Medicaid and CHIP Managed Care

Program Integrity Toolkit

42 CFR 438 Subpart H

Treatment of Recoveries and Overpayments §§438.608(a)(2) and (d)

Last Updated: 11/01/2023

Table of Contents

Content Summary

Through the Medicaid and the Children's Health Insurance Program (CHIP) Managed Care Program Integrity Toolkits, CMS features key topics that will help state Medicaid agencies, as well as managed care plans (MCPs) [Endnote 1], improve program integrity through greater oversight, accountability, and transparency.

This Treatment of Overpayments and Recoveries Toolkit discusses how recoveries of network provider overpayments may be treated under 42 CFR 438.608(d) and (a)(2). These regulations provide states with flexibility on how to handle recoveries made by MCPs to create incentives for MCPs to proactively oversee network provider billing practices and identify fraud, waste, and abuse.

Introduction

Medicaid and CHIP are federal-state partnerships, and those partnerships are central to the programs' success. Given the extensive and expanding use of managed care in Medicaid and CHIP, it is critical that the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies (SMAs) ensure accountability and strengthen program integrity safeguards in states' managed care programs.

This toolkit summarizes and clarifies certain program integrity provisions in 42 CFR 438 Subpart H, as finalized in the "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability" rule (referred to as the 2016 Managed Care Final Rule). [Reference 1] This toolkit provides information and examples regarding oversight practices SMAs should consider to ensure that effective program integrity measures are in place. [Endnote 2, Reference 2]

Note: This toolkit does not contain an exhaustive list of all federal requirements and is only intended to be a tool to aid SMAs in the development of contracts with, and oversight of, its Medicaid and CHIP MCPs. The contents of this toolkit do not have the force and effect of law and are not meant to bind the public or any parties in any way, unless specifically incorporated into a contract. This toolkit is intended only to provide clarity to existing requirements under the law and may be revised and updated periodically to reflect statutory, regulatory, and other policy changes. The "Last Updated" date is the date this toolkit was most recently updated.

Background

On May 6, 2016, CMS published the 2016 Managed Care Final Rule that included important program integrity safeguards in Part 438, Subpart H [adopted in CHIP via cross-reference at §457.1285 with the exception of §§438.604(a)(2) and 438.608(d)(4)]. Specifically, these regulations outlined requirements to help address fraud and other improper payments caused by MCPs and related network providers. The final rule also tightened standards for MCPs' submission of certified data, information, and documentation that are critical to program integrity oversight by state and federal agencies.

States and MCPs are required to comply, as applicable, with the program integrity requirements in §§438.600 (statutory basis and applicability), 438.602 (state responsibilities), 438.604 (data, information, and documentation that must be submitted), 438.606 (source, content, and timing of certification), 438.608 (program integrity requirements under managed care contracts), and 438.610 (prohibited affiliations). States have been required to comply with §§438.602(a), 438.602(c) – (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d), since no later than the rating period for contracts starting on or after July 1, 2017. States have been required to comply with §§438.602(b) and 438.608(b) since no later than the rating period for contracts beginning on or after July 1, 2018.

A. Applicability to Medicaid

Federal statute and regulations specify the authorities and requirements under which states can offer services via contracts with Medicaid MCPs [see generally, sections 1902 through 1905 and 1932 of the Social Security Act (the Act)]. These statutory provisions provide the basis of the federal regulatory structure found in Part 438 Subpart H. The SMA must have a monitoring process for compliance with requirements of the state's managed care program and the MCP contract with the state. SMAs are responsible for ensuring that MCPs comply with federal regulations. MCPs must provide the safeguards necessary to ensure that eligibility is determined, and that services are provided, in a manner consistent with simplicity of administration and the best interests of the recipients (see section 1902(a)(19) of the Act).

There are basic requirements listed in Part 438 Subpart H for MCPs to receive payment under a Medicaid managed care program. In general, most of the requirements apply to most MCPs, but there is variation with respect to primary care case managers (PCCMs) and primary care case management entities (PCCM entities). For example, §§438.600(b) and (c) apply to PCCMs and PCCM entities but §§438.608(a) and (d) do not. PCCMs and PCCM entities must comply with the requirements in §§ 438.604, 438.606, 438.608, and 438.610, as applicable.

B. Applicability to CHIP

Most of the program integrity requirements of Part 438 Subpart H apply to CHIP via a cross reference in §457.1285. Specifically, §457.1280 governs contracting standards and §457.1285 applies the Medicaid program integrity safeguards of Part 438 Subpart H to CHIP. [Endnote 3]

Treatment of MCP Overpayment Recoveries (§§438.608(d), (a)(2))

CMS regulations require MCPs and states to identify and recover overpayments, and if required by the state contract, return the overpayments to the state and CMS. States may develop specific templates for MCP overpayment reporting to ensure consistency among MCPs.

In addition to recovering overpayments, states may implement cost avoidance measures to reduce the likelihood of improper payments in the future. [Reference 3] Although cost avoidance varies by state, there are several measures states may implement. For instance, states may implement appropriate prior authorization requirements and/or educate providers on correct billing practices. Some state Medicaid and CHIP programs may also use electronic visit verification (EVV) systems linked with claims systems to calculate cost avoidance for claims that fail to verify a visit.

A. Overpayment Reporting and Retention Policies (§§438.608(d)(1), (3) – (4))

CMS regulations at §438.608(d)(1) require states to specify in their contracts with MCPs how recoveries of provider overpayments must be treated. Section 438.600(c)(1) requires that states be compliant with §438.608(d) no later than the rating period for contracts starting on or after July 1, 2017.

The regulations provide states with significant flexibility when determining how to treat recoveries made by MCPs, with the goal of creating incentives for MCPs to proactively oversee network provider billing practices and identify fraud, waste, and abuse. CMS regulations require the contracts to address the following general elements:

- Retention policies for the treatment of recoveries of all overpayments from the MCPs to a provider, specifically including the retention policies for the treatment of recoveries of overpayments due to fraud, waste, and abuse. (§438.608(d)(1)(i))

- Process, timeframes, and documentation required for reporting the recovery of all overpayments. (§438.608(d)(1)(ii))

- Process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the MCPs are not permitted to retain some or all of the recoveries of overpayments. (§438.608(d)(1)(iii))

Section 438.608(d)(1)(iv) clarifies that §438.608(d)(1) does not apply to any amount of a recovery retained under False Claims Act cases or through other investigations. The preamble to the 2016 Managed Care Final Rule states that "[a]lthough states have the flexibility to implement overpayment retention contract provisions, the policies in the contract would not prohibit the federal government from retaining the appropriate share of recoveries of overpayments due to their own audits and investigations." [Reference 4]

The refunding of the federal share of any overpayment recovered by an MCP is dependent on the retention policy outlined in the contract between the state and the MCP, as required under §438.608(d)(1). Below are examples of common contractual retention policies and guidance on when the federal share must be refunded to CMS:

- States can implement a "finders keepers" arrangement, whereby the MCP or state will retain the overpayment recoveries depending on which entity identified the overpayment. Under this arrangement, if the MCP identifies the overpayments through its own data analysis or other program integrity activities, the MCP can retain the recoveries. If the contract allows the MCP to retain the overpayment, then no federal financial participation (FFP) is due back to CMS. Alternatively, if the state identifies overpayments by analyzing an MCP's payment data and the MCP has not yet identified the overpayments, the state can require the MCP to recover the overpayment and refund the overpayment to the state. In this case, the federal share of any amount returned to the state must be refunded to CMS under §433.312. [Reference 5]
- States can allow MCPs to retain overpayments. If the contract allows the MCP to retain the entire overpayment, then no FFP is due back to CMS.

- States can require MCPs to recover all overpayments and refund them to the state. In this case, the federal share of any refund to the state must be refunded to CMS under §433.312.

No matter which payment retention policy is implemented, states must ensure that MCPs are reporting all identified or recovered overpayments annually as required under §438.608(d)(3), and the state must use this information to set actuarially sound Medicaid capitation rates consistent with §438.4, as required under §438.608(d)(4) and outlined in the Medicaid Managed Care Rate Development Guide. [Reference 6]

As noted on the previous page, if the state requires the MCP to refund overpayments to the state, the state must refund the federal share of those overpayments to CMS in accordance with §433.312. The state should apply the Federal Medical Assistance Percentage (FMAP) rate in effect at the time the overpayment was made to determine the amount to be refunded to CMS. States should continue to follow existing CMS financial management guidance to determine the appropriate line on which to document the refund of the federal share of the overpayment. Importantly, with respect to the Unified Program Integrity Contractor (UPIC) investigations that (a) result in the identification of an overpayment and (b) occur in states that require MCPs to return the overpayment, states should report the federal share of the recovery on Line 9C1 Recoveries: Fraud, Waste and Abuse Efforts, using feeder Form CMS-64-9C1, Line 5, CMS Medicaid Integrity, Contractors (MICs). [Reference 7]

In addition, §438.608(d)(1)(iii) requires contracts to specify the process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the MCPs are not permitted to retain some or all of the recoveries of overpayments. When implementing a timeframe, states should not establish an open-ended timeframe for MCPs to recover overpayments, as such an approach may not properly incentivize MCPs to take swift action when overpayments are identified.

B. "Prompt" Reporting of Overpayments (§438.608(a)(2))

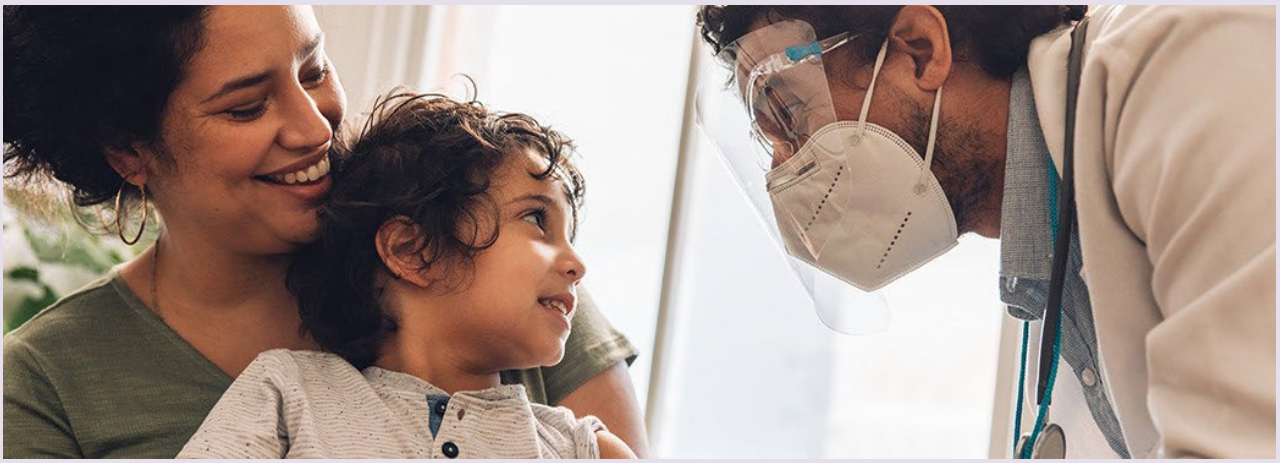
CMS regulations at §438.608(a)(2) require MCPs to promptly report to the state all overpayments identified or recovered, specifying the overpayments due to potential fraud. Section 438.600(c) requires that states be compliant with §438.608(a)(2) no later than the rating period for contracts starting on or after July 1, 2017.

The state should establish a clear timeline in the MCP contract for the "prompt" reporting of such overpayments. In the context of MCPs reporting overpayments to states, CMS encourages "prompt" to be defined as within 10 business days of identifying or recovering the overpayment. [Reference 8] Requiring 10 business days would provide an MCP sufficient time to investigate overpayments and determine whether they are due to potential fraud or other causes, such as billing errors, and also quickly provide the State with awareness to mitigate other potential overpayments across its networks and managed care programs.

In addition, 10 business days would allow states to be better equipped to: direct MCPs to look for specific network provider issues, identify and recover managed care and fee-for-service claims that are known to be unallowable, take corrective actions to correct erroneous billing practices, or consider a potential law enforcement referral.

C. Self-Reported Network Provider Overpayments (60-Day Rule) (§438.608(d)(2))
State contracts must require MCPs to have a mechanism for a network provider to self-report to the MCP when it has received an overpayment and return the overpayment to the MCP within 60 calendar days after the date on which the overpayment was identified. This requirement incorporates the statutory requirement for the return of overpayments under section 1128J(d) of the Social Security Act. The network provider must also notify the MCP in writing of the reason for the overpayment, pursuant to §438.608(d)(2). MCPs should follow states' contract language for the overpayment retention policies, as described above, when receiving self-reported overpayments from network providers.

MCPs may monitor network providers who self-report overpayments to determine if the overpayments are indicative of a broader pattern of possible fraud, waste, or abuse. Additional provider education may also be appropriate. Whenever an MCP suspects fraudulent provider activity, the MCP should follow the state's established procedures for reporting such activity, as described in §438.608(a)(7).



Conclusion
Detecting risks and implementing mitigation activities are shared responsibilities among CMS, states, and MCPs. These shared activities are critical to protecting Medicaid and CHIP from fraud, waste, and abuse. This toolkit will help states and MCPs achieve their program integrity goals and remain in compliance with CMS requirements.

Endnotes

1. Managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and primary care case management entities (PCCM entities) are also referred to throughout as managed care plans (MCPs.). Contracts with Health Insuring Organizations (HIOs) that began operating on or after January 1, 1986, and are not explicitly exempt by statute from requirements in section 1903(m) of the Act, are subject to the requirements of Part 438 Subpart H to the same extent that the requirements apply to MCOs.

2. Medicaid managed care provider screening and enrollment requirements under §438.602(b)-(d) are referenced but not fully addressed in this toolkit. These requirements have been addressed separately in the Medicaid Provider Enrollment Compendium (MPEC).

3. Requirements at §§438.604(a)(2) and 438.608(d)(4) are not applicable to separate CHIP MCPs.

References

1. 81 FR 27497 (May 6, 2016), https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

2. The Medicaid Provider Enrollment Compendium (MPEC), https://www.medicaid.gov/affordable-care-act/program-integrity/index.html.

3. 81 FR 27608, https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

4. Cost avoidance measures are referenced but not fully addressed in this toolkit. Cost avoidance is addressed separately in the Improving the effectiveness of Medicaid program integrity report to Congress, https://www.macpac.gov/wp-content/uploads/2019/06/Improving-the-Effectiveness-of-Medicaid-Program-Integrity.pdf.

5. §433.312 is applicable to CHIP through a cross-reference at §457.628(a).

6. Requirements at §438.608(d)(4) are not applicable to separate CHIP MCPs, however CHIP capitation rates must be developed in compliance with §§457.1201(c) and 457.1203, https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html.

7. Requirement to report the federal share of the recovery on Line 9C1 Recoveries: Fraud, Waste and Abuse Efforts, using feeder Form CMS-64-9C1, Line 5, CMS Medicaid Integrity, Contractors (MICs), https://www.cms.gov/files/document/mpi115appendices.pdf.

8. On May 3, 2023, CMS published a proposed rule, "*Medicaid Program; Medicaid and*

Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," (CMS-2439-P), in which we proposed to establish a uniform definition of the term "prompt" for MCPs reporting identified or recovered overpayments to states as within 10 business days.

Disclaimer

This document was current at the time it was published or uploaded onto the web. Medicaid and CHIP policies are subject to change. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

This document was prepared as a service to the public and is not intended to grant rights or impose obligations. This document may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. Use of this material is voluntary. Inclusion of a link does not constitute CMS endorsement of the material.