



Administrator
Washington, DC 20201

DEC 07 2007

The Honorable Lois Capps
House of Representatives
Washington, DC 20515

Dear Ms. Capps:

Thank you for your letter about the operation of the Recovery Audit Contractor (RAC) demonstration project being conducted in California. The Centers for Medicare & Medicaid Services (CMS) has been working cooperatively with the California Congressional delegation and the California Hospital Association to specifically address concerns related to the review of inpatient rehabilitation facility (IRF) claims during the RAC demonstration.

I would like to address your specific concerns and discuss what you can expect to see with respect to nationwide implementation of this important new program.

My staff first discussed the RAC program with the California delegation at a meeting on August 1, 2007. After that meeting, CMS instructed the RAC in California to cease the review of specific IRF claims -- this action became known as the "pause" referenced in your letter. The purpose and nature of the pause was to allow for an independent review of claims denied by the RAC but which earlier had been paid to IRFs. We conducted this review by tasking another contractor, AdvanceMed, to independently review a sample of 30 claims that had been previously reviewed by the RAC in California as well as discussing IRF medical review with other Fiscal Intermediary medical directors.

With respect to the reviews of IRF claims conducted in California, it is clear that the RAC, fiscal intermediary (FI), our independent review entity, as well as appeal contractors involved have not consistently applied our coverage and payment policies for IRF services. For example, AdvanceMed agreed with the California RAC on more than 60 percent of the cases they reviewed; however, on the remaining cases, they did not agree.

I am taking three steps as a result of this review. First, we are conducting detailed education sessions with the RAC, the FI, AdvanceMed, and the appeals contractors involved on the medical review of IRF claims. I invite you and your staff to participate in these sessions. Second, once the training is complete, I am directing the RAC to re-review all IRF claims where they previously found an overpayment using consistent medical review methodology under the demonstration, including claims that are under appeal. I will direct the RAC to initiate repayment to the provider on any reversed cases. Finally, I am directing that the RAC suspend review on any IRF claim in its system that has not yet been reviewed based on the medical necessity criteria so that it can focus on ensuring that the IRF reviews conducted to date are completed using the information provided in our education sessions.

I want to emphasize my commitment to the RAC program and to the process they use to make their decisions. The actions I am taking here are specific to RAC review of IRF claims only. RACs have been able to recover past improper payments, and given that the overall appeal (12.5 percent) and reversal (5.5 percent) rates are quite low, I believe the RACs are a good tool to use in protecting the Medicare program. However, I now have a greater understanding of the need for enhanced education on our IRF policies specifically, which will become part of our nationwide implementation of this program.

The pause on reviewing new IRF claims will remain in effect through the end of the demonstration, which is March 27, 2008. This is because under the terms of the demonstration contract, the last day for a RAC to request medical records from a provider was December 1, 2007.

As we near the completion of the demonstration, now would be an appropriate time to provide some information on our efforts to meet the statutory requirements to implement the program nationwide. I want to assure you that we are taking into account the input from providers and Members of Congress about what went well with the demonstration, as well as where the demonstration fell short. These lessons learned have helped us formulate an implementation strategy that should mitigate some of the problems we saw with the demonstration.

As you know, the law requires that we implement recovery auditing in all states by January 1, 2010. Our primary focus in carrying out this mandate is to reduce, to the maximum extent practicable, any confusion or uncertainty on the part of physicians, hospitals and other providers. To that end, we will implement the program on a rolling basis, beginning in 2008, on a schedule that is tied to our timeline for procurement of Medicare Administrative Contractors. This strategy allows each RAC adequate time to perform outreach to health care providers prior to activities beginning in their state and mitigates any potential conflicts with MAC transition timelines. I am attaching a chart which shows how this transition will be implemented nationally.

Under this strategy we began our procurement this fall and plan to have awards made for each of the four RAC jurisdictions by April. Actual claims review in the 50 states would then phase in over the following 18 months. Note that under our proposed schedule, hospitals and physicians in California will not receive RAC-related requests for medical records until some time after October 2008, and no request will be made for medical records related to services provided before October 1, 2007.

We have also made changes to the national program based on our experience to date with the demonstration States. For example:

- Unlike with the demonstration, RACs as implemented nationally will be required to have a medical director.

- We are limiting the amount of time that a RAC can “look back” for improper claims to a maximum of 36 months, but under no circumstances before October 1, 2007. In other words, no claims from before October 1, 2007 will be reviewed in the national program. Not until October 1, 2010 will RACs be able to exercise the maximum 36-month “look back” for improper claims.
- We are requiring that if a RAC determination is overturned at any level of appropriate administrative or judicial review, then the RAC must refund any associated contingency fee collected.
- We have established nationwide limits on the number of medical records that a RAC may request.
- We have established a new process whereby RACs notify CMS of any new issues they wish to investigate after only 10 claims have been reviewed. In this way, CMS coverage and policy experts can determine whether RACs need to be educated in the review policy before beginning widescale reviews.

I am enclosing a side-by-side comparison chart illustrating these and other changes we are making to the national program. Many of these changes have already been incorporated into the demonstration operations. For example, the RACs have already agreed to return fees when claims are overturned at the ALJ level of appeal; the RACs have all hired medical directors, even though we do not require it under their contract; and the new issue review process described above was implemented for the demonstration in September.

As you can see by the many reforms we have put into place, we are taking your concerns very seriously by working to balance the legitimate concerns of the hospital and physician community with an effective implementation strategy for this program.

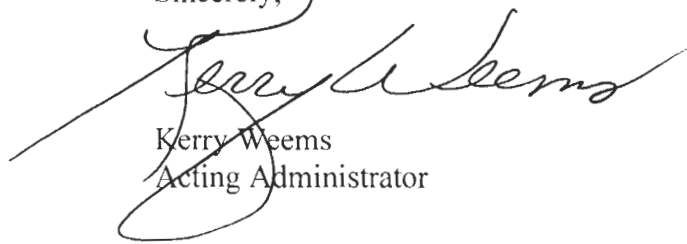
Finally, we believe recovery auditing is a valuable tool in the Medicare program, both in terms of recovering past improper payments and in helping CMS to prevent improper payments in the future. Within the past month, we announced that for 2007 the Medicare fee-for-service claims payment error rate has dropped to 3.9 percent, from 4.4 percent last year. The RAC program is an important component of our overall strategy to continue this positive trend in reducing claims payment errors.

Thank you for bringing your concerns and your constituents’ concerns about the RAC demonstration program to my attention. In doing so, you have helped us refine and improve the program. More specifically, these findings have greatly influenced our development of the national program and are translating into significant program reforms that should provide for greater transparency and improved performance with respect to this national initiative.

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I share your commitment to making sure this important program works and look forward to continuing to work with you on this issue. I will also provide this response to the co-signer of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Kerry Weems", written over a printed name and title.

Kerry Weems
Acting Administrator

Enclosures

CC The Honorable Pete Stark
The Honorable Dave Camp
The Honorable Charles Rangel
The Honorable Jim McCrery
The Honorable Max Baucus
The Honorable Charles Grassley