



Coordination of Benefits: A Road Map to Payment Integrity for Medicaid and Managed Care Plans

The payment integrity problem

As today's health plan market becomes more aggressive and markets narrow, payment integrity (PI) is taking on more importance as both a key challenge and an opportunity to improve efficiency, savings and member experience. Meanwhile, determining primacy has become even more complex because of the increasing number of members with multiple coverage.

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According to the Centers for Medicare & Medicaid Services, about 12 million people were enrolled in both Medicaid and Medicare in 2017. Over one-third of dual eligibles were enrolled in Medicare managed care in 2017, compared with 11% in 2006. In addition, evol-

ving health care policies mean complex, changing rules that differ by state as Medicaid expands in some states but not in others. As a result, robust PI and coordination of benefits (COB)/third-party liability (TPL) are essential, particularly for Medicaid and managed care organization (MCO) payers.

The numbers reflect this importance. Data from recent years shows that:

- Improper payments reached \$144 billion in fiscal 2016, nearly tripling over the past decade and now representing nearly 4.7% of all payments.¹
- PI is worth \$362 billion to the health care industry as a whole, in medical cost savings and decreased overpayments.²
- National health spending is projected to grow at an average of 5.5% per year and to reach nearly \$6 trillion by 2027.³

MCO payers also face financial consequences in the form of withheld federal funds for failure to ensure accurate COB/TPL.

Even worse for health plans than the financial consequences is that poor coordination of benefits also creates a negative experience for both members and

providers. Patients have a frustrating, confusing experience when COB isn't done right, and there is provider abrasion because of unnecessary burdens and inefficiencies under the recovery payment model.

But when done right, PI benefits each party — the health plan, provider and member — in the following ways:

- It helps the health plan fulfill its obligations under licenses and contracts.
- Medicaid and Medicare managed care plans stand to benefit from significant cost savings. Comprehensive and coordinated PI functions are estimated to save these plans between \$124 and \$153 per member, per year.⁴
- On an operational level, PI brings together disciplines that traditionally operate in silos to form a more complete, focused and effective operations unit.
- Providers reduce unnecessary burden and have a more positive experience with the health plan.
- Most importantly, members have a smoother, less-stressful experience and are not put in the middle of payers' COB/TPL compliance efforts.



Done right, COB gives patient-members a smoother, less-stressful experience and keeps them out of confusing payer processes.

CMS efforts to promote PI

While PI clearly creates value for all parties, achieving that value can feel like aiming at a moving target — especially given state-by-state Medicaid expansion as a result of the Affordable Care Act. The Supreme Court ruling on the constitutionality of the ACA in June 2012 essentially left the expansion decision up to each state, and as of February 2019, 37 states (including the District of Columbia) had expanded eligibility.⁵ This has further complicated plans' coverage identification and primacy determinations.

Meanwhile, improper Medicaid payments, such as for ineligible patients or for services not provided, were estimated to be \$36.2 billion in fiscal 2018, accounting for 9.8% of Medicaid spending.⁶

In this increasingly complex and costly environment, the CMS is tuned in to the importance of PI. Medicaid PI activities have led to substantial recoveries, including \$785 million in combined federal and state share recoveries reported by states for FY 2017.⁷ These efforts play an important role in CMS' focus on vulnerable populations and in ensuring resources are used appropriately.

They also put pressure on MCO payers to prevent inaccurate payments before they happen to avoid loss of federal funds. Under the Medicaid Managed Care Rule, MCOs must provide encounter-data on enrollees to the states in which they operate. If they fail to do so, the federal government can withhold matching funds to states, which, in turn, may impose penalties on MCOs or withhold capitation payments. For example, New York levies a penalty of 1.5% of Medicaid premiums on MCOs



that do not submit complete, accurate data on time, or those whose data causes an excessive rejection rate.⁸

Barriers to achieving greater PI and accountability

The barriers to achieving better PI and COB/TPL come down to incomplete, out-of-date data. Data shortfalls make it difficult to identify coverage responsibility and determine primacy, and they typically can be traced to outdated data-collection processes. Relying on retrospective data sources, like member surveys, for PI increases costs because plans are always playing catch-up — never getting ahead of the process to avoid errors.

Health plans currently gauge PI success by major recoveries, but this is not ideal because errors and waste have already occurred. This includes resources directed to recovery vendor management and fees, as well as the in-house resources required for the outdated, retrospective “pay and chase” model.

However, the right tools and access to the right data can help plans efficiently determine coverage responsibility and primacy order as well as identify eligible claims to earmark for recovery. For plans that want a better COB process, secure access to comprehensive health plan data can be a game-changer.

A road map to better COB compliance

Where does effective COB/TPL start? The first step to solving COB challenges, staying compliant and demonstrating value is to develop a prospective approach and source of data to use in COB operations. Lack of a comprehensive and current data source is one of the most common mistakes health plans make in their efforts.

The road map to better COB/TPL includes the following best practices:

Implement a neutral, prospective data solution.

Health plans need a neutral, prospective solution with access to a national coverage database of health plan data, updated weekly. It should identify data for the exclusive benefit of the plan and should focus on using that data for claims payment prevention, rather than recovery. It should also charge a predictable, per member annual fee and should not charge a recovery fee or have any other incentive for inefficiency, advises Morgan Tackett, a senior product manager for CAQH.

Get it right the first time. Plans should put tools and processes in place to determine primacy correctly the first time. This is possible by using the most comprehensive data available and collaborating with other payers, Tackett notes.

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Secure data as close to the health plan source as possible. Electronic data-matching software alone is unreliable, and often results in the use of outdated health plan data. Plans need a solution that is HIPAA-compliant with strong administrative, technical and physical safeguards to maintain patient privacy. It must also be updated frequently and securely.

Develop a detailed strategy for prevention activities. Plans need a detailed, effective strategy to flag and prevent improper payments before they happen.

Create a comprehensive process for managing the volume of data that a high-quality source can provide. Accessing data isn't enough; COB/TPL relies on effective management of that data at scale.

Develop partnerships for communication with other health plans. Effective COB/TPL benefits from communication and collaboration among health plans.

One example of this type of solution is CAQH's COB Smart. It uses patient-matching logic to ensure accurate data, achieving a 99% match accuracy rate, while a built-in primacy engine determines the order of benefits

responsibility. COB Smart offers health plans exclusive access to a national coverage database that is updated weekly with data on more than 175 million covered lives sourced from participating health plans.

The road to accountability is only growing more complex, and payers, especially Medicaid and MCO plans, cannot succeed without a strong strategy for effective COB/TPL. This should include access to secure, frequently updated health plan data on millions of members across the country. With this type of solution, health plans can quickly and reliably determine their own coverage responsibilities without needing to involve their members in the process or create provider abrasion.

Better COB is the solution for health plans in today's environment, and the right data solution is key to better COB.

Learn more

COB Smart is designed for industrywide participation. As more health plans adopt COB Smart, the benefits will continue to grow for everyone.

Get started with COB Smart. Visit www.cobsmart.org.



SOURCES

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