Coordination of Benefits
Shelly Winston, CMS
John Albert, CMS

[Applause]

Shelly Winston: Thank you, Stacy.

Good afternoon, everyone. When we were asked to speak about coordination of benefits, or "COB", I was not at all surprised. Since the last time thatthe Office of Financial Management conducted a one-third audit and there were findings related to COB, we've had pretty much non-stop questions about it. So we felt that we should have a seminar about it, and we did last November; and questions keep on coming in. The Part D mailbox that's appropriate for questions is Part D underscore COB at CMS.gov [PartD_COB@CMS.].

So want we plan to do today is go over some of the issues that we think are still unresolved; and there were also quite a few questions about the BCRC and curiosity about that, so John will speak about that once we go over some of the policy issues with coordination of benefits.

Just to level set, what I would like to cover is some of the COB requirements for Part D plans, including PACE, and then go over some of the frequently asked questions and concerns and also some observations that I've made about PACE plans and their COB efforts.

To remove any question, yes, all Part D plans are required to coordinate benefits with other providers of prescription drug coverage. That is really unquestioned, and it comes from the statute; so it's something that we really must follow pretty much to the letter. There are also some other requirements. Since we're running a little bit behind, I will not read the slides; you have them. But basically, you *must* convey drug costs and TrOOP values to the other sponsors.

I think what I've gathered from people who have asked questions is that they understand it's a legal CMS requirement or an HHS requirement, but they really don't see the value in doing COB. So what I wanted to do was to do something that I'm not sure all the PACE plans understand, which is really how does the Part D benefit in non-PACE plans work and how PACE COB fits into those.

So this is the Standard Part D Benefit. This is just by point of reference. I put up the Standard Benefit and the values for 2018. Clearly, not all Part D plans offer just a Standard Benefit; but for purposes of illustration for the COB and PACE, we can start with that.

You can see the basic structure is four phases: the deductible, the initial coverage limit, the gap, and catastrophic. So keeping in mind that Part D plans get paid differently for beneficiaries who are in the different phases, if you have a Medicare-only beneficiary, they would leave the PACE and need to pay the deductible and go all the way through the benefit. However, if the PACE plan for a Medicare-only beneficiary hasn't conveyed those values, then the beneficiary would really be stuck…maybe in the ICL or in the gap…where really their drug costs would warrant them moving forward.

I know what you're thinking, which is…okay, but 95% to 99% of our beneficiaries are dual eligible; so how does it apply to them?

One of the things for COB, what counts as TrOOP, is the entire amount paid by the Government for Low Income Subsidized individuals. So let's take an example. So you see that the deductible will be $405 for 2018. but you would know that somebody who is a full benefit dual wouldn't pay anything. However, the way that the benefit is structured, the amount that is paid by the Government for a low-income subsidy, a LIS member, would count as TrOOP. Therefore, if you're not carrying over for your low-income subsidy beneficiaries…you're not giving the gross covered drug costs and the TrOOP expenditures…then the beneficiary will be behind If they disenroll from a PACE plan.

So in this case, that would throw off Medicare's payments to the plans. You can see in particular there's reinsurance applied in the catastrophic phase; so you could see where perhaps the TrOOP values are not conveyed and the Plan is mispaid. We have to go through it, and the beneficiary would likely complain; and we would go through ultimate payments and appeals. So we just really want to get it right the first time for Medicare payment purposes.

So what about the beneficiary? What's the impact of that?

For a beneficiary, for a low-income subsidy member, their cost sharing – really that differs in three phases rather than four. So depending upon the level of low-income subsidy, his/her deductible can be anywhere from zero dollars to $83. In the gap, you can see the various copay levels; and the lowest copay is in catastrophic. So suppose for the beneficiary you've really paid gross costs that would land them in the gap; that would give them a different copay level than if they were in catastrophic. So when you don't accrue the correct values and convey them to the next plan if the beneficiary disenrolls, which is really what we're talking about, then the beneficiary will end up paying more…unless, of course, they appeal it.

The point here is TrOOP is really pretty important for both Medicare payment as well as for accurate beneficiary copays.

Here are the Part D requirements for retroactivity. A number of you have asked about that, so I just thought I'd pull it out on a slide. There are also some time frames that are in regulation that might be of interest to you…which means that suppose you get audited; and there's a finding that requires you to reverse PDEs or change. You have 45 days once you receive notification of that; that's in reg, and there is a time limit. So suppose you have a beneficiary and you find out after the fact that they have an SPAP or an ADAP or another insurance; and you say, all right, that was last year. Well, not so fast; the COB requirement is 36 months from the date of dispensing…so just wanted to point to that as well.

Then this is a cheat sheet, something to keep over your desk…what accrues to TrOOP and what doesn't, just for your information. We went over it at the seminar; and I think it's useful information. Put it on your refrigerator or wherever you will see it.

So what are the basic requirements?

There's been a little bit of confusion. Because PACE plans are not obligated to do automatic TrOOP balance transfers, ATBT…we encourage it, but we know it's not right for all PACE organizations. But if you don't, then you still do need to convey those values when a beneficiary leaves your plan during the year.

So there are some more requirements. Again, in deference to time, I'm not going to read the slides; but you have those. We also had some questions, particularly post financial audit, about the EOB requirement. So I think that EOB is – of course your PACE organizations are exempt from the EOB requirement. All other health plans have to distribute the EOB monthly if there are expenditures; you guys do not. But that doesn't eliminate a requirement to coordinate utilization with the beneficiaries, particularly when they're going to leave the plan.

I think the reason why people use the term "EOB" is that it's much shorter than Participant Notice of Benefit Information for Your New Medicare Prescription Drug Plan. I think if we could have a shorter acronym, we would probably use that; but you need to send that information to the beneficiary and also inform the new plan within seven days.

Medicare Secondary Payer I'm not going to go into because that's really John's area, and he's going to cover that in greater detail.

This was a common certain that people had. They really didn't know who came first; and, of course, coordination of benefits has two elements to it, which is who pays first as well as conveying the information between payers. So I tried to do this in sort of a shorter form to help people. The Part D Program was started to really add coverage. The intent wasn't to relieve financial burden from those who already were paying.

So from an employer view, if the beneficiary has an employer health plan, they would pay first…same thing with no-fault automobile insurance, Black Lung. SPAPs are those programs operated by pharmaceutical manufacturers, so they would pay first. These are payers supplemental to Part D; again, John is going to get into those. And these are mutually exclusive; so if something is paid for under Part A on another benefit, they cannot be paid under Part D. Again, Medicaid cannot wrap around; Part D cannot wrap around; and then VA drugs, except if they're part of the waiver plan.

So here is my first polling question, if you guys wouldn't mind. The question is: "PACE organizations are exempt from COB requirements…true or false?"

Awesome, awesome, 100%, great…can't do better than that! Oops, after we told the answer too…91%, okay. We're assuming it's a data error, and it's 100%.

Now I'd like to introduce my friend John Albert.

[Applause]

John Albert: Thank you, Shelly.

Hi, my name is John Albert. I'm a Senior Technical Divisor in the Division of Medicare Secondary Payer Operations. We are the ones who run all of the coordination of benefits contracts that collect data for COB purposes, as well as initiate recovery actions where possible.

Shelly kind of skipped over some of her stuff so maybe mine won't be as redundant, but I wanted to reiterate some things before I get into the BCRC itself; and that is about MSP. As she mentioned, MSP is the term used when the Medicare program does not have primary payment responsibility; that is, when another entity is primary to Medicare.

Basically, the statutes have been in place for a long time. On my next slide, which I'll get to in a second, when Part D was passed, the laws were extended to the new Part D program as well so that MSP applies equally to parts A, B, C, and D. The statute states, and the regulations require, that all entities that bill Medicare for items of services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those items or services. But it even goes beyond that; it's not just billing, it's basically anybody who is involved in paying claims or billing claims related to Medicare beneficiaries. All have an equal responsibility to ensure that the right payers pay correctly.

This is just for the policy wonks…some of the cites in the law.

So the first part about MSP I want to talk about briefly is MSP and group health plans, which is different than the other side, which is non-group health plans, which are your liability, workers' compensation, and no-fault insurers. There are very specific rules set up, depending on the reason

for entitlement, to determine whether Medicare is the primary payer or not.

For example, if someone is entitled due to age, there are rules related to whether the coverage originates through their current work or their spouse's current work. There are also employer size factors as well, which means that what the law says is that if you're covered through the policy holder's current employment status and the employer has 20 or more employees, Medicare is secondary payer to that group health plan insurance.

There are similar rules for disability; but in disability, the difference is it's not just self and spouse. It's self and family members. So *anybody* in the family who is covered and has Medicare due to disability and is covered by an employer group health plan, again, Medicare is the secondary payer. The difference is also that the employer size threshold size is higher; it's 100 or more employees. Then you get into situations where you have multiple group health plans, and you have to consider the largest employer within that group is what applies to *any* employer within that group. So if it was a group health plan that one employer had 500 employees and one had 2 employees, the 100-or-more rule would apply to both employers in that group.

Finally, the last one, which also has its own little quirks, is end stage renal disease, or kidney failure. In these cases, employment doesn't matter. There's a 30-month coordination period, as you probably already know; and, again, it's coverage through yourself or any of your family members as well…much like disability.

I would point out to people that if they need a publication, there's a guide to who pays first out there for employers. If you just search "MSP who pays first," it will be the first hit; and it's a really good booklet to give you a lowdown of the different MSP rules.

Finally, you also have situations in MSP where you have dual entitlement situations; and there are rules based on that as well. Generally, what drives it is “what was the first reason you had entitlement?” For example, if you had already aged into Medicare and developed ESRD, it wouldn't matter. The coordination period wouldn't apply in that case because the person aged into it first.
Now, with non-group health plans, which include liability insurance…which includes self-insurance, Workers' Compensation, and no fault…Medicare is secondary payer, period. The difference is that with non-group health plans, often these cases, especially for liability cases, these are inherently in dispute. So if somebody slips and falls in Walmart and they have $10,000 in medical bills and they have Medicare, well, until that beneficiary actually decides I'm going to sue Walmart and they actually receive a settlement, judgment award, or other payment, there really is no MSP in effect in terms of CMS's ability to recover.

So Medicare will make a conditional payment until that happens, if it ever does. I mean, you can have liability cases that are five years old, and maybe they settle and maybe they don't. But again, until there is actually a settlement, judgment award, or other payment that essentially has the effect of releasing medicals, which is the really critical term, then there technically is no MSP until that other party accepts that responsibility. Again, once that occurs, Medicare – meaning our contractors in the COB&R world – will assert that recovery right, at least in terms of for Part A and Part B.

So like any organization…and that was the one question…MSP does apply to PACE. They're like any organization involved in beneficiary healthcare. They have the same responsibilities as any other entity.

Moving on from PACE and its responsibility, now we're starting to get into the functionality of MSP and coordination of benefits. The MSP program is in place to ensure that Medicare is aware of other payers that are out

there so that it makes correct payments the first time; and, if it needs to, recover mistaken payments.

As you see on the bottom of the slide, I mentioned earlier that all entities connected to Medicare COB… which includes employers, beneficiaries, insurers, providers….everybody involved has a legal requirement to properly coordinate benefits under MSP. And with any mistaken payments, those same entities are joint and severally liable to Medicare. So Medicare has a lot of authority to recover mistaken payments from anybody involved; and generally, in the case of group health plans, we recover from employers and insurers. In the case of non-group health plans, where the beneficiary has received a settlement, we recover directly from the beneficiary.

Again, this is kind of a summary of what the MSP responsibilities are…which are again to identify payers. This is all front-end work when someone is first receiving services. The hospital should ask; the plan should ask; everybody should ask and try to get that information.

To properly facilitate COB and help everybody, we have this Coordination of Benefits and Recovery Program in place. All these activities related to the collection and management and posting of data is what we do in COB&R. That's where we get into the primary contractor that most people interface with, which is the Benefits, Coordination and Recovery Center. This kind of goes back to the original coordination of benefits contract that was in existence since about 2000, which was the very first Medicare Integrity Program contract. The point of all this MSP activity and COB&R was to consolidate all of this front-end activity and recovery activity into centralized locations.

For those that have been around a long time like me, when I first started in Medicare, we had 80 fee-for-service Medicare claims processing contractors. Now we have like 16 max; but again, they all did their own COB, and they all did their own recovery. So you can see how confusing

and challenging it could be. So by Congress giving us this authority to consolidate, we did so; and it resulted in tremendous savings to the program, as well as much more efficient coordination of benefits.

So the primary functions of the BCRC, which I listed on the slide, are the identification of MSP. This is primarily through mandatory reporting and voluntary reporting by insurers and employers. We also take self-reports from beneficiaries, attorneys, or anybody who knows of a potential MSP situation.

But again, the primary MSP identification tool today is the Mandatory Insurer Reporting process, which is also referred to as Section 111 reporting. The law was finally passed that gave us the authority to require all insurers to report MSP data to CMS. Unfortunately, when that law was passed, it only applied to Parts A and B…not to Part D. So while we do have processes in place to collect all this and we certainly get a lot of data, I just wanted to note for all those out there that there is no requirement to report supplemental Part D coverage or primary Part D coverage in the Section 111 reporting.

Now, a lot of people that offer comprehensive GHP coverage will report it, and we do get supplemental data as well from lots of different partners; but again, that is still a voluntary process. So whatever you can do to encourage reporting, please do so.

Also, the BCRC does recovery of the settlements and liability situations that I mentioned. I had that little factoid up there about how much they recovered last year just for that. Overall, the COB&R program saves the Government close to $9 billion a year in preventing mistaken payments as well as other recoveries.

They also administer the Claims Crossover process, which is basically a process that we administer to take in – when there's another supplemental payer and when Medicare is the primary payer, we will take

the claims in and basically do our processing and then cross that claim over electronically to the other supplemental payer. This, again, is for Parts A and B. That saves them a lot of money and generates some fees for Medicare.

Finally, which is of most interest here, is that we do all the Part D data collection for primary as well as supplemental health insurance.

This is just a schematic of the current COB&R contracts.The Benefit Coordination Recovery Center is the main public facing contractor. Then the Commercial Repayment Center is the other contractor that we use for recovering group health plan debts, as well as for non-GHP where there's no dispute involved…typically like a Workers' Comp situation where the Workers' Comp just pays up front. That's who they would deal with there. Then we have a Workers' Compensation Review Contractor, which deals with Medicare set-asides for Workers' Comp issues. The other two are support contractors.

Next comes kind of an important topic, and that's the role of the BCRC in building CMS data that's used by everybody to actually pay claims. I like to refer to the BCRC as the gatekeeper to CMS's systems of records, which includes the Medicare Common Working File and the Medicare Beneficiary Database. They collect the data; they edit the data. They do it for everyone, and all data flows through them; but again, they are the gatekeeper, not the owner of the data. The data has to actually make it through processing and be posted to CMS's internal systems…again, the Medicare Beneficiary Database and the Medicare Common Working File…for it to be official.

I'll probably go off script a little bit and just talk about that briefly. Again, people will come to BCRC; they will report data to them; and then maybe three months later, they find out that nothing has changed. Well, there's usually a reason it didn't change; and that is because it failed all the validation processes that we use to take in that data to post it on MBD. If

it's an electronic record, we edit it on the fly and send it to MBD. Usually if it passes the COB edits, it will pass the MBD and CWF edits. CWF actually has a more rigorous editing routine for MSP.

But if it doesn't, especially in the case of, like leads data that comes in through a letter or something like that, we attempt to develop that data; but if it doesn't pass muster, we don't post it. So that's a very common occurrence: Example: “Why didn't my records post? -- I told you guys that this guy has other coverage, or I told you guys that this person this or that or whatever.” But basically, the information has to go through a rigorous process because, again, we'd rather have no data than inaccurate data. We've always erred on paying claims first versus not paying, and we don't want to risk withholding benefits when someone goes to the hospital or the doctor and suddenly Medicare is not paying because there's an erroneous record on the CMS system.

So that's one thing I just wanted to touch base on, which is a really important point when you're wondering what happened to the stuff that I submitted? We certainly have a lot more self-help tools available…Web portals, things like that…for different users so they can be better informed as to the status of their data or, in particular, any recovery actions that CMS is taking.

In terms of the BCRC, in terms of what it does, I basically put a list of some of the high-level things on the slide. They initiate the MSP investigations. Again, people will report stuff to us; but the BCRC has to actually go out and confirm it. A lot of times this is done through correspondence forms, development forms, questionnaires, phone calls. We have a huge Call Center that takes in calls…I don't know, I can't remember how many hundreds of thousands of calls a year, but it's a lot. It's a big Call Center of like over 300 people.

So the investigationdetermines whether Medicare or the other insurance has the primary responsibility. Again, I mentioned they must meet certain

criteria or the record will not be posted. This criteria goes for new information as well as any updates to existing information. The only exception that's pretty easy to push through is a termination for a group health plan coverage. The most common update to a record is, “hey, I retired or I don't have that insurance anymore”; and that's one area where the Medicare contractors can still submit simple terminations that refer to that…a guy retired and no longer has primary group health plan coverage.

Again, we collect the information on employer group health plan coverage and liability insurance, et cetera. Again, I mentioned that Section 111 is probably 95%-plus of the data. We've built our processes around the Section 111 reporting because the law says the insurers *must* do this or there's a really big fine if they don't do it right. So we built our processes around the expectation that the insurers will comply; and, again, Section 111 is the biggest source of information that we get.

That also means that in terms of – I think Shelly touched on hierarchy a little bit - the insurer data in our internal hierarchies that we use…not just for the Part D hierarchy but for other stuff as well…we tend to put the insurer data up near the very top of the reliability factor when deciding, if there are two pieces of conflicting information, which one we should use. But again, even in those cases, an insurer can be wrong. In every event the BCRC has the final say in what happens. In fact, they can even, under CMS direction, lock a record so that *nobody* can touch it. But again, the BCRC is the gatekeeper; that's their responsibility.

They also transmit all this data they collect after editing it to the MBD for proper coordination of prescription drug benefits. This includes building the Part D payer order that Shelly talked about earlier. Again, BCRC has the final say.

So what the BCRC does *not* do…and there has been some confusion out there. BCRC is not involved in Medicare eligibility, enrollment, or

entitlement issues. For most cases, if there's any dispute about Medicare entitlement or enrollment, it really is between the beneficiary and the Social Security Administration to resolve that. There are some situations where CMS will kind of act as a go-between. We do have a group within CMS that works on some of those issues because, again, Social Security Administration does all the enrollment for Medicare. So again, the BCRC, if there's an issue with enrollment, they really can't respond and will point them to the beneficiary and Social Security Administration.

The BCRC is also *not* involved in claims processing and claims payment determinations. Again, they are totally removed from that. They are merely building records of other insurance coverage and are also establishing some payer orders. The claims payment processing has to take place with the plans or the fee-for-service contractors. There are all those dispute and appeal rights for all cases that the beneficiairy can use; but the BCRC is not involved in those determinations.

They're also not CMS's system of records. As I mentioned before, this has always been a confusing thing. We can certainly take in information and update records; but until it shows up at the MBD or CWF, which means that the contractors have access to it through either, the MARx feed or access to MBD or the common working file, it's not an official record until it shows up there. That's the record that everybody should be using when making determinations in terms of what is out there. If you think it should be different, contact the BCRC; they can then take your information and hopefully make that update.

Also again, this relates to when I mentioned the data shared with the contractors comes from CWF and MBD, not the BCRC: this goes back to they use the term the "COB feed" to the Parts C and D plans. It really doesn't come from the old COB contractor; it comes from MBD and MARx.

So when to contact the BCRC?

This is kind of general for everybody…not just folks in the audience, and that is to report employment changes or any other insurance coverage information; to report a liability, auto or no-fault claim or case; to ask general MSP questions; also questions regarding correspondence and claim development letters, things like that. I don't think you guys really necessarily see all that.

But the one important thing that you guys *do* have access to is the Electronic Correspondence Referral System or ECRS. This is the primary interface all entities that do COB with the BCRC use to submit information regarding other possible payers out there. There is a whole manual out there; and ECRS is the primary and most efficient way to submit information to BCRC. Again, they take that information – if it's something easy, they can usually quickly update CMS records with that. But if it's something that requires further development, they might take that high-level information and go out and pursue development of new leads and things like that…which, again, unless we get an answer back and it's an answer that's a good answer, we can't do anything with it. But again, ECRS is a little bit easier way to track that process.

I did include, just for your information, the two areas that kind of lead to everything; and that is, the first one is the Medicare Coordination of Benefits and Recovery Home Page. It's a whole section on CMS.gov, and you can dig down into it regarding different audiences and things like that. There's also a lot of good background information as well in terms of the Medicare law and rules, et cetera. Then the other, of course, is the section from the PACE Manual, the Chapter 14 Manual, that includes all of the MSP requirements for PACE.

Again, if you haven't seen them, they're both pretty clearly written. The COB one has reams and reams and reams of information; but that's because it's a big program, and $9 billion in annual savings is nothing to sneeze at.

And on that, that's all I had.

[Applause]

Kaye Rabel: At this time, we do have a few moments that we can ask some questions. So if anyone in the audience has any questions, please step forward to the microphone. State your name and where you're from.

[Pause for responses]

It looks like we don't have any questions, so I'd like to go ahead and thank Shelly and John for the discussion on the Coordination of Benefits.

[Applause]

If you would like to evaluate this session, go ahead and take out your phones. Text your response or go to the Poll EV link using your tablet, smartphone, or computer. Enter "A" in response to the question, "I would like to evaluate the session," and send your response.

It is now time for a quick 15-minute break. Please return promptly at 2:30 p.m. for the next session.

Remember, any webcast participants, if you have any questions please send them via the "Ask CMS Questions Live" link on the CTEO website. Thank you.