Michael D. Maves, MD, MBA, Executive Vice President, CEO

April 9, 2007

Craig Gillespie
Contract Specialist
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
7500 Security Boulevard
MS: C2-21-15
Baltimore, MD 21244-1850

Dear Mr. Gillespie:

The American Medical Association (AMA) appreciates the opportunity to comment on the Recovery Audit Contractor (RAC) Request for Information (RFI) (Reference #: RFI-CMS-70445RAC). Given that the RAC pilot mandated by the Medicare Modernization Act of 2003 (MMA) in California, Florida, and New York has been expanded under the Tax and Healthcare Act of 2006, we appreciate the Centers for Medicare and Medicaid Services' (CMS) collaborative approach to this project.

At a time when the average Medicare physician payment in 2007 is approximately the same as it was in 2001 and when physicians are facing a 10% cut in 2008 and nearly 40% cuts over the next 8 years, the RAC program significantly damages morale. We remain concerned about this program given the burden this program has placed on physicians who have undergone audits. The very low average amount recouped from physicians simply does not justify the administrative costs to physicians nor does it warrant taking physicians away from their patients. A fairer approach would be one that takes a strictly educational approach that uses outreach to communicate where physician billing errors are occurring.

As you are aware, the majority of RAC recoupments have occurred under Medicare Part A. Recoupments for physicians under Part B have made up only a small fraction of the overall monies recovered. In fact, according to the RAC Status Document published in November 2006, RAC recoupments from physicians were among the six percent of recoupments identified for physicians, ambulance, and labs. This is compared to 78 percent of inpatient hospital and skilled nursing facilities recoupments that were identified. Further, of the data available from the pilot, the Florida RAC collected only, on average, $135 from physicians compared to, on average, $5,800 from inpatient hospitals. Similarly, in California, the RAC

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collected, on average, $216 from California physicians versus, on average, $164,372 collected from inpatient claims. Thus, we agree it makes sense that, as CMS rolls out the expanded RAC program in the spring of 2008, efforts are expected to focus initially on Medicare Part A providers.

In addition, we are pleased that CMS added incentives for the RACs to identify underpayments after the start of the RAC pilot contracts and we strongly support such efforts. We are concerned, however, that RACs are traditionally skilled in locating overpayments, rather than underpayments, and strongly encourage CMS to consider underpayment identification skills when selecting RAC contractors.

According to the RAC Statement of Work (SOW), CMS plans to require a minimum of one Contractor Medical Director (CMD) per RAC jurisdiction under the expanded program. RAC jurisdictions are expected to consist of four areas that mimic the current Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) jurisdictions. We appreciate that CMS recognizes the importance of CMDs, but encourage CMS to assess the need for additional CMDs as the expanded RAC program proceeds.

Responding to a RAC inquiry for additional information or a demand letter is a lengthy and involved process. According to the RAC SOW, CMS would prohibit RACs from sending a demand letter for amounts less than $10 per single claim. While we appreciate this limitation, we urge CMS to confer with the AMA and other stakeholders to determine a dollar amount that will not result in unreasonably burdening physicians over nominal claims.

Further, the draft RAC SOW does not include requirements regarding the number of overpayment demand letters or requests for information a physician may receive. Some physicians in California have received as many as 50 requests for information under the RAC pilot, a considerable burden on those physicians who then had to interrupt patient visits to focus on pulling claims, which, incidentally, did not result in the identification of any overpayments. We therefore urge CMS to institute a limitation on the number of times a physician may be audited and we encourage CMS to consult with the AMA on determining these limitations. Additionally, we urge CMS to require the RACs, when they do not locate a physician overpayment following an audit, to reimburse physicians for the administrative cost of undergoing the audit as this can place an exceptional financial burden on physicians. Moreover, this would serve to limit the RACs from pursuing senseless audits.

As the RAC expansion moves forward, we are hopeful that CMS will continue to work with the AMA to develop standardized demand letter and request for information letter language so that the information given to physicians as part of a RAC audit is understandable, and the reason they are being contacted is well articulated. We have already supplied CMS with some proposed language for demand letters and we are eager to continue working with CMS to develop standardized letters that will be used by all RAC contractors in the expanded program. We urge CMS to prohibit various RACs from developing their own content for demand letters and requests for information, as we believe a standardized approach will reduce questions and institute a more consistent approach.

Under the RAC SOW, CMS requires the RAC to use another Medicare affiliated contractor to validate the occurrence of any underpayments the RAC has located. We are unclear why the "validation" process required by CMS will only be used to validate underpayments and is not required to verify that an overpayment has truly occurred. We were under the impression that CMS was considering requiring the RACs to use a "validation" process intended to ensure that another entity would review potential improper payments before physicians are contacted. It appears however, that validation by an affiliated contractor is only required under the SOW in the case of underpayments. We are unclear if this was CMS' intention. While we agree that validation of potential improper payments would be useful, a clarification on the use of the validation process would be helpful.

We are pleased CMS has decided to shorten the timeframe under which contractors are permitted to review claims. Under the current RAC pilot, contractors are permitted to go back as far as four years after the initial determination date. Under the expanded program, however, CMS is proposing to limit this to three years and would exclude from any review claims processed and or paid in the past twelve months.

Lastly, we are concerned about Section K, "Public Relations and Outreach," which states that "[t]he RACs shall not educate providers on Medicare policy." Education was intended to be a critical component of the RAC pilot. Thus, we believe that considerably more outreach is needed to ensure physicians have a strong understanding of Medicare's coverage and reimbursement policies. We urge CMS to make education and outreach a priority in the expanded RAC program.

We look forward to continuing an open dialogue with CMS on the RAC program as it is expanded and to address Medicine's concerns as they arise. Should you have any questions about our comments, please contact Mari Johnson of my staff at (202) 789-7414 or mari.johnson@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA