PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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I. RELATED POLICIES:

A. CMP-09 Investigating & Reporting Fraud, Waste and Abuse

B. CMP-30 Records Retention and Access Requirements

C. FIN-410 Cost Avoidance and Post Payment Recoveries for Other Health Coverage (OHC)

II. IMPACTED DEPTS:

A. All

III. DEFINITIONS:

A. Overpayment: is any payment made to a network provider by PHC to which the network provider is not entitled to under Title XIX of the Social Security Act.

B. Network Provider: is any provider, group of providers, or entity that has a network provider agreement with PHC, or PHC's subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render covered services as a result of PHC's contract with DHCS.

C. Fraud: is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 452.2: W. & I. Code Section 14043.1(f).

D. Waste: is the overutilization, underutilization or misuse of resources, and typically is not a criminal or intentional act.

E. Abuse: is 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. This also includes beneficiary practices that result in unnecessary costs to the Medicaid program (42 CFR 455.2)

IV. ATTACHMENTS:

A. PHC Internal Overpayment Reporting Template to Cost Avoidance Unit (CAU)

V. PURPOSE:

To establish a policy for PHC's recovery of all overpayments to network providers and reporting of overpayments to the Department of Health Care Services (DHCS) in accordance with state and federal

requirements.

VI. POLICY / PROCEDURE:

This policy applies to all overpayments and recoveries of overpayments from PHC to a network provider, 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. This policy does not prohibit recoveries from non-contract providers that may be otherwise considered an overpayment.

A. Retention of Overpayments

1. PHC shall retain all recoveries of a single overpayment occurrence of less than $25 million**.**
2. If PHC recovers a single overpayment of $25 million or more, PHC and DHCS will share the recovery amount equally. DHCS will recoup the overpayment from PHC from capitated payment with a statement reflecting the overpayment.
3. Recoveries retained under False Claims Act cases or through other investigations are not subject to this policy.
4. PHC reserve spending that is excluded from PHC's cost experience reporting on the rate development template (RDT) is not subject to this policy.
5. Post-payment recovery for other health coverage or third party tort liability is not subject to this policy

B. Internal Notification, Processing, and Review of Overpayments

1. Any PHC department, who identifies overpayments including any overpayments due to possible fraud, waste, and abuse, shall notify PHC's Finance Department's Cost Avoidance Unit (CAU) Inbox at CAU_Inbox@partnershiphp.org. Information reported to the CAU Inbox shall include, at least, the provider name, provider number, reason for overpayment, amount of overpayment and any additional comments, as appropriate, according to reporting template specifications.
2. Overpayments may be identified in a variety of ways including, but not limited to, routine audits, required provider reporting, and other data analytics.
3. CAU will log and evaluate reported overpayment upon receipt.
4. PHC may recoup overpayments by one of the following methods:
   a. Recoupment against future payment
   b. Capitation payment adjustments
   c. Direct payments from providers
5. At least on a bi-annually basis, overpayments evaluated by CAU will be reviewed for accuracy and reported to Regulatory Affairs via the Fraud Waste and Abuse Committee.

C. PHC Notification to Providers of Overpayments

1. PHC will notify providers of any overpayments made, including overpayments related to suspected fraud, waste, and abuse upon discovery.
2. Providers may be notified through the following mechanisms:
   a. 30-day Refund Request Letter
   b. PHC pharmacy benefits manager
   c. Other communication such as email, with copy to CAU email Inbox.

D. Reporting of Overpayments to DHCS

1. PHC shall promptly report to DHCS overpayments made to PHC network providers in accordance with DHCS contractual requirements and other related guidance, including overpayments due to

possible fraud, waste, and abuse, as specified.

2. In the event an PHC identifies or recovers an overpayment to a Provider due to potential fraud, waste or abuse, PHC shall notify its MCOD CM and the DHCS Audits and Investigations Intake Unit at piu.cases@dhcs.ca.gov within 10 days of identifying the overpayment, regardless of the amount
3. PHC shall report overpayments to network providers of $25 million or greater to the PHC contract manager at DHCS within 60 days after the date that the overpayment was identified.
    a. The CAU shall provide to Regulatory Affairs - Compliance Department, information necessary for timely reporting to the DHCS contract manager, including the following information:
        1) The overpayment amount that was recovered;
        2) The reason for the overpayment;
        3) The service(s) the overpayment was related to, if applicable;
        4) The provider(s) information; and
        5) The steps taken to correct and/or prevent future occurrences.
    b. PHC will work directly with DHCS to either recoup the overpayment from PHC's capitated payment (and reflect the overpayment in the statement issued by DHCS) or require a check or wire from PHC.
4. PHC shall report annually to DHCS on overpayments and related recoveries of overpayments to network providers, 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.
    a. These reports shall be submitted through the existing rate setting process as specified by DHCS.
    b. PHC must report annually to DHCS using the rate development template on its recoveries of overpayments, regardless of amount or category. This includes 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
5. PHC shall submit documentation, including retention policies, process, timeframes and documentation required for reporting the recovery of all overpayments, upon request by DHCS.

E. Document Retention

1. Finance department will retain all identified overpayment records and related reports generated in accordance with PHC document retention policy CMP-30.

F. Provider Reporting Requirements

1. PHC network providers are required to report to PHC when an overpayment has been received. The provider must return the overpayment to PHC within 60 calendar days after the date on which the overpayment was identified, and must notify PHC in writing of the reason for the overpayment as specified in the provider contract.
2. Providers must notify PHC as follows:
    a. Claims Inquiry Form CIF process (preferred) with comment for the reason for PHC overpayment, and/or
    b. CAU Inbox at CAU_Inbox@partnershiphp.org to include, at least;
        1) Beneficiary Full Name
        2) Claim Control Number
        3) 3-digit number explaining the type of bill
        4) Admission Date (MM/DD/YY)
        5) Discharge Date (MM/DD/YY)
        6) Date Claims was Paid (MM/DD/YY)

7) Amount of Over Payment
8) Reason for PHC overpayment
9) Provider name,
10) Provider number

c. Credit Balance Letter sent to:

Email to:
Cost Avoidance Unit
CAU_inbox@partnershiphp.org

Fax to:
Partnership HealthPlan of California Finance Department
Attn: Cost Avoidance Unit
Fax Number: (707) 420-7898

Mail to:
Partnership HealthPlan of California
Attn: Cost Avoidance Unit
4665 Business Center Drive
Fairfield, CA 94534

d. If PHC identifies an overpayment and notifies the institutional or professional provider. PHC must follow the requirements in Health and Safety Code section 1371.1.

VII. REFERENCES:

A. DHCS All Plan Letter (APL) 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers
B. PHC/DHCS Contract
C. PHC Provider Agreements
D. Title 42, Code of Federal Regulations, §438.608 (d)
E. Title 42, Code of Federal Regulations, 438.2
F. Title 42, Code of Federal Regulations, 455.2

VIII. DISTRIBUTION:

A. PowerDMS
B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Director of Internal Audit, Finance Department, Department Directors

X. REVISION DATES:

Effective: 7/1/2017
Created: 5/8/2017
Revision dates: 12/11/2019, 11/15/2021, 02/28/2024, and 03/05/2025 No change
Replaces: ADM-14: Taking back/paying out funds from Capitated and Non-Capitated entities

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PREVIOUSLY APPLIED TO:
Enter N/A if not applicable