# HHS Publishes Proposed Rules on Medicaid RACs


**(November 30, 2010):** The United States Department of Health and Human Services ("HHS") recently published a Proposed Rule applying the Recovery Audit Contract ("RAC") process to claims under the Medicaid program. As background, the RAC process has been a part of the Medicare program since 2005, first as a demonstration project from 2005 – 2008, and then extended to the entire nation effective no later than January 1, 2010.

Under the Medicare RAC program, HHS retains private contractors for a post payment review process to identify over and under payments on a contingency fee basis. There are two types of reviews – data mining, which involves simply reviewing data to identify improper payments, and complex reviews, which require reviews of medical records to determine the "legitimacy" of a payment. To date, HHS has contracted with four RACs – one covering each of four national regions. HHS pays the RAC a contingency fee based upon a percentage (currently ranging from 9 – 12.5 percent) of the amounts of overpayments that the Federal government recovers and underpayments that HHS repays providers based upon the RAC review. Overpayment recoveries have far exceeded underpayments that the program has reimbursed providers.

The process was highly controversial during the demonstration, and HHS implemented a number of changes for the national roll out. Among others, HHS: shortened the look back period; set limits on the number of records that the RACs could request at any one time; precluded RACs from retaining their contingency fee payments where the provider prevailed at any stage of the appeals process; required RACs to receive approval from HHS, and publish, the types of claims that they were reviewing; and required RACs to retain physicians as medical directors. Despite theses changes, the process still requires providers to expend substantial amounts of increased administrative expenditures to accommodate these reviews.

Although several States have conducted RAC type audits under their Medicaid programs, most have not. However, as part of the health reform legislation, Congress required all States to establish a Medicaid RAC program by December 31, 2010.[1] *See* §6411 of the Patient Protection and Affordable Care Act.

The proposed rules require that States submit a state plan amendment ("SPA") by the December 31, 2010 deadline. However, recognizing that responses to the proposed rule are not even due until January 10, 2010, the proposal also indicates that States are not required to implement the program until April 1, 2011. The proposal also recognizes that some States may need to change their State laws to implement the RAC program, and thus states that HHS may grant exceptions in certain areas, albeit on a limited basis.

The proposed rules would grant substantial flexibility to states in how they establish their RAC programs. However, the rules provide that the fees States pay Medicaid RACs for overpayments and underpayments combined may not exceed the amounts that the State collects from overpayments. This means that both the States and RACS will be strongly incentivized for the RACs to find over, as opposed to under, payments.

The rules require the State to establish an appeals process for providers to dispute overpayments identified by the RACS. However, the preamble to the proposed rules would require states to return the Federal match for an overpayment that is identified even if the State does not recover that overpayment from the provider. If this is construed to require the State to return the Federal share of overpayments that the RAC identifies even if the provider prevails on appeal, this would place a strong disincentive for the State to establish a vigorous and unbiased appeal process. Similarly, it is unclear whether HHS would recover the Federal portion of identified overpayments even in those cases where the State otherwise would have settled a claim in this process.

Further, it is not clear whether HHS will attempt to recover the share of the entire identified overpayment, even if it is clear that the provider would have been entitled to a partial payment if the claim had been properly submitted, *e.g.* in States that pay hospital providers under a DRG system, hospital transfer cases, or cases where the RAC concludes that a hospital case that was billed as an inpatient admission should have been billed as observation. Absent such authorization, the State would avoid payment for even the portion of treatment that its RAC concluded was legitimate and actually provided, albeit mistakenly claimed.

Under the proposed rules, it appears that States would have substantial flexibility in designing their programs. Thus, it would behoove providers and their trade associations not only to submit comments on the proposed Federal rules (which are due on January 10, 2010), but also to become involved in the development of the State process. Liles Parker attorneys have had success in the past in assisting providers in one State to change the process in an analogous circumstance, to, among other things: shorten the period for which claims were reviewed; assist providers in convincing the State to implement a routine process to minimize the chance that record requests would be lost; limit the number of medical records that could be requested; limit reveries to the difference between amounts that were claimed and those that could have been claimed under the RAC's analysis; the qualifications of RAC staff that review medical necessity claims; and establishing the specific criteria that would be used to review medical necessity issues.

Also, providers will want to discuss with their States a number of other issues such as the extent to which physician judgment will be relied upon in second guessing medical necessity and treatment decisions, the process that will be used to challenge RAC determinations, and the extent to which the State will increase Medicaid payments for the added administrative expense involved in staffing up for these reviews. This is especially critical under the Medicaid program, where State payments often are far below the cost of providing the service as a result of deficient appropriations.

Finally, providers will need to develop their internal processes for ensuring that requests for records are properly tracked and timely processed, and for appealing appropriate cases.

**Liles Parker attorneys have extensive experience in all of these areas and are prepared to assist providers and their trade associations in commenting on the proposed Federal rules, assisting in negotiations with States on the development of their RAC programs, and appealing overpayment determinations. Providers wishing to discuss these issues should contact Michael Cook at (202) 298-8750.**

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[1] Congress also expanded the Medicare RAC program to parts C (Medicare Advantage) and D (Medicare Outpatient Prescription Drug program) of Medicare. We will address these changes in a later issue.