

POLICY AND PROCEDURE	
Title: Coordination of Benefits (COB), True-Up and Financial Information Reporting (FIR)	
Primary policy owner: Pharmacy	Policy #: PH34
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) <input type="checkbox"/> All Departments 2) <input type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input checked="" type="checkbox"/> Benefits Administration (BA) 4) <input type="checkbox"/> Case Management (CM) 5) <input checked="" type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input checked="" type="checkbox"/> Configuration (CFG) 9) <input type="checkbox"/> Provider Contracting (CONT) 10) <input checked="" type="checkbox"/> Cultural & Linguistics (CL) 11) <input checked="" type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input checked="" type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input checked="" type="checkbox"/> Information Technology / Core Systems (IT) 16) <input checked="" type="checkbox"/> Pharmacy (PH) 17) <input type="checkbox"/> Provider Networks (PRO) 18) <input type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input checked="" type="checkbox"/> Medical Management (MM)
Product Type: <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> D-SNP	Supersedes Policy Number: NA

I. PURPOSE

To ensure Health Plan of San Joaquin and Mountain Valley Health Plan (“Health Plan”) is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-

compliance. Health Plan Workforce and Delegates perform Coordination of Benefit (COB), apply True Out-Of-Pocket (TrOOP) calculations and Financial Information Reporting (FIR) according to the Centers of Medicare and Medicaid Services (CMS) regulations and in compliance with federal and state regulations and other program requirements.

II. POLICY

- A. Health Plan must coordinate with State Pharmaceutical Assistance Programs (SPAPs) and other providers of prescription drug coverage with respect to the payment of premiums and coverage, as well as coverage supplementing the benefits available under Part D.
- B. Health Plan must establish effective exchange of information and coordination between SPAP, Medicaid programs, group health plans, Federal Employees Health Benefits Program, military coverage (including TRICARE), Indian Health Services, Federally Qualified Health Centers, and other programs that provide financial assistance for the purchase of Part D drugs on behalf of eligible members (such as AIDS Drug Assistance Programs).
- C. Health Plan must keep track of the members TrOOP amount by calculating Part D allowable incurred costs paid by the member or a third party on behalf of the member including low-income subsidy.
- D. Health Plan must adjust the TrOOP amounts when retroactive changes to a member's claim is reversed or when enrollment or Low-Income Subsidy (LIS) level affects member's cost-sharing, and/or plan benefit phase.
 - 1. Health Plan must adjust the TrOOP amount when a claim is reversed at the Point-Of-Sale (POS).
 - 2. Health Plan must make the retroactive adjustments timely and issue refunds or recovery notices within 45 days of receipt of LIS changes, FIR, and/or, Nx transactions necessitating the claims adjustment.
- E. Health Plans must use the National Council for Prescription Drug Programs (NCPDP) FIR standard to transfer TrOOP balances and gross covered drug

costs whenever a beneficiary makes an enrollment change at the contract-level during the coverage year.

1. Health Plan must successfully transfer TrOOP accumulator data within 15 days of the effective date of the new enrollment.

III. PROCEDURE

- A. Health Plan works with the Pharmacy Benefit Manager (PBM) to ensure effective exchange of information and coordination between health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Part D drugs on behalf of eligible beneficiaries.
 1. Health Plan receives members' COB File via Medicare Advantage and Prescription Drug System (MARx). The COB File contains full-record replacements for enrollees with newly discovered or changed Other Health Insurance (OHI).
 2. Health Plan shares members' eligibility files daily with the PBM.
- B. The PBM uses its COB processes to coordinate benefits processes, as required by CMS by ensuring the following:
 1. POS claims processing shall adjudicate claims and track TrOOP in real time.
 2. POS claims processing shall use the OHI information registered for a beneficiary.
 3. The PBM processes NCPDP Nx transactions relating to secondary claims processing by other payers generated by the Transaction Facilitator and adjust the TrOOP accumulation for the beneficiary based on the other payer's TrOOP eligibility status.
- C. The PBM conducts retroactive changes to the TrOOP through a True Up process:
 1. The PBM executes the True Up adjustment process approximately every three weeks to accommodate the CMS requirement to either issue a refund or collection notice within 45 days of the retroactive event.
 2. Retroactive changes shall include, among others, members with External Accumulators, Members with N1 Claims, member that

- moved from Low Income Cost Sharing (LICS) to non-LICS and members with any LICS change.
3. The True Up process reviews all claims since the time of the retroactive change to determine the current beneficiary cost share, TrOOP, and total drug cost for each claim based on movement between phases of the Part D benefit.
 4. Claim adjustments and Prescription Drug Event (PDE) adjustments are created on claims where differences are determined.
 5. Upon completion of an individual beneficiary's True Up, and based on whether there is a balance due to Health Plan or balance due to the member, the PBM provides a detailed report to Health Plan.
- D. The PBM is delegated the process of performing FIR: a process by which a member who has changed from one health plan to another health plan or point-in-time financial information is moved real-time from the previous Part D sponsor to the new Part D sponsor.
1. Health Plan must have a signed Business Associate Agreement (BAA) with the Transaction Facilitator (RelayHealth).
 2. Each year, Health Plan attests on the Annual Readiness Assessment, under section J. COB and Automatic TrOOP Balance Transfer, whether the organization executed a business associate agreement (BAA) with the Transaction Facilitator, or not.
- E. Health Plan completes, annually, the "Annual ATBT and Nx Report Distribution Email list for 20xx -20xx" form and send to tbtsupport@relayhealth.com. The completed form is submitted, annually, to TBTSupport@relayhealth.com no later than December 18 to be effective as of January 2 of the following year.
- F. Health Plan completes the "Annual PBM Reject Aging Report Distribution Email List" document and sends to TBTSupport@relayhealth.com each year, no later than December 18 to be effective as of January 2 of the following year.
- G. The PBM's provides Health Plan with the FIR Transaction Activity Report with beneficiary level and financial details associated to every outgoing (F1, F3) and incoming (F2, F3) FIR transaction for the reporting period.

H. Health Plan and PBM receive their respective version of the “Daily Cumulative Aging” report that identifies every beneficiary with an unsuccessful FIR transaction as of the report date. Health Plan works with the PBM and the Enrollment Department to investigate the eligibility issue. Health Plan and the PBM resolve eligibility errors within 15 days from the time of initial error.

IV. ATTACHMENT(S)

- A. Desk- Level Procedure (DLP) or Department Job Aide
- B. State Medicaid Agency Contract (SMAC)
- C. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)
- D. [Glossary of Terms Link](#)

V. REFERENCES

- A. Code of Federal Regulations 42 CFR§ 423.466(a) and § 423.800(e)
- C. Medicare Prescription Drug Benefit Manual (PDBM) Chapter 14: Coordination of Benefits
- D. Medicare Part D Coordination of Benefits and COB Recovery Program Description: <https://www.cms.gov/medicare/coordination-benefits-recovery/overview>

VI. REVISION HISTORY

Version*	Revision Summary	Date
001		
002		
003		
004		
Initial Effective Date: 09/29/2025		
Published Date:09/29/2025		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee	001	09/24/2025
<ul style="list-style-type: none"> Privacy & Security Oversight Committee 		
<ul style="list-style-type: none"> Program Integrity Committee 		
<ul style="list-style-type: none"> Audits & Oversight Committee 		
<ul style="list-style-type: none"> Policy Review Committee 		
Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> Quality Operations Committee 		
<ul style="list-style-type: none"> Grievance Committee 		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)			
Department of Managed Care (DMHC)			

IX. Approval signature*

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy