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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 20, 2022

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: **APL 22-003E: ERRATA TO TREATMENT OF RECOVERIES MADE BY DENTAL MANAGED CARE PLANS OF OVERPAYMENTS TO PROVIDERS**

SUPERSEDES DENTAL ALL PLAN LETTER 22-003

Note: This Errata is an updated All Plan Letter (APL) to reflect the changes noted below.

- Definitions have been revised to match the Centers for Medicare and Medicaid Services' Fraud, Waste and Abuse Toolkit and 42 CFR § 455.2.
- Additional requirements and revised language to Dental Managed Care (DMC) Plan Retention and Reporting of Provider Overpayments, DMC Plan Annual Reporting Requirements, and Provider Reporting Requirements to DMC Plans.
- Additional requirements from the DMC Plans to DHCS.

PURPOSE:

The purpose of this APL is to provide guidance and clarification to DMC Plans regarding federal and state legal requirements for a DMC Plan's recovery of all overpayments made to providers.

BACKGROUND:

Effective July 1, 2017, Title 42 of the Code of Federal Regulations (CFR), section 438.608(d), requires the Department of Health Care Services (DHCS) to specify in its contracts policies and procedures related to the treatment of DMC Plans' recovery of overpayments made to providers. Exhibit E (Additional Provisions), Provision 27 of the DMC contract generally sets forth the requirements of 42 CFR section 438.608(d). This APL provides additional guidance and clarification on (1) overpayment retention and reporting policies; (2) annual reporting requirements; and (3) the DMC Plan's duty to require reporting by network providers.[1]

[1] 42 CFR section 438.608(d).

An “overpayment” is any payment made to a network provider by a DMC Plan to which the network provider is not entitled under Title XIX of the Social Security Act.[2]

A “network provider” is any provider, group of providers, or entity that has a network provider agreement with a DMC Plan, 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 a DMC Plan.[3]

“Fraud” is 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]

“Waste” is the overutilization, underutilization or misuse of resources, and typically is not a criminal or intentional act.[5]

“Abuse” is provider practices that are inconsistent with sound fiscal, business, or dental practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for dental 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 from the DMC Plan to a network provider, and recoveries of such overpayments, including overpayments due to fraud, waste, or abuse, identified by the DMC Plan.

A. DMC Plan Retention and Reporting of Provider Overpayments

Each DMC Plan shall create an internal retention and documentation process for recovery of all overpayments and review bi-annually for accuracy.

Recoveries less than $1 million
The DMC Plan shall retain all overpayment recoveries less than $1 million. The DMC Plan is not required to report an overpayment of less than $1 million to DHCS within 60 calendar days of when the overpayment was identified.

---

[2] 42 CFR section 438.2.
[3] *Id.*
[4] 42 CFR section 455.2; Welfare & Institutions Code section 14043.1.
[5] Fraud, Waste, and Abuse Toolkit. Healthcare Fraud and Program Integrity: An Overview for Providers. (2015). Centers for Medicare and Medicaid Services. Retrieved at https://dbhids.org/wp-content/uploads/2015/10/Health-Care-Fraud-and-Program-Integrity-An-Overview-for-Providers.pdf.
[6] 42 CFR § 455.2.

Recoveries equal to or more than $1 million
The DMC Plan shall split equally all overpayment recoveries of $1 million or more with DHCS. The DMC Plan must report an overpayment of $1 million or more to DHCS through Medi-Cal Dental Services Division at dmcdeliverables@dhcs.ca.gov within 60 calendar days of the date that the overpayment of $1 million or more was identified, and provide the following information:

1. The overpayment amount that was recovered;
2. The reason for the overpayment;
3. The services the overpayment was related to, if applicable;
4. The provider(s) information; and
5. The steps taken to correct future occurrences.[7]

DHCS will work directly with the DMC Plan to either recoup the overpayment from the DMC Plan's capitated payment and reflect the overpayment in the statement issued to the DMC Plan or require a check or wire from the DMC Plan.

Recoveries of any amount
In the event a DMC Plan identifies or recovers an overpayment to a provider due to potential fraud, the DMC Plan must notify DHCS within ten days of identifying the overpayment, regardless of the amount.[8]

Recoveries retained under False Claims Act cases or through other investigations are not subject to this policy.[9]

B. DMC Plan Annual Reporting Requirements

Each DMC Plan must report annually to DHCS through the Rate Development Template on their recoveries of overpayments, regardless of amount or category, including overpayments 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.[10] Furthermore, the DMC Plan must resubmit encounter data for all identified overpayments.

DMC Plans shall submit documentation, including but not limited to, retention policies and the process, timeframes and documentation required for reporting the recovery of all overpayments, upon request by DHCS.[11]

[7] 42 CFR section 438.608(c)(3).
[8] 42 CFR section 438.608(a)(2).
[9] 42 CFR section 438.608(d)(1).
[10] 42 CFR section 438.608(d)(3).
[11] 42 CFR section 438.608(d)(1).

C. Provider Reporting Requirements to DMC Plans

Each DMC Plan shall require network providers to report to the DMC Plan when the network provider has received an overpayment, to return the overpayment to the DMC Plan within 60 calendar days after the date on which the overpayment was identified, and to notify the DMC Plan in writing of the reason for the overpayment.[12]

REQUIREMENTS:
If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in the DMC Plan's policies and procedures (P&Ps), the DMC Plan must submit its updated P&Ps in track changes to dmcdeliverables@dhcs.ca.gov within 90 days of the release of this APL. If the DMC Plan determines that no changes to its P&Ps are necessary, the DMC Plan must submit an email attestation to dmcdeliverables@dhcs.ca.gov within 90 days of the release of this APL, stating that the DMC Plan's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DMC Plans are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs. These requirements must be communicated by each DMC Plan to all subcontractors and network providers.

If you have any questions regarding this APL, please contact the Medi-Cal Dental Services Division at dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by Carolyn Brookins for:

René Mollow, MSN, RN, Deputy Director
Health Care Benefits & Eligibility
Department of Health Care Services

[12] 42 CFR section 438.608(d)(2).