primary.
- Protects the Medicare plan if payment can reasonably be expected from another source.
- Includes group health plans, workers' compensation liability insurance, or no-fault insurance.

Order of Payment
Payers that are Primary to Part D

- Employer Group Health Plan including Federal Health Benefit Plans (FEHBP)
- Auto insurance (no fault), Liability, Workers' Compensation, Black Lung
- CMS approved Patient Assistance Programs (PAP) that submit eligibility to CMS

If the Payer is…

- Employer Group Health Plan including Federal Health Benefit Plans (FEHBP) – the PACE program should not pay unless they know the claim has been submitted to the primary payer first.
- Auto insurance (no fault), Liability, Workers Compensation, Black Lung, and PAP – the PACE must determine what drugs are covered under these programs and must not pay as primary for those drugs.

Order of Payment
Payers Supplementary to Part D

- Commercial Supplemental Insurance
- Health Reimbursement Accounts
- State Pharmaceutical Assistance Programs (SPAPs)
- AIDS Drug Assistance Programs (ADAPs)
- Charities

Order of Payment
Mutually Exclusive to Part D

- Drug covered under other Medicare programs such as Medicare A or B.
- Medicaid
- Veteran's Administration (VA) except if part of the PACE/VA waiver plan

Polling Question

True or False

PACE Organizations are exempt from COB Requirements.

Benefit Coordination and Recovery Center (BCRC)

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Presentation Overview

- Medicare Secondary Payer Background
- MSP and PACE
- MSP Operations and Role of BCRC

Medicare Secondary Payer

- Medicare Secondary Payer (MSP) is the term used when the Medicare program does not have primary payment responsibility – that is, when another entity has the responsibility for paying before Medicare.

MSP Laws

- Medicare statute and regulations require that all entities that bill Medicare for items or services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those items or services.
- Section 1862(b) of the Social Security Act.
- Title 42 CFR Part 411.

MSP Laws for Part C and D

- Section 1860D–2(a)(4) of the MMA extends the MSP procedures applicable to Medicare Advantage organizations, under Section 1852(a)(4) of the Act and 42 CFR § 422.108, to Part D sponsors and their provision of qualified prescription drug coverage.
- In other words, the MSP rules are the same for traditional Parts A & B fee-for-service Medicare as it is for Medicare Advantage and Part D.

MSP and Group Health Plans (GHPs)

- Different rules based on reasons for Entitlement
  1. Entitlement Based on Age.
  2. Entitlement Based on Disability.
  3. Entitlement Based on End Stage Renal Disease.

- Rules for dual reasons for entitlement as well.

MSP and Non-GHPs

- Medicare is secondary to Liability Insurance, including Self-insurance.
- Medicare is secondary to Workers' Compensation.
- Medicare is secondary to No-Fault Insurance.

Non-GHPs

- Keep in mind that, especially in the case of Liability Insurance, there is often a dispute regarding responsibility for medicals.
- If there is a dispute, Medicare will make a conditional payment.
- Medicare will continue to pay until a settlement, judgment, award or other payment is made that has the effect of releasing medicals.
- Medicare will then seek recovery of its conditional payment.

MSP Applies to PACE

- Medicare does not pay for PACE services to the extent that Medicare is not the primary payer under the MSP Statute.
- PACE organizations play a role in coordinating benefits with other payers.

MSP and Coordination of Benefits

- The Medicare Secondary Payer (MSP) program is in place to ensure that Medicare is aware of situations where it should not be the primary, or first, payer of claims.
- If a beneficiary has Medicare and other health insurance, Coordination of Benefits (COB) rules decide which entity pays first.
- All entities connected to Medicare COB, such as employers, beneficiaries, insurers and providers, have a legal requirement to properly coordinate benefits under MSP.

PACE Obligations Under MSP

- PACE organizations have the same obligations as any other entity to properly coordinate benefits with other payers.
- The PACE organization is required to do the following:
  1. Identify payers that are primary to Medicare under Part 411;
  2. Determine the amounts payable by those payers;
  3. Coordinate benefits to Medicare participants with the benefits of primary payers.

  [42 CFR § 460.180(d)(2)]

MSP Operations

- To properly facilitate COB, there are a variety of methods and programs used to identify situations in which Medicare beneficiaries have other insurance that is primary to Medicare.
- Activities related to the collection, management, and reporting of other insurance coverage for beneficiaries is performed by the Benefits Coordination & Recovery Center (BCRC).

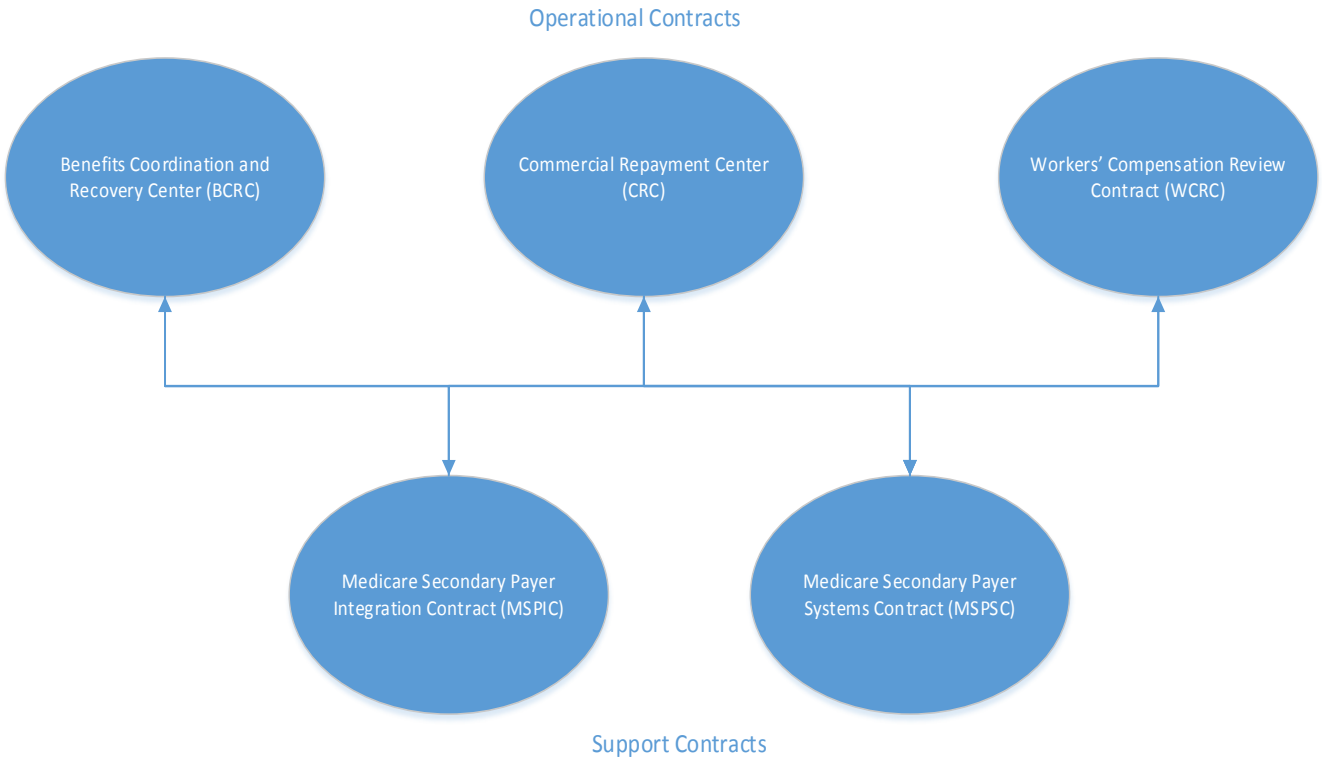
The BCRC Charge

- The BCRC consolidates the activities that support the collection, management, and reporting of other insurance coverage for beneficiaries.
- The BCRC takes actions to identify the health benefits available to a beneficiary to help Medicare coordinate the payment process to prevent mistaken payment of Medicare benefits.

Roles of BCRC

- MSP identification (Section 111 Mandatory Insurer Reporting, Self-Reports, Data Sharing Agreements.
- MSP Recovery for NGHP settlements where beneficiary is the debtor ($530.7M in FY2016).
- Coordination of Benefit Agreement (COBA) claims crossover operations.
- Part D Primary/Supplemental other health insurance identification.

BCRC is 1 of 5 Coordination of Benefits & Recovery Contractors



The CMS Records Gatekeeper

- BCRC is the primary point of contact to where all records of other beneficiary coverage are reported.
- All records of other coverage that appear in the Medicare Beneficiary Database (MBD) and the Medicare Common Working File (CWF) are initially processed, edited and uploaded by the BCRC from a variety of other sources.
- Important to remember that MBD and CWF run their own edits and processing before records are officially posted on CMS' Systems of Record.
- There are many times where reported information fails edits at either the BCRC or MBD and CWF, and the record is not posted.
- Finally, records can be overlaid by data from other sources.

What the BCRC Does

1. Initiates an investigation when it learns that a person has other insurance.
2. The investigation determines whether Medicare or the other insurance has primary responsibility for meeting the beneficiary's health care costs.

What the BCRC Does (cont.)

3. Collects information on employer group health plan coverage and liability insurance (including self-insurance), no-fault insurance and workers' compensation, and updates this information on Medicare databases every time a change is made to insurance coverage.
4. Information comes from these sources: beneficiary, doctor/provider of service, employer, GHP, liability, no-fault and workers' compensation entity, and attorney.

What the BCRC Does (cont.)

5. Establishes MSP occurrence records on MBD and CWF to keep Medicare from paying when another party should pay first.

What the BCRC Does: Part D

6. Transmits other health insurance data to the Medicare Beneficiary Database (MBD) for the proper coordination of Rx benefits.
7. This includes building the Part D other insurance payer order for other prescription drug payers that are either primary or secondary to Medicare.

What the BCRC Does Not Do

- BCRC is not involved in Medicare eligibility, enrollment or entitlement issues. Social Security Administration is source of that data. Beneficiary must resolve.
- BCRC is not involved in claims processing and claims payment determinations.
- BCRC is not CMS' official system of record for other coverage data. MBD and CWF are the systems of record.
- Data shared with Medicare fee for service contractors and Part C and D plans comes from CWF and MBD.

When to Contact the BCRC

- To report employment changes, or any other insurance coverage information.
- To report a liability, auto/no-fault, or workers' compensation case.
- To ask a general MSP question.
- To ask a question regarding the MSP letters and questionnaires (i.e. Secondary Claim Development (SCD) questionnaire).

Electronic Correspondence Referral System (ECRS)

- There is an electronic interface between PACE Part D sponsors and the Coordination of Benefits contractor known as the Electronic Correspondence Referral System (ECRS).
- ECRS allows PACE Part D sponsors to submit post-enrollment transactions that change or add to currently known Coordination of Benefits information.

Resources

- https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c14.pdf