STATEMENT OF

DENNIS G. SMITH

DIRECTOR OF

CENTER FOR MEDICAID & STATE OPERATIONS

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICAID PROVIDERS AND UNPAID TAX LIABILITIES

BEFORE THE

SENATE HOMELAND SECURITY & GOVERNMENTAL AFFAIRS

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Testimony of Dennis G. Smith
Director of the Center for Medicaid and State Operations at the
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Chairman Levin, Senator Coleman, and distinguished members of the Subcommittee, thank you for inviting me to participate in the discussion about potentially adding Medicaid to the Federal Payment Levy Program (FPLP). In Fiscal Year (FY) 2008, Medicaid will pay an estimated $345.6 billion to hundreds of thousands of health care providers and plans including hospitals, nursing homes, physicians, and even taxi cabs to provide health care services to 50 million Americans. Medicaid is designed and administered by the States and many Medicaid providers are small businesses who contract directly with the States to provide services to beneficiaries. We do not, at the Federal level, either enroll or pay providers directly. As a result, States have a considerable stake in this discussion and would be instrumental partners in any potential solution.

In light of that fact, my objective today is to explain how Federal payments are made to States for health care services covered by the Medicaid program for Medicaid-eligible individuals. I hope this information will be helpful in any deliberations on how to proceed in concert with the Internal Revenue Service (IRS), the U.S. Treasury's Financial Management Service (FMS) and critically, the States.

Medicaid: A Partnership with States

Medicaid is a means-tested health care program for low-income Americans, administered by the States within a Federally defined framework. The Centers for Medicare & Medicaid Services (CMS) provides matching payments to States and Territories to cover Medicaid services and related administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. The Federal government's share of a State's Medicaid expenditures for medical assistance is called the Federal Medical Assistance Percentage (FMAP), which currently ranges between 50 and 76.29 percent.

Each State and Territorial Medicaid program is unique. States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines. State governments have a great deal of programmatic flexibility within which to tailor their Medicaid programs to the unique political, budgetary, and economic environments in each State. Accordingly, there is variation among the States in terms of eligibility, covered services, and provider reimbursements. States administer the Medicaid program, set rules and reimbursement rates for providers and health plans, and make payments to the providers and plans. Critical to the issue under discussion today, CMS does not pay Medicaid providers or health plans; CMS financing of Medicaid is limited to making payments to States to match State expenditures for medical assistance.

As noted earlier in my testimony, the Federal share of a Medicaid payment varies from State to State. For example, the Federal share of a Medicaid payment to a provider in New York, based on a 50 percent FMAP, would be less than the Federal share of a payment to a provider in Mississippi, which has a FMAP of 76.29 percent. These divergent FMAPs are compounded by the different rates of reimbursement for covered services, which are individually set by States. More to the point for today's discussion, these Federal share differentials could result in two providers in two different states with the same Federal tax liability being subject to different amounts withheld.

Medicaid Financing and Payments

The CMS is responsible for making quarterly payments of Federal matching funds to States and Territories for their allowable expenditures for services rendered and administration. On a quarterly basis, a State estimates its Medicaid expenditures prospectively by electronically submitting Form CMS-37 through the State's Medicaid/SCHIP Budget & Expenditure System (MBES) for the next quarter. Completion of this form is necessary for CMS to issue the initial quarterly Medicaid grant award money to the State. Upon review of Form CMS-37, CMS determines the amount of the grant award to be made available to the State. CMS may conclude that MBES expenditures be increased, decreased, or accepted. If a State's grant award is insufficient, the State may also submit a revised Form CMS-37 to request additional funding at a later time.

Based on this review, the initial quarterly grant award is then prepared and forwarded to CMS's Office of Financial Management (OFM) for processing. Upon receipt of the award notices, OFM records the amount into the Apportionment Control System to verify there are sufficient Medicaid funds available to issue to State agencies. A grant award letter is mailed to the State, and funds from the U.S. Treasury are made available to State agencies to draw down electronically.

At the end of each quarter, a State then submits the Quarterly Medicaid Statement of Expenditures (Form CMS-64), which provides the actual quarterly State Medicaid expenditures information. Form CMS-64 is also filed electronically through the MBES to CMS. On this form, States report both the current expenditures and any such adjustments from previous time periods. CMS then reconciles Medicaid grant funds that were provided in advance to States with actual State Medicaid expenditures. If the reconciliation process finds that a payment is required of CMS to the State, a supplemental grant award letter is issued through the same process as outlined for the estimated quarterly expenditures. CMS may also find that claims filed by the State do not adhere to Federal statute, or do not constitute appropriate services covered under Medicaid. Consequently, payments can be disallowed or deferred. A notification letter is

sent out to the State regarding any such actions. A State may appeal an adverse determination to the Health and Human Services (HHS) Departmental Appeals Board and eventually through the Federal courts.

For purposes of today's discussion, it is critical to keep in mind that actual payments to Medicaid providers happen at the State level. CMS does not cut checks directly to providers. In many cases, third-party vendors holding contracts with the States issue the provider reimbursement payments. States typically pay their vendors every two weeks through their MMIS. Payments are automated. The vendors that run these systems are typically paid whenever an edit is made to change the amount of payment and on a transaction basis. It is difficult to assess the most cost-effective means for participating in the levy program across all the States. Solutions and approaches may vary depending on the number of providers involved in the FPLP in a particular State.

Medicaid Claims Processing

To further illustrate this payment system and the overall complexity of State Medicaid payments, I'd like to explain how States typically reimburse providers participating in a State's Medicaid program. When a health care provider sees a Medicaid patient, she first verifies that the person is eligible for Medicaid coverage, typically using an on-line real time electronic confirmation with the State. A series of procedures are undertaken and identified by code number on an electronic bill, using standard, Health Insurance Portability and Accountability Act (HIPAA)-compliant formats, with each code pegged to a specific charge by the provider.

This bill is then sent electronically to the State's claims processing system, generally known as the Medicaid Management Information Systems (MMIS). The claim is bounced against several internal files within the MMIS to verify from the State's perspective that:

- The bill is from a Medicaid-certified provider of care (the provider file);
- The bill is filed on behalf of a person eligible on that day for Medicaid benefits (eligibility file);

- There is no other insurer or other payer who should pay all or a portion of the costs (because Medicaid is the "Payer of Last Resort");
- The services provided are within the scope of the State's benefit package and appropriate for the diagnosis; and
- The services provided are against a fee schedule that the State has agreed to pay for the particular procedure. Most State Medicaid reimbursement rates are considerably less than what the provider would charge other insurers.

There may be additional edits to the individual claim as well, depending upon the State. Assuming all edits are passed, the Medicaid agency typically sends the bill on to the appropriate financial State agency for payment, which generally occurs in a State Department of Finance or State Department of Treasury. After these steps, the Medicaid provider receives a check from the State Agency or an electronic payment deposited into the provider's bank account.

Naturally, these specific payment steps vary among small and large providers participating in the Medicaid program. If the provider is a member of a larger health care group practice, the practice rather than the individual provider would generally submit the bill to the State and receive the payment, after which the individual provider may receive payment in whole or in part, depending upon the practice's financial arrangement. Similarly, with regard to managed care organizations (MCOs), the MCO may bill the State on behalf of multiple payers on a fee-for service basis, or choose to lump all services via monthly capitation rate times the number of participating providers within the MCO regardless of specific services rendered.

Current Limitations

Current law does not readily allow for the expansion of the FPLP to the Medicaid program, nor do State and Federal budgets anticipate the costs that would be incurred as a result of this potential change. Neither CMS nor the State Medicaid agencies have the authority to examine the tax records of providers. Moreover, many States contract with private businesses to process claims. CMS does not enroll providers or reimburse them

directly for their services; this is an administrative activity that varies by State and is entirely a State function. Therefore, States would be likely to view the FPLP as an unfunded mandate, outside the scope of their responsibilities to pay for medical services.

This endeavor would be significantly more complex for Medicaid than what CMS has been working towards on Medicare; there are different vendors, different systems, and different platforms among the 56 independent Medicaid jurisdictions. The challenges that would be associated with such an approach involve the number and complexities of the payment system in each State, the difficulties and costs associated with making changes to them for this tax levy purpose, the need to establish electronic pathways between FMS and each system which do not currently exist, and the potential delays in payments to Medicaid providers due to constant auditing and adjusting of their claims history. Since payment to each Medicaid provider is a mix of Federal and State dollars, which varies from State to State ranging from 50 to 76.29 percent for the Federal portion, these different FMAP rates would need to be included in any algorithm that would be necessary for this purpose. While all States use their respective MMIS for making payments, there are additional systems that may also be paying claims to certain providers or subsets of providers which would also need to be modified.

It is difficult to determine a precise cost estimate for these changes. The Federal government would have the expenditure of working with each State individually to build the infrastructure necessary to link State and Federal systems, and States may themselves face constraints in terms of how quickly they could complete work on their end. In addition, apart from the software and consulting services needed to maintain the flow of day-to-day operations for all of the other providers who not affected by this new program, the State would incur some level of additional cost for staffing oversight, response to complaints, etc.

Finally, it is important to point out that many States may not want to competitively bid this new work, but would instead prefer to have their incumbent contractor do the work on a “sole source/no-bid” basis. To do anything else would run the risk of another

contractor making changes incompatible with the normal flow of the claims payment processing engine already in place in each State.

Conclusion

CMS is already collaborating with the IRS and Treasury's FMS in the Federal Contractor Tax Compliance (FCTC) Task Force to determine how best to address Medicare providers delinquent in the realm of tax obligations. CMS supports the work of the Task Force to examine, assess and ultimately implement policies to ensure that payments to providers are levied in the most effective and appropriate manner. As we further discuss unpaid tax liabilities in the Medicaid program, CMS will build on our existing role in the Task Force and provide technical assistance regarding the legal and practical challenges of expanding the FPLP to Medicaid.