Statement To

DEPART OF HEALTH AND HUMAN SERVICES

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

SUBCOMMITTEE ON STANDARDS

June 10, 2014

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Members of the Subcommittee, I am Laurie Darst, Revenue Cycle Regulatory Advisor at Mayo Clinic. I would like to thank you for the opportunity to present testimony today concerning Coordination of Benefits (COB). The focus of my testimony is to discuss potential opportunities related to Payer-to-Payer COB and the associated issues the industry would need to address to realize the administrative simplification benefits.

Current Medicare Crossover Process

Currently, the only Payer-to-Payer COB activity currently conducted is the Medicare Crossover. This process greatly benefits both the provider and the patient. The Medicare Crossover process allows the participating Medicare supplement payers to send their subscriber enrollment information to Medicare. Medicare then uses this information to flag processed claims. Medicare creates an 837 form with the processed claim payment information which is sent to the payer immediately after the Medicare payment has been issued. There is no delay in expediting secondary payment consideration. Providers do not need to expend resources matching up the Medicare Explanation of Benefits (EOBs) and then sending the claims to the Medicare supplemental payer. Payment is made more timely which benefits both the provider and the patient. There are currently 900 payers signed up to participate in the Medicare Crossover process. At Mayo Clinic, we identified 55,711 claims that Medicare automatically sent COB information to secondary payers in the month of April. This claim volume translates to an 11 FTE savings in claim filing resources.

As beneficial as the Medicare crossover process is to providers, there are a few opportunities for improvement with COB that I will address later in my testimony. These opportunities will be an important factor as we look at potentially expanding COB to other commercial payers.

Expanding COB to Other Payers

Given the success of the Medicare Crossover process, we feel there is an opportunity to further expand Payer-to-Payer COB. Payer-to-Payer COB would cut down on resources required to match primary payer EOBs and send the primary payment information along with the claim to the secondary payer. If Payer-to-Payer COB was implemented, resource savings projections for our organization alone are an average of 23,000 claims per month, with an anticipated staffing resource savings opportunity of 4.6 FTE. In addition, providers would

receive their payments sooner, thereby reducing their Days Receivable Outstanding (DRO). Finally, our patients would benefit by having their claims adjudicated sooner.

Another potential benefit of expanding COB to commercial payers is the opportunity for reducing COB denials and associated rework when a provider does not have the most up-to-date primary insurance information. Today, both providers and payers rely on patient supplied information to update primary/secondary coverage changes. If the industry considered adoption of the same type of subscriber enrollment file exchange that is used for Medicare, most of the COB denials and rework could be dramatically reduced. In the situation where the receiving payer was not the primary payer, they could forward the claim to the primary payer based on the information they received in the enrollment file.

To summarize, the potential benefits of Payer-to-Payer COB for providers include:

- Reduced administrative overhead of filing claims to a secondary payer
- Reduced DRO with faster payment from the secondary payer
- Potential opportunity to update or correct primary/secondary designation, resulting in less COB denials and rework
- Benefits to patients due to more timely payment processing

Issues for the Industry to Address in Order to Realize These Benefits

There are a number of issues that need to be addressed if we move forward with Payer-to- Payer COB. It would be important to have open dialog between stakeholders to make Payer-to-Payer COB viable. Some of the issues that need to be addressed from a provider perspective include:

- Clear understanding on which payers are participating with Payer-to-Payer COB. This is critical so resources and duplication of effort do not occur.
- It would also be important to know those instances when a participating COB payer did not forward the claim. In today's Medicare crossover, a remark code is indicated when the crossover occurs and to which payer. However, no notification is sent if the crossover fails.
- Timely updates to insurance changes are essential, whether new insurance or change in primary/secondary designation. This is an issue today.
- Small payers may not have the resources or technology in place to do COB

Conclusion

In conclusion, we feel there are cost reduction opportunities and DRO savings with Payer-to-Payer COB. The technology to automate COB is there, but is not widely deployed. There are barriers to overcome to streamline this process. We would recommend further exploration be done by the industry (perhaps by CORE Operating Rules or WEDI) to determine the feasibility and essential steps to implement of Payer-to-Payer COB.

I would like to thank the Committee for the opportunity to testify today.