State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: March 30, 2017

ALL PLAN LETTER 17-003

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TREATMENT OF RECOVERIES MADE BY THE MANAGED CARE HEALTH PLAN OF OVERPAYMENTS TO PROVIDERS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) relating to an MCP's recovery of all overpayments to providers.

BACKGROUND:
Effective July 1, 2017, Title 42 of the Code of Federal Regulations (CFR), section (§) 438.608(d), requires DHCS to specify in its contracts policy and procedures related to treatment of MCP recovery of overpayments to providers. The MCP contract, Exhibit E, Attachment 2, sets forth generally the requirements of 42 CFR §438.608(d). This APL provides additional guidance on (1) overpayment retention policies; (2) annual reporting requirements; and (3) the MCP's duty to require reporting by network providers.[1]

An "overpayment" is any payment made to a network provider by an MCP to which the network provider is not entitled to under Title XIX of the Social Security Act.[2]

A "network provider" is defined as any provider, group of providers, or entity that has a network provider agreement with an MCP, or a subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCP.[3]

"Fraud" is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.[4]

1 42 CFR §438.608(d)
2 42 CFR §438.2
3 42 CFR §438.2
4 42 CFR §455.2 and Welfare and Institutions (W&I) Code §14043.1

"Waste" is not specifically defined but is generally understood to mean the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.[5]

"Abuse" is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.[6]

POLICY:
This policy applies to all overpayments and recoveries of overpayments from the MCP to a network provider, including overpayments due to fraud, waste, or abuse, identified by the MCP.

A. MCP Retention of Provider Overpayments

Each MCP shall create an internal retention and documentation process for recovery of all overpayments and review quarterly for accuracy.

The MCP shall retain all recoveries less than $25 million.

In the event an MCP recovers an overpayment to a provider of $25 million or more, DHCS and the MCP will share the recovery amount equally. 60 days after the date that the overpayment was identified, the MCP must report the overpayment to DHCS through their contract manager. DHCS will recoup the overpayment from the MCP capitated payment. The statement issued to the MCP will reflect the overpayment. The MCP shall submit the overpayment amount that was recovered, the provider(s) information, and steps taken to correct future occurrences to the MCP's assigned Managed Care Operations Division Contract Manager.

Recoveries retained under False Claims Act cases or through other investigations are not subject to this policy.

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5 Fraud, Waste, and Abuse Toolkit. Healthcare Fraud and Program Integrity: An Overview for Providers.(2014). Centers for Medicare and Medicaid Services. Retrieved at http://ow.ly/Mnb130al2By.
6 42 CFR §455.2

B. MCP Annual Reporting Requirements

Each MCP must report annually to DHCS on their recoveries of overpayments, including those made to a network provider that was otherwise excluded from participation in the Medicaid program and those made to a network provider due to fraud, waste or abuse.[7] These reports shall be submitted though the existing rate setting process in a manner specified by DHCS. In addition, MCPs shall submit documentation, including retention policies, process, timeframes, and documentation required for reporting the recovery of all overpayments, upon request by DHCS.[8]

C. Provider Reporting Requirements to MCP

Each MCP shall require network providers to report to the MCP when it has received an overpayment, to return the overpayment to the MCP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCP in writing of the reason for the overpayment.[9]

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

[7] 42 CFR §438.608(d)(3)
[8] 42 CFR §438.608(d)(1)
[9] 42 CFR §438.608(d)(2)