

Programs of All-Inclusive Care for the Elderly (PACE)

Chapter 14 – Coordination of Benefits

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(Rev. 2, Issued: 06-09-11)

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10 - Introduction

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional primary plans. These provisions are known as the Medicare Secondary Payer (MSP) provisions and are found at Section 1862(b) of the Social Security Act. These provisions prohibit Medicare from making payment if payment has been made or can reasonably be expected to be made by the following primary plans when certain conditions are satisfied: group health plans, workers' compensation plans, liability insurance, or no-fault insurance (The private insurance industry generally talks about "**Coordination of Benefits**" when assigning responsibility for first and second payment).

The purpose of the Coordination of Benefits (COB) process is to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits.

20 - Part C Medicare Secondary Payer Provisions (MSP)

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

20.1 - Basic Rule

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Medicare does not pay for PACE services to the extent that Medicare is not the primary payer under Part 411. A PACE organization may charge or authorize a provider to seek reimbursement for services from a beneficiary or third parties to the extent that Medicare is made a secondary payer under Section 1862(b)(2) of the Act. Section 1860D-2(a)(4) of the MMA extends the Medicare secondary payer (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.

[42 CFR § 460.180(d)(1) and (3)]

20.2 - Responsibilities of the PACE Organization

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The PACE organization is required to do the following:

- Identify payers that are primary to Medicare under Part 411;
- Determine the amounts payable by those payers;
- Coordinate benefits to Medicare participants with the benefits of primary payers.

[42 CFR § 460.180(d)(2)]

20.3 - Charges to the Individual or Entities

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The PACE organization may charge other individuals or entities for PACE services covered under Medicare for which Medicare is not the primary payer as follows:

- If a Medicare participant receives from a PACE organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, any liability insurance policy or plan, including a self-insured plan, group health plan or large group health plan, the PACE organization may charge any of the following:
 - The insurance carrier, the employer, or any other entity that is liable for payment for the services under Part 411; and
 - The Medicare participant, to the extent that he or she has been paid by the carrier, employer, or entity.

[42 CFR § 460.180(d)(3), (4), and (5)]

20.4 - Federal Black Lung Program

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

As set forth in Section 1862(b)(2)(A)(ii) of the Social Security Act, Medicare payment may not be made if payment has been made or can reasonably be expected to be made under a workmen's compensation law. As further specified in 42 CFR § 460.180(d) of the PACE regulation, Medicare does not pay for services to the extent that Medicare is not the primary payer. The PACE organization must ask questions to secure insurance information and identify payers other than PACE and whether PACE is the primary or secondary payer. The beneficiary must be queried about other possible coverage that may be primary to PACE.

The Federal Black Lung Program is a form of workmen's compensation. As such, Medicare does not pay for services covered under the Federal Black Lung Program because the Black Lung program pays for covered services in full. As such, the PACE organization may seek payment from the Federal Black Lung Program on behalf of Black Lung-eligible PACE participants. To the extent that the participant has been paid by the Federal Black Lung Program for services furnished by the PACE organization, the PACE organization may seek payment from the participant. Illnesses or injuries not related to black lung would be covered by the PACE organization.

The PACE organization is required to report all Medicare Secondary Payer (MSP) information to CMS. As outlined in the final "45-Day Notice" for 2010, released on April 6, 2009, there has been a policy change in the way plans are to report the MSP information. The new policy is outlined in the final "45-Day Notice" for 2010, released

on April 6. (The Notice may be viewed at: <http://www.cms.hhs.gov/medicareadvtspecratestats/ad/List.asp>. This change now supersedes the requirement for plans to submit the results of membership survey data to CMS via the new Transaction 85 for the 2010 MSP factor. Plans should ignore the information outlined in the April Release notification sent in January 2010, regarding the new Transaction 85.

Since CMS has already calculated 2009 MSP plan level factors and they are in use, there is no need to submit data on the new Transaction 85. Anything submitted will be ignored by the system. The COB process as outlined in the “45-Day Notice” is the process that will be used for 2010 and going forward.

30 - Medicare Part D COB

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

On December 8, 2003, Congress enacted the MMA of 2003 (PL 108– 173). Several sections of the MMA impact PACE organizations. Most notably, Section 101 of the MMA affected the way in which PACE organizations are paid for providing certain outpatient prescription drugs to any Part D eligible participant. As specified in Sections 1894 and 1934 of the Act, PACE organizations shall provide all medically necessary services, including prescription drugs, without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid.

Prescription drugs provided under Medicare Part D will be covered in the Medicare capitation rates paid to PACE organizations and payment for non-Medicare covered outpatient prescription drugs and prescribed over-the-counter medications covered in the Medicaid capitation rate.

30.1 - Collection of COB Information for Prescription Drug Coverage

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The Part D sponsor must have a system for collecting and updating information from enrollees about their other health insurance, including whether such insurance covers outpatient prescription drugs, and must report that information to the Coordination of Benefits (COB) Contractor (PACE Part D Solicitation; Medicare Prescription Drug Benefit Manual, Chapter 14 -Coordination of Benefits).

30.2 - COB Surveys for Prescription Drug Coverage

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

As provided in the MMA, beneficiaries are legally obligated to report information about other prescription drug coverage or reimbursement for prescription drug costs that the beneficiaries have or expect to receive; any material misrepresentation of such information by a beneficiary may constitute grounds for termination of coverage from a Part D plan. PACE Part D sponsors must, therefore, regularly survey their participants

regarding any other prescription drug coverage they may have and report that information to the Coordination of Benefits contractor so that it can be validated, captured, and maintained for Coordination of Benefit purposes. Anytime a PACE organization receives information concerning a change, this information should be sent electronically to the Coordination of Benefits contractor within 30 days of receipt.

Except as noted, the Coordination of Benefits survey should be performed within 30 days of the date the PACE organization processes a participant's enrollment and annually thereafter. If a participant indicates on his or her enrollment form that there is no other prescription drug coverage, no PACE organization follow-up is required until the annual survey is performed. However, if the enrollee indicates on the enrollment form that he or she in fact has other prescription drug coverage or does not provide any response to those questions, the sponsor must perform the 30-day survey.

The survey should collect from the participant the same information on other payers that Part D sponsors must submit electronically to the Coordination of Benefits contractor. PACE Part D sponsors have the flexibility to design their survey process according to their own needs. PACE Part D sponsors may conduct their survey by telephone, mail, email if available, or in-person. The survey should not require that the participant provide his or her Social Security Number; instead, PACE Part D sponsors should use other identifiers, such as the Member ID. Also, in addition to providing a self-addressed return envelope for mail surveys, sponsors should include, on the survey form itself, the mailing address to be used for completed surveys in case the envelope is lost or damaged.

A non-response to the survey regarding other prescription drug coverage cannot be interpreted as a negative answer since effective coordination of benefits with other prescription drug coverage requires that sponsors be aware of any other prescription drug coverage a beneficiary may have. Therefore, PACE Part D sponsors are required to follow up with participants who fail to respond. Follow-up with non-responding participants may be conducted by telephone, mail, email if available, or in person. After unsuccessful attempts to gain a response using one mode, PACE Part D sponsors may find a change to another mode is more productive. Also, if the participant has had drug claims, PACE Part D sponsors may contact the pharmacy to determine if Coordination of Benefits information was captured while the participant was in the pharmacy. PACE Part D sponsors are expected to make a minimum of three attempts to follow up with non-responding participants. At least one of the follow-up efforts must involve the use of a different method of contact. For example, if the initial survey was mailed, at least one of the follow-up attempts must be other than a mailed survey, i.e., must be conducted by telephone, email if available, or in-person.

PACE Part D sponsors also are responsible for sending electronic updates about their participant's other sources of prescription drug coverage to the Coordination of Benefits contractor. Since supplemental payer information is essential for Coordination of Benefits, PACE Part D sponsors should submit this information to the Coordination of Benefits contractor at least monthly.

For more information, refer to:

<http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter14.pdf>.

30.3 - Connecting to Systems for COB

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

30.4 - Data from CMS to PACE Part D Sponsors

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The Coordination of Benefits contractor performs a daily update of information on other coverage to the Medicare Beneficiary Database (MBD). PACE Part D sponsors must establish connectivity with CMS systems, which, among other things, allows Part D sponsors to have direct access to other payer status information as often as their business requirements dictate. Every Federal business day, the Coordination of Benefits contractor pushes out updated information to MBD and then CMS sends the Coordination of Benefits file to the PACE Part D sponsors. For more information on receiving Coordination of Benefits files, see the Plan Communications User's Guide (PCUG) available on the CMS Web site. It is incumbent upon Part D sponsors to note any changes to other payer status included in CMS systems and to send that information to the Coordination of Benefits contractor.

30.5 - Data from PACE Part D Sponsors to the COB System

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

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. PACE Part D sponsors may send ECRS transactions in any of three possible ways: 1) by using Network Data Mover (NDM) (a secure file transfer process) to connect to the ECRS Online Application; 2) by using NDM to send an ECRS flat file; or 3) by using a current SFTP connection to send an ECRS flat file. Part D sponsors are updated on the status of these transactions as they move through the Coordination of Benefits systems and informed on the determination made by the Coordination of Benefits contractor on the transactions via a Coordination of Benefits data report/file. Further information on ECRS is contained in the ECRS User Guide available on the CMS Web site.

The data provided by the Coordination of Benefits contractor on supplemental payers and order of payment are generally the best available information for PACE Part D sponsors and pharmacies to act upon. However, it is important to note that PACE Part D sponsors must coordinate benefits with all other payers providing coverage for covered Part D drugs, even if the COB contractor is unaware of some payers who have submitted batched claims after the point-of-sale transaction at a network pharmacy. Although the Coordination of Benefits contractor may be unaware of them, these other payers may submit claims directly to the PACE Part D sponsor or through the TrOOP facilitation contractor, thereby enabling benefit coordination by the Part D sponsor. Once a sponsor

becomes aware of these other payers, sponsors must submit this information via ECRS to the Coordination of Benefits contractor.

Sponsors should utilize the electronic interface established with CMS (via the MARx system) to handle plan enrollments, to transmit certain other payer data elements upon enrollment, and to receive daily transmissions of validated Coordination of Benefits information. As new information about other prescription drug coverage is discovered, sponsors should use ECRS to send the information to CMS. Sponsors should not use the enrollment update transaction to communicate this subsequent information.

Beyond the electronic data transfer requirements described above, PACE Part D sponsors must establish procedures for at least weekly file processing. Sponsors are required to not only receive information, but also apply it to their systems.

The PACE Part D sponsor has a detailed claims adjudication process including flow charts, claims management, data capture and claims data retrieval processes.

PACE is a comprehensive, coordinated model of care designed to meet the needs of frail elders. There are several key differences between the way in which PACE organizations provide the Part D benefit and how it is provided by other Part D sponsors. As such, some Part D requirements are waived for PACE organizations. (See Medicare Prescription Drug Benefit Manual, Chapter 14 - Coordination of Benefits, Appendix F – Part D Requirements Waived for PACE Organizations).

30.6 - Dual Eligible Beneficiaries

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

CMS fully subsidizes dual-eligible individuals' Part D coverage in PACE organizations. Therefore, consistent with PACE rules, there is no beneficiary out-of-pocket expense. However, True Out-of-Pocket (TrOOP) is to be tracked and reported, although the processes may vary by plan. If a beneficiary disenrolls from a PACE plan mid-year, the participant will need to be provided their Gross Covered Drug Costs and TrOOP amount (even if that amount is \$0). For plans that do not participate in the automated troop balance transfer, there is a manual calculator that plans can use to provide information to their participants. It's important to note that if a participant disenrolls to a stand-alone PDP mid-year (either a full dual or Medicare-only) they will have co-pays. For a dual eligible, the participant will not be exempt from co-pays until they reach the catastrophic level, at which time TrOOP can be applied.

30.7 - Beneficiaries Eligible for Only Medicare

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

PACE beneficiaries who are only Medicare eligible pay a supplemental premium based on the anticipated cost-sharing covered by the PACE plan. As a result, for these beneficiaries, TrOOP does not apply.

30.8 - Accessing Covered Part D Drugs

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

PACE Part D sponsors fully coordinate their participants' access to covered Part D drugs, providing prescriptions directly to the participant. As a result, most PACE Part D sponsors are not set up for real-time, on-line prescription drug claims processing and neither have nor report 4Rx data to CMS.

30.9 - Transferring Data When a Beneficiary Changes Sponsors

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

When a beneficiary disenrolls from a PACE organization and re-enrolls in another Part D sponsor at any time during the coverage year, the PACE organization is required to transfer the TrOOP balance (if any) and the gross covered drug costs to the new sponsor of record to permit the correct placement of the beneficiary in the benefit.

Prior to the January 1, 2009, implementation of the automated TrOOP balance transfer (TBT) process, PACE organizations must send the beneficiary's year-to-date TrOOP and gross covered drug costs, including amounts accumulated during the beneficiary's period of enrollment in the PACE organization plus amounts previously reported to the PACE organization by a prior plan sponsor for months of enrollment during the same coverage year. For beneficiaries who are Medicare and Medicaid dual eligibles, PACE organizations should use the Dual Eligible PACE Plan Beneficiary Accumulated True Out-of-Pocket Cost Calculator to calculate the amount of TrOOP to be reported to the new plan sponsor. The calculator is available on the CMS Web site at:

<http://www.cms.hhs.gov/apps/troopcalculator/>.

After the January 2009 implementation of the automated TBT process, PACE organizations will no longer be required to forward amounts from any prior plans of enrollment (unless the prior plan was a PACE organization). These amounts will be reported to the new sponsor via the FIR transactions. PACE organizations will be exempt from the automated TBT process; therefore, PACE organizations must continue to use the current manual process to report TrOOP balances and gross covered drug costs for beneficiaries transferring enrollment to the new plan sponsor as reflected on the TRR reporting the disenrollment from the PACE organization. More information may be found in the Medicare Prescription Drug Benefit Manual Chapter 14: Coordination of Benefits <http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter14.pdf>.

CMS will continue to develop guidance to further clarify the applicability of the Coordination of Benefits requirements to PACE organizations.

30.10 - Guidance Regarding PACE Enrollees with Retiree Drug Subsidy

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

CMS systems will compare PACE Part D enrollment transactions to information CMS has regarding the existence of employer or union sponsored qualified prescription drug

coverage for which the beneficiary is also being claimed for the Retiree Drug Subsidy (RDS). If there is a match indicating that the individual may have such other coverage, the PACE Part D enrollment will be conditionally rejected by CMS systems as incomplete. Within 10 calendar days of receipt of the Code 127 conditional rejection, the PACE organization must contact the individual to confirm the individual's intent to enroll and that the individual has discussed and understands the implications of enrollment in a Part D plan on his or her employer or union coverage. Individuals will have 30 calendar days from the date they are contacted to respond. The PACE organization must ensure that plan benefits are available to the individual as of the effective date of the initial enrollment request. The organization may contact the individual in writing or by phone, or may discuss this in person and must document this contact and retain it with the record of the individual's enrollment request. If the individual indicates that s/he is fully aware of any consequence to his/her employer or union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the PACE organization must update the transaction with the appropriate "flag" (detailed instructions for this activity are included with CMS systems guidance) and re-submit it for enrollment. The effective date of enrollment will be based upon the individual's initial enrollment request. This effective date may be retroactive in the event that the confirmation step occurs after the effective date. Organizations may use the Code 62 enrollment transaction code to submit the enrollment transaction directly to CMS, as described in the Plan Communication Users Guide (PCUG):

- The Part D sponsor must use a number other than an enrollee's Social Security Number (SSN) or Healthcare Insurance Claim Number (HICN) on enrollee identification cards. (PACE Part D Solicitation);

The Part D sponsor must provide the beneficiary's gross covered drug spend and true out-of-pocket (TrOOP) balance to the beneficiary as of the effective date of disenrollment. (PACE Part D Solicitation, PACE Plan Addendum – Implementation of Automated Troop Balance Transfer Process).

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R2PACE	06/09/2011	Initial Publication of Manual	06/03/2011	NA
R1_SO	06/03/2011	Initial Publication of Manual - Rescinded and replaced by Transmittal 2	06/03/2011	NA

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