Policy:	MA.4015
Title:	**Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/16/2024*
Effective Date:	01/01/2010
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines CalOptima Health's process to ensure medical claims are paid in the proper sequence if Other Health Coverage (OHC) has been identified and verified for a OneCare Member.

II. POLICY

A. The Centers for Medicare & Medicaid Services (CMS) does not pay for services to the extent that there is a third party that is required to be the Primary Payer. When there is a Primary Payer other than Medicare, Coordination of Benefits (COB) is required.

B. A OneCare Member may have Other Health Coverage (OHC), including, but not limited to, an employer group health plan (EGHP), retiree coverage, military coverage, a worker's compensation claim, or a third-party liability claim.

C. For Members with OHC in addition to Medicare, Medicare regulations dictate which coverage is Primary Payer.

D. CalOptima Health shall ensure the proper sequence of payers for medical claims in accordance with Section III.C. of this policy.

E. The CalOptima Health Enrollment & Reconciliation (E&R) staff shall update OneCare Member data systems with a flag indicating OHC to facilitate COB.

F. A Member's EGHP may terminate while they are a OneCare Member. If the Member's EGHP terminates, the CalOptima Health E&R staff shall enter the EGHP termination into Medicare's Electronic Correspondence Referral System (ECRS) and update the CalOptima Health core business system.

III. PROCEDURE

A. CMS sends CalOptima Health a combined monthly MSP/COB Medicare Secondary Coverage/Part D COB data file listing OneCare Members with EGHP or OHC.

B. CalOptima Health may also receive an ad hoc notice about EGHP or OHC through other sources, including, but not limited to, information volunteered by Members, information received with medical claims, and information offered by Providers.

C. To ensure the proper sequence of payers for medical claims, the CalOptima Health E&R staff shall:

1. Research, identify, and validate EGHP or OHC as provided by the Centers for Medicare & Medicaid Services (CMS) in the Medicare Secondary Payer/Part D COB data files.

2. Enter accurate and complete updates directly into Medicare's web-based electronic correspondence referral system (ECRS) and the CalOptima Health core business system.

3. Maintain documentation of EGHP, or OHC, to facilitate COB.

D. For MSP/COB updates, within thirty (30) calendar days of receipt of EGHP or OHC information, CalOptima Health's E&R staff shall outreach to the other health plan to validate the information. CalOptima Health's E&R staff shall follow unsuccessful outreach attempts to the other health plan with a written request to the OneCare Member for confirmation of other EGHP or OHC data.

E. CalOptima Health's E&R staff shall track EGHP, or OHC, data and outreach findings in an Excel file located on a shared drive and accessible to designated staff in CalOptima Health's Claims Departments.

F. The E&R staff shall maintain the core business system with EGHP and OHC updates, identifying Members accordingly, to facilitate claims COB.

G. The E&R staff shall enter EGHP, or OHC, additions, changes, or updates directly into Medicare's ECRS.

H. The E&R staff shall monitor and ensure that a Member's termination of EGHP results in deletion of the OneCare Member's name from the subsequent monthly MSP data file.

IV. ATTACHMENT(S)

A. OneCare Complete Other Health Care Coverage Letter
B. OneCare Flex Plus Other Health Care Coverage Letter

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. Medicare Managed Care Manual, Chapter 4, Sections 120 and 130.
C. Social Security Act, §1862(b) [42 USC, §1395y(b)(5)]
D. Title 42, Code of Federal Regulations (C.F.R.), § 422.108

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2010	MA.4015	Medicare Secondary Payer (MSP)	OneCare
Revised	01/01/2010	MA.4015	Medicare Secondary Payer (MSP)	OneCare
Revised	02/01/2014	MA.4015	Medicare Secondary Payer (MSP)	OneCare
Revised	09/01/2015	MA.4015	Medicare Secondary Payer (MSP)	OneCare
Revised	01/01/2017	MA.4015	Medicare Secondary Payer (MSP)	OneCare
Revised	06/01/2018	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare
Revised	10/01/2019	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare
Revised	07/01/2020	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare
Revised	10/01/2021	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare
Revised	11/01/2022	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare
Revised	10/01/2023	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare
Revised	11/01/2023	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare
Revised	12/01/2024	MA.4015	Medicare Secondary Payer (MSP)/Part D Coordination of Benefits (COB)	OneCare

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs
Coordination of Benefits (COB)	The practice of ensuring that insurance claims are not paid multiple times when an enrollee is covered by more than one health plan at the same time.
Medicare Secondary Payer (MSP)	The term generally used when the Medicare program does not have primary payment responsibility.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Other Health Coverage (OHC)	Evidence of health coverage other than OneCare including, but not necessarily limited to: 1. The CalOptima Health Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
Primary Payer	Any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a group health plan or large group health plan, a worker's compensation law or plan, an automobile or liability insurance policy or plan, including a self-insured plan), or no fault insurance. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.