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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: July 1, 2019

MHSUDS INFORMATION NOTICE NO.: 19-034

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS
CALIFORNIA STATE ASSOCIATION OF COUNTIES
CALIFORNIA CONSORTIUM OF ADDICTION PROGRAMS AND PROFESSIONALS

SUBJECT: OVERPAYMENTS RECOVERY AND REPORTING PROCEDURES

REFERENCE: TITLE 42, CODE OF FEDERAL REGULATIONS SECTION 438.608

EXPIRES: Retain until superseded

PURPOSE

This information notice provides guidance to Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Counties, herein referred to as Plans, on their obligations to recover and report overpayments made by the Plans to their contracted providers per the Federal Medicaid Managed Care Final Rule (Final Rule) and the Federal Mental Health and Substance Use Disorder Services Parity Final Rule (Parity Rule) requirements.

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule CMS-2390-F in the Federal Register (81 Fed. Reg. 27497) aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. County Plans are classified as Prepaid Inpatient Health Plans, and therefore,

must comply with federal managed care requirements (with some exceptions). On March 30, 2016, CMS issued Final Rule CMS-2390-P in the Federal Register (81 Fed. Reg. 18390) to apply the Paul Wellstone Mental Health Parity and Addiction Equity Act to Medicaid benefits. The Parity Rule strengthens access to mental health and substance use disorder services for Medicaid beneficiaries. These regulations amend and expand the requirements of Title 42, Code of Federal Regulations (CFR) Part 438, pertaining to managed care. This information notice addresses the program integrity requirements contained in 42 CFR, section 438.608(d).

ADMINISTRATIVE REQUIREMENTS

1. Plans must ensure that they have:
    a. Retention policies for the treatment of recoveries of all overpayments from providers, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. An overpayment means any payment made to a network provider by the Plan to which the network provider is not entitled to under Title XIX of the Act or any payment to the Plan by the State to which the MHP is not entitled to under Title XIX of the Act.
    b. A written process, timeframe and documentation requirements for the recoveries of all overpayments due to the Department of Health Care Services (DHCS), (Medi-Cal reimbursable claims overpayment recoveries).
    c. A written process, timeframe and documentation requirements for the recoveries of all overpayments **not** due to the state (Non Medi-Cal reimbursable claims overpayment recoveries).

    The requirements above do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

2. Plans must have a mechanism, that allows a network provider to report to the Plan whenever they have received an overpayment. The overpayment must be returned to the Plan within 60 calendar days after the date on which the overpayment was identified. The network provider must also notify the Plan in writing of the reason for the overpayment. Any future changes or reversals to claims must meet all claim timeliness requirements.

REPORTING REQUIREMENTS

1. Plans must void all approved Medi-Cal claims associated with overpayment recoveries from providers using the normal Short-Doyle Medi-Cal claim voiding process. Plans do not need to report to the DHCS overpayments for Non Medi-Cal reimbursable services.

2. As an addition to the normal claim voiding process, and per the new requirements of 42 CFR, section 438.608(d), Plans must create a void report using the attached template, listing all voided claims in a Microsoft Excel spreadsheet format with the following headers:
    a. Payer Claim Control Number
    b. Client Index Number
    c. Health Care Provider National Provider Identifier
    d. Payment Amount
    e. Federal Financial Participation Amount
    f. Recovery Type Classification
        - 42 CFR, section 438.608(d) or;
        - All other Medi-Cal

3. The excel spreadsheet void report must be sent to DHCS on an annual basis no later than the last day of February, following the close of every state Fiscal Year (FY) to MedCCC@dhcs.ca.gov with the subject line in the following format: "Annual Void Report-Plans Program Type (MHP or DMC-ODS)-2 Digit County Code-FY XXXX-XX". See the examples below that uses "99" as a two digit county code and "FY 2018-19" as the year of the void report:

    Annual Void Report-MHP-99-FY 2018-19
    Annual Void Report-DMC-ODS-99-FY 2018-19

4. Plans must also submit a signed certification in accordance with 42 CFR, section 438.606 using the certification form in the attached template. The signed certification is specific to this information notice.

For any questions regarding this information notice, please contact Moses Ndungu, Chief, Fiscal Policy Section, Mental Health Management and Outcomes Reporting Branch, Mental Health Services Division, at Moses.Ndungu@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services

Enclosures