KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Coordination of Benefits (COB) / Medicare Secondary Payer (MSP)	**Policy #**	6.43- P
Policy Owner	Claims	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	03/12/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to establish a standardized process for managing Coordination of Benefits (COB) and Medicare Secondary Payer (MSP) to ensure claims payment integrity, accurate claims processing, and compliance with Centers for Medicare & Medicaid Services (CMS) rules and regulations. By implementing this policy, KHS aims to:

1. Ensure compliance with CMS rules and regulations
2. Accurately identify primary and secondary payer responsibilities and adjudicate claims accordingly
3. Minimize financial errors and safeguard against claim overpayments due to improper claims coordination.

II. POLICY

KHS is required to coordinate benefits in compliance with CMS Medicare Secondary Payer (MSP) guidelines. It is the policy of KHS to ensure that benefits are coordinated for enrollees who have multiple health insurance coverages as outlined by CMS guidelines governing Medicare Advantage plans. The COB process ensures that claims are paid correctly by identifying the health benefits available to a Medicare beneficiary by coordinating the payment process, ensuring that the primary payer, whether KHS or other insurance, pays first.

The claims adjudication system in use must be configured to apply COB rules automatically by checking primary payment amounts before calculating the payment responsibility of KHS. KHS will identify when enrollees have additional insurance coverage, typically collected during enrollment and updated annually or as needed. Eligibility and coverage details are to be verified through CMS databases and sources, including the Medicare Secondary Payer (MSP) file, Common Working File (CWF), etc.

In cases where KHS is determined to be secondary to other health insurance (OHI), the amount payable by KHS must be determined. On paper claims, an Explanation of Payment (EOP) from the primary payer must accompany the claim, identifying that the primary insurance payment or denial has been received and applied corrected. In cases where the claim was denied by the primary payer, the reviewer is required to research the reason for the

initial denial:

1. If the denial by the primary payer is related to the need for additional information or development, the claim will not be payable by KHS until all claim development has been completed. The claim must then be denied with an appropriate reason code stating clearly that once the claim has been fully processed and adjudicated by the primary payer, a final EOP must be resubmitted along with the claim.

2. If the primary claim was denied for benefit or coverage reasons (e.g., not a covered service, service exceeds plan benefits, coverage not effective on date of service, etc.), the claim should be processed under associated Medicare coverage benefits in accordance with Medicare regulations.

3. Per this policy, claim denials or underpayments by the primary payer should be adjusted according to plan benefits.

Similarly, KHS may use electronic data exchanges with other insurers to improve accuracy and efficiency in identifying other payer information. KHS is also required to coordinate submitting accurate COB information to CMS as required to maintain compliance with Medicare Advantage reporting requirements. KHS may also bill group health plans (GHP) and large group health plans (LGHP) for services furnished to enrollees who are also covered under the GHP or LGHP and may bill the enrollee to the extent that he or she has been paid by the GHP or LGHP.

Specific Provisions for Part D Coverage:

The COB process must accommodate the needs for Part D benefits. The COB process must provide the True Out-of-Pocket (TROOP) Facilitation Contract and Part D plan with the secondary, non-Medicare prescription drug coverage that it must have to facilitate payer determinations and the accurate calculation of the TrOOP expenses of beneficiaries.

As part of the monitoring and oversight process, COB/MSP processes must be routinely audited to ensure compliance and claim payment accuracy.

III. PROCEDURES

A. Coordination of Benefits (COB) and Medicare Secondary Payer (MSP)

KHS shall administer Coordination of Benefits (COB) and Medicare Secondary Payer (MSP) activities in accordance with applicable requirements of the Centers for Medicare & Medicaid Services (CMS) and the Medicare Secondary Payer Act, as applied to Medicare Advantage organizations.

B. Identification of Other Coverage

1. KHS shall obtain and maintain accurate information regarding enrollee coverage under other health benefit plans.

2. Other coverage information shall be collected at enrollment and updated when KHS becomes aware of changes.

3. Systems shall be maintained to document and track primary and secondary payer status.

C. Determination of Payer Order

1. KHS shall determine primary and secondary payer responsibility in accordance with CMS MSP guidelines.

2. Payer order determinations shall be applied consistently and supported by documented evidence.

3. System controls shall ensure claims are processed in alignment with established payer order.

D. Claims Adjudication

1. When KHS is the primary payer, claims shall be adjudicated in accordance with the enrollee's plan benefits.

2. When KHS is the secondary payer, claims shall be coordinated based on the primary payer's adjudication and in accordance with CMS requirements.

3. KHS shall ensure that total payments do not exceed allowable amounts and that duplicate payments are prevented.

IV. DEFINITIONS

TERMS	DEFINITIONS
Coordination of Benefits (COB)	The process that determines the order in which multiple health insurance plans will pay benefits to ensure that payment does not exceed 100% of the covered healthcare expenses.
CMS	Centers for Medicare & Medicaid Services, the Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations.

TERMS	DEFINITIONS
D-SNP/SNP	Dual Special Needs Plan or Special Needs Plan. Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.
Enrollee or Member	An individual who has completed an application to enroll into the plan and been confirmed by CMS.
Group Health Plan	A GHP is any plan of, or contributed to by, one or more employers to provide health benefits or medical care (directly or otherwise) to current or former employees, the employer, or families
Large Group Health Plan (LGHP)	A group health plan that is available to employees of one or more employers who normally employed at least 100 employees on at least 50 percent of its business days during the previous calendar year.
Medicare Advantage (MA)	Medicare Advantage Plans are another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D).
Medicare Secondary Payer (MSP)	Regulations that require Medicare to pay secondary to certain group health plans and other insurances when specific criteria are met. Generally used when the Medicare program does *not* have primary payment responsibility.
Primary Payer	The health plan that has the primary responsibility of paying a claim.
Secondary Payer	The health plan that has the secondary responsibility for paying a claim after the primary payer has fulfilled its obligations.
True Out-of-Pocket (TrOOP) Costs	Refers to the expenses that count toward a Medicare beneficiary's out-of-pocket limit for Part D coverage. Once the enrollee reaches the maximum TrOOP, Medicare typically covers most of the drug costs.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type:	Specific Reference:
Regulation / Guideline	42 CFR § 422.108 Medicare secondary payer (MSP) procedures (
Regulation / Guideline	Medicare Secondary Payer (https://www.cms.gov/medicare/coordination-benefits-recovery/overview/secondary-payer)
Regulation / Guideline	Medicare Secondary Payer Manual, Chapter 5 § 40.8.1 – 50.1.1

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with D-SNP	Claims

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
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