Reinventing Coordination of Benefits:

6 Strategic Approaches to COB Innovation

Coordination of benefits (COB) is a longstanding process in the healthcare sector that has grown progressively more complex over time. As healthcare costs continue to soar, organizations spanning all programs and plan types face mounting cost pressure and scrutiny. Many are struggling to lower the total cost of care while demonstrating quantifiable improvements in the quality of care delivered.

Coordination of benefits has the potential to maximize healthcare dollars and improve the efficiency of healthcare delivery. To deliver on this promise, however, COB must be transformed through a variety of technological, data and process-related advancements.

In this white paper, we'll explore six ways that healthcare organizations can innovate coordination of benefits programs to enhance efficiencies across the care continuum.

The Challenges Facing Coordination of Benefits Today

In theory, coordination of benefits is a relatively straightforward concept — the process of determining the order of payment responsibility when an individual is covered by more than one health plan or insurance policy. In practice, however, fragmented delivery mechanisms, combined with disparate systems and data sources, have made identifying other coverage extremely complex.

Legislative developments and industry trends have brought COB challenges to the forefront. Examples include the Affordable Care Act, value-based care and third-party liability:

- In 2010, the Affordable Care Act (ACA) was signed into law. The ACA resulted in more covered lives than ever before through the introduction of the healthcare exchange system and expansion of the Medicaid program. At the same time, the law unearthed new challenges related to coordinating benefits across Medicaid, Medicare and commercial payers with more options creating more overlap[i] in eligibility and enrollment.

- Value-based care models have highlighted the importance of COB in care coordination. According to the Health Care Transformation Task Force (HCTTF), its member providers and payers reported that over half of their business (52%) in 2018 came from value-based payment arrangements. This was up from 47% in 2017.[ii] As providers and payers shift from volume to value, it's essential that stakeholders understand and maximize all sources of health coverage. To make the most of all available healthcare resources and fully address each patient's needs, it's essential to have a comprehensive view of every patient's medical, behavioral, social and economic characteristics. This information ensures that care is coordinated around the needs of the whole person.

- Third-party liability (TPL) laws and regulations ensure that Medicaid remains the payer of last resort. They require third-party carriers to pay all or part of medical care expenses before tapping Medicaid. TPL helps secure Medicaid as a safety net and is an important aspect of COB. Ongoing changes to the healthcare system, however, have made TPL more complicated. As more states move to managed care, it's often unclear which party is ultimately responsible for TPL oversight. If managed care organizations (MCOs) fail to maximize third-party recovery and cost avoidance efforts, the financial burden invariably falls back on the states.

Coordination of Benefits Challenges by the Numbers

- **Erroneous Payments.**
  According to the US Government Accountability Office (GAO), improper Medicaid payments comprised $36.7 billion of Medicaid spending in 2017, up from $29.1 billion in fiscal year 2015.[iii]

- **Administrative Costs.**
  The Medical Group Management Association (MGMA) has calculated the average cost of claims rework at $25 per claim, not factoring in the cost of labor, benefits, facilities and electronic filing fees.[iv]

- **Organizational Silos.**
  Third-party liability touches many parts of an organization from Finance to Operations, Procurement, and Compliance, but end-to-end oversight is often lacking. In most payer systems, third-party liability can save more than 2% of overall spend. For large health plans, this often translates into several millions of dollars of retained revenue.

Shifting the Mindset: 6 Approaches for COB Innovation

Integrative models are needed to break down silos that exist in both fee-for-service and MCOs. When it comes to coordination of benefits, it's not productive to view the process as task-based. Instead, COB should be viewed as part of a larger, multi-dimensional strategy that spans the care continuum. This type of thinking spurs innovation.

COB innovation can be generated through technology, stakeholder collaboration, government and industry relations and more. Here are six tips for shifting the mindset around coordination of benefits:

1. Improve Data Sharing & Interoperability

Data is the key to driving effective coordination of benefits. Without widespread data sharing among carriers, however, even the most advanced analytics and technologies can't solve the fundamental challenges associated with COB. Leading COB partners prioritize continuous expansion of data use agreements (DUAs), invest in alternative data sources to overcome DUA limitations and implement new ways to use healthcare data. These actions maximize cost avoidance and recoveries, while creating a more efficient and sustainable healthcare system for those who need it most. Expanded data use agreements are particularly important for both COB and value-based care. Value-based care requires access to current and comprehensive patient information to care for the whole person. Intelligent integration of patient health data across various sources is also essential for understanding a patient's full range of health benefits.

In addition to data sharing, interoperability is one of healthcare's biggest priorities and challenges today. The 21st Century Cures Act defines interoperability as "technology that enables the secure exchange of electronic health information with, and use of electronic health information from, other health IT without special effort on the part of the user."[v]

Data interoperability is essential for coordination of benefits. This means aggregating, matching and reporting coverage information across health plans and care settings. To make data interoperability a reality, organizations need information systems with modular and flexible architectures that enable segregation of duties and seamless data integration across different platforms. At the same time, given the inherent risk in data exposure, healthcare organizations need to invest in security and set high standards of certification, such as HITRUST, for parties sharing in coordination of benefits data.

Common Misconceptions About Coordination of Benefits and Third-Party Liability

Coordination of benefits is a common practice in the healthcare sector, yet misconceptions still exist about how best to handle COB processes. Here are three examples of common fallacies related to third-party liability:

1. Third-party liability information is a commodity item. Many organizations believe that it's fine to use the lowest cost data supplier, but this approach often leads to financial losses, non-compliance and stakeholder abrasion.

2. Third-party liability doesn't require maintenance or monitoring. Some organizations fail to establish benchmarks or report on performance, resulting in unrealized processing issues and other hidden problems.

3. Third-party liability isn't a concern, since a partner organization processes claims. Unfortunately, when it comes to TPL, unmonitored partners can be a source of financial leakage and non-compliance.

2. Adopt Emerging Technologies to Lower Costs & Maximize Recoveries

When deployed strategically, artificial intelligence (AI) technologies like machine learning (ML), natural language processing (NLP) and robotic process automation (RPA) have the power to transform coordination of benefits. For example, AI and machine learning models identify pockets of opportunity in claims inventories that analysts would never find by combing through huge volumes of data.

Additionally, much of the administrative work done by recovery specialists can be automated using RPA. This frees up time so claims specialists can focus on the most challenging cases that require human intervention. In addition, AI can be used to analyze past third-party liability claims and identify which claims are highly likely to be denied by carriers. A good example of this is soft denials — these are claims where carriers ask to review additional medical records before agreeing to pay.

Instead of waiting for carriers to request additional documentation, AI models can identify the claims most likely to generate a soft denial, proactively gather the necessary information and attach it to the claim the first time it is sent to the carrier. These models also use machine learning to continuously monitor whether there are changes in the carriers' behavior for certain types of claims. When changes are detected, the automated ML and AI models update algorithms accordingly and if significant changes to outcomes are predicted, claims analysts will be alerted.

Applying advanced technologies to the COB process means that it's possible to proactively address issues before claims are ever sent out. As a result, speed to recovery is increased and waste is eliminated from the healthcare system. Fewer claims are immediately denied, resulting in fewer calls to call centers and less manual work for carriers and providers due to paper-based appeals.

3. Implement Real-Time Verification for Marketplaces & Exchanges

When consumers apply for coverage, insurance marketplaces like HealthCare.gov must efficiently and accurately verify eligibility during special enrollment periods. Of particular interest is whether applicants have maintained minimum essential coverage (MEC) prior to applying for a new health plan.

Identifying applicants without prior MEC is essential to controlling costs, mitigating risk and maintaining compliance with federal and state regulations. Managing this process manually, however, generates additional administrative costs. Data-driven, real-time verification solutions can now match applicants with their coverage history in seconds, and feed this information directly into the exchange systems. This enables exchanges, health plans and subsidizing government programs to better understand their applicant pool and operate more efficiently and sustainably.

4. Shape Policy Through Government Relations & Industry Activism

Today, there are numerous efforts underway at both the federal and state levels to drive improvements in the coordination of benefits process. While the term innovation is often associated with development of new technologies, it can also be applied to changes in non-technical fields such as public policy or business workflows. In today's healthcare environment, true innovation requires the alignment of data, technology and advocacy. This is a proven way to effect change at the policy level and ensure that new legislation and regulations utilize the technologies currently available to the maximum extent possible.

An example of COB innovations that were facilitated by advocacy include federal and state level Deficit Reduction Act legislation, which includes provisions for third-party entities to share coverage data with Medicaid and Medicaid managed care plans for the purpose of determining third-party liability. Health Insurance Premium Payment (HIPP) programs, which enable Medicaid programs to help Medicaid members enroll in their employer sponsored plans, were also triggered through advocacy efforts.

5. Leverage Foundational Relationships & Multidisciplinary Expertise to Boost Collaboration

The shift toward value-based care means that stakeholders must collaborate to deliver the best possible care at the lowest possible cost. While coordination of benefits has traditionally been a payer function, in today's world, however, COB can no longer be a siloed process. To maximize savings for payers, providers and patients, coordination of benefits must become a collective responsibility across all stakeholders.

New forms of collaboration include:

- **The Payer-Provider Relationship**
  Coordination of benefits must be a shared responsibility between payers and providers. This requires solutions that integrate seamlessly into the provider workflow, enabling greater productivity and more transparency into the available benefits to consumers.

- **The State-Managed Care Plan Relationship**
  For Medicaid and CHIP programs, managed care organizations must look holistically at states' requirements to ensure that third-party liability efforts are maximized on both sides. Analyses across state and managed care plan COB efforts often uncovers gaps in results and new ways to help states better manage their processes. Likewise, for dual eligible populations, Dual Special Needs Plans (D-SNPs) have rigorous eligibility and verification requirements that can be automated with advanced data matching processes

Coordination of Benefits — Seven Best Practices

1. **Draw from a comprehensive and continuously updated dataset.**
   This includes identifying the broadest base of third-party liability data as possible, including all coverage types — medical, behavioral, pharmacy, vision and more.

2. **Consider process changes that may be necessary to improve COB.**
   For instance, it's advisable to move COB activities as far upstream as possible; and to utilize electronic instead of paper billing for reclamation claims.

3. **Tap into new technologies to drive process efficiencies.**
   Machine learning can identify TPL claims that are likely to be denied so that they can be adjusted before submission. In addition, robotic process automation can eliminate manual processes — allowing staff to focus their efforts on higher level functions.

4. **Analyze submarket nuances and build customized business rules accordingly.**
   This has become more important given the increased oversight from both state and federal agencies. Customized business rules may relate to dual populations, pharmacy carve-outs, non-disallowance states, no recovery states, etc.

5. **Identify risks that are flowing down to sub-contractors.**
   It's important to build in COB services for sub-contractors like independent practice associations (IPAs) or management services organizations (MSOs).

6. **Coordinate benefits with government programs.**
   It is common for individuals have access to both commercial and government coverage. Beyond Medicaid, other sources of coverage may include Tricare, Medicare and Veterans' benefits.

7. **Identify non-healthcare TPL sources.**
   Healthcare claims that are the result of accident or injury are often the responsibility of casualty or workers' compensation insurance companies. These cases are often complex and high dollar requiring specialty expertise.

Looking Ahead — Our Predictions for the Future of COB

For decades, HMS has been the COB partner to hundreds of health plans, government agencies and providers. Our client consultants predict the following trends will impact the essentials of COB in the years to come:

1. **Third-party liability rules and touchpoints will continue to evolve as health insurance product offerings become more complex.** More Administrative Services Only (ASO) arrangements and increased risk sharing with employees will drive the demand for coverage transparency and coordination. We also anticipate seeing tighter networks, reduced formularies, step therapy programs, and increased emphasis on authorizations for high-cost services, which will require strong program knowledge to maximize TPL savings.

2. **Government programs will continue to grow, affecting coverage and coordination.** Medicare is expected to grow more than 7 percent annually, while people are living and working longer. Barring a single-payer system, this will lead to increased coverage coordination between commercial payers and Medicare and Medicare Advantage plans; and will likely result in changes to benefits, capitation rates and Medicare Secondary Payer (MSP) rules.

3. **Changing risk models will drive providers' need for COB services.** Increased adoption of risk-sharing or value-based reimbursement models is expected, driving the need to move comprehensive COB process to providers, accountable care organizations (ACOs) and other risk-bearing entities as they seek to manage costs in new ways.

- **The Payer-Payer Relationship**
  Medicaid and Commercial COB-related reclamation tends to be high volume and variable. Collaborative relationships with primary, secondary and third-party payers are essential for managing expectations and resources. Implementing electronic billing between parties and establishing process protocols results in better coordination of benefits for all parties involved.

- **The Payer-Consumer Relationship**
  Expanding the scope of COB from a cost containment function to a care continuum issue opens the door to new approaches that can redefine the landscape and better serve consumers. Ensuring consumers understand their coverage options and provide accurate coverage information to providers is an essential first step. Examples include leveraging consumer health engagement technologies and benefits-specific case management to empower consumers by providing information about how to use multiple policies and all available coverage resources to advance their well-being.

6. Shift from Mail-Based COB to Real-Time Verification

Delivering reliable, actionable coordination of benefits data prior to claims submission results in better patient experiences, improved quality of clinical care, and smoother processes across the healthcare continuum. This means shifting away from mail-based COB information and adopting data-driven, real-time verification of coverage and benefits.

Proactive verification of coverage information during enrollment periods or before prior authorizations, service delivery or billing prevents improper payments from occurring. It also alleviates many of the challenges associated with post-pay recovery, such as "pay and chase," claims rework and other administrative burdens. Moving the COB process to the prior authorization process also enables providers to schedule patients more effectively and have a more complete picture of the benefits available to their patients..

It's important to recognize, however, that mandatory pay and chase requirements and reporting lags still drive the need for post-pay recovery. As a result, organizations need a holistic, 360-degree approach to maximize efforts on both ends of the COB spectrum.

Conclusion

Coordination of benefits is an essential function of all healthcare programs. While it is common for healthcare organizations to have an established COB or TPL process, the process should not be left to maintenance mode. A well-run COB program incorporates data, technological, policy and partnership innovations to drive improved cost savings, administrative efficiency and care coordination.

For over 45 years, HMS has been developing innovative solutions to address the needs of payers, providers, and consumers in coordinating health benefits and maximizing healthcare dollars. Today, HMS continues to move healthcare forward as an advocate and vanguard in COB for Medicaid, Medicare, commercial health plans, marketplaces and exchanges in an effort to help make healthcare work better for everyone.

Visit HMS.com to learn more about our comprehensive coordination of benefits solutions.

HMS® advances the healthcare system by helping healthcare organizations reduce costs and improve health outcomes. Through our industry-leading technology, analytics and engagement solutions, we save billions of dollars annually while helping consumers lead healthier lives. HMS provides a broad range of coordination of benefits, payment integrity and population health management solutions that help move the healthcare system forward. Visit us at **www.hms.com** follow us on Twitter at **@HMSHealthcare**

hms.com

References

[i]Association For Community Affiliated Plans (ACAP). "Overlap Between Medicaid Health Plans and QHPs in the Marketplaces: An Examination." April 2016. Retrieved from http://www.njhcqi.org/wp-content/uploads/2016/11/Association-for-Community-Health-Plans-Overlap-Between-Medicaid-Health-Plans-and-QHPs-in-the-Marketplace-April-2016.pdf

[ii]Health Care Transformation Task Force (HCTTF). "Health Care Transformation Task Force Announces Substantial Increase in Value-Based Payments." 18 Dec 2018. Retrieved from https://hcttf.org/2017-member-transformation-progress-report

[iii]GAO. "MEDICAID Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks (Statement of Gene L. Dodaro, Comptroller General of the United States)." 27 Jun 2018. Retrieved from https://www.gao.gov/assets/700/692821.pdf

[iv]Graham, Tina. "You might be losing thousands of dollars a month in 'unclean' claims." n.d. Retrieved from https://www.mgma.com/resources/revenue-cycle/you-might-be-losing-thousands-of-dollars-per-month

[v]The Office of the National Coordinator for Health Information Technology. "Interoperability." Retrieved from https://www.healthit.gov/sites/default/files/facas/TEF_TF_21stCenturyCures_4003.pdf