STATEMENT OF

LESLIE V. NORWALK, ESQ.

ACTING ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

RECOUPMENT OF UNPAID TAX LIABILITIES OF MEDICARE PHYSICIANS

BEFORE THE

SENATE HOMELAND SECURITY & GOVERNMENTAL AFFAIRS

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

March 20, 2007

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of Leslie V. Norwalk
Acting Administrator, Centers for Medicare & Medicaid Services
on
Recoupment of Unpaid Tax Liabilities of Medicare Physicians
Before the
Senate Homeland Security & Governmental Affairs
Permanent Subcommittee on Investigations
March 20, 2007

Good afternoon Chairman Levin, Senator Coleman and distinguished Members of the Subcommittee. I appreciate the opportunity to appear before you today to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to recoup unpaid tax liabilities of Medicare physicians.

CMS is the largest purchaser of health care in the world. We provide coverage to nearly 100 million beneficiaries – one in every three Americans, in fact. Medicare, the Federal health insurance program for individuals over age 65 and certain populations with disabilities or end-stage renal disease (ESRD), insures more than 43 million lives. In Fiscal Year 2008 (FY08), total gross spending on Medicare benefits is projected at $454 billion.

Medicare benefits fall into four categories – Parts A, B, C and the program's most recent addition, D. In short:

- **Part A** includes (and reimburses providers for) inpatient hospital care, skilled nursing facility care, qualified home health care, and hospice care.
- **Part B** includes physicians' services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, certain elements of home health care, and other medical services and supplies.
- **Part C**, the Medicare Advantage (MA) program, offers beneficiaries a variety of coverage options including traditional health maintenance organizations (HMOs), preferred provider organizations (PPOs), special needs plans, and private fee-for-service (PFFS) plans paid under a capitated monthly payment from Medicare.

- **Part D**, enacted in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) offers beneficiaries a standard outpatient prescription drug benefit through private plans that contract with Medicare.

To date, roughly 645,000 physicians are assigned Medicare provider numbers, allowing them to bill the program for covered items and services provided to beneficiaries. Medicare payments to physicians in 2006, the most recent year for which data is available, totaled $58.7 billion.

CMS processes claims and reimburses for physician services through contracts with private companies, i.e., Carriers, Fiscal Intermediaries (FIs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs).[1] This year alone, CMS estimates that Medicare contractors will process well over *one billion* claims from institutional providers, physicians, and suppliers for covered items. Contractors review submitted claims to ensure payment is made solely for covered services for eligible individuals. In addition, CMS contracts with Program Safeguard Contractors (PSCs) to detect and deter Medicare fraud and abuse. Finally, Quality Improvement Organizations (QIOs) are charged with investigating beneficiary complaints about quality of care and ensuring that payment is made for only medically necessary services.

CMS Partnerships with Other Agencies Promote Accountability

CMS is firmly committed to ensuring the highest measure of accountability within the Medicare program. Appropriately, model stewardship of taxpayer dollars requires partnership with other Federal agencies. Consistent with the President's Management

[1] Medicare Contracting Reform (MCR), as stipulated in MMA, calls for consolidation of a wide spectrum of contractor functions. Heretofore, all contractors processing Medicare claims are called "Medicare Administrative Contractors" (MACs). While durable medical equipment regional carriers (DMERCs) have been fully replaced by DME MACs, the longtime designators 'Carrier' and 'FI' remain in common use for other contractors as MCR progresses further.

Agenda (PMA), a government-wide effort to improve financial management , CMS works closely with the Department of the Treasury (Treasury), Department of Justice (DOJ) and Office of the Inspector General (OIG) in the Department of Health and Human Services (HHS) to identify improper Medicare and other high-risk program payments; to establish aggressive improvement targets; and to implement corrective and remedial action as expeditiously as possible.

CMS is collaborating with the Internal Revenue Service (IRS) and Treasury's Financial Management Service (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.

In the case of Medicare physician payments, which currently are not disbursed through FMS, CMS processes paper levies received from the IRS. Historically, based on Medicare legislation, CMS has used private contractors to process claims. This structure has complicated the coordination of the levy program. CMS is currently in the process of reducing the number of contractors and streamlining the paper levy process, as well as evaluating the feasibility of making these payments through FMS.

Next Steps: Potential for Moving Additional Disbursements to FMS

As mentioned previously, CMS is actively engaged in discussions with FMS about the

feasibility of using the federal disbursement center for all Medicare payments. By law, Medicare physician payments can be levied, but cannot be offset by FMS to collect non-tax debt. Currently, physician payments go through the carrier system and are not subject to offset through the TOP; however, they are subject to paper levy.

CMS currently uses a decentralized banking system that relies on nine commercial banks to issue Medicare payments. Across the country, Medicare payments are issued on a daily basis using a pre-authorized draw-down of federal funds. These arrangements are not routine federal disbursements that occur on an established, periodic schedule. CMS makes 50-60 million payment transactions per year, or roughly 5 million per month. Roughly 65 percent of these are in the form of paper checks mailed primarily to physicians.

Over the years, CMS has made significant headway in streamlining and simplifying current banking arrangements, and as noted previously, reducing the number of contractors that process Medicare Part A and B claims under different claims processing systems. We are on course to have all Medicare contractors on the HealthCare Integrated General Ledger Accounting System (HIGLAS) by 2011. Such steps make it more feasible than ever before to revisit current banking arrangements, examine moving physician disbursements to FMS, and explore other options for levying payments.

CMS is working with representatives from FMS to explore legal, procedural and technical issues, and will prepare a written report by the end of the year elaborating on our solution. As we continue to assess options and realistic timelines for new payment disbursement arrangements with FMS, CMS is working with the IRS to improve the

processing of paper levies to achieve greater success in collecting the tax debts of physicians receiving Medicare reimbursement. We are working with IRS to compare 1099 data submitted each year by the Medicare contractors with IRS delinquent-tax information. This would result in the routing of paper levies to the appropriate Medicare contractor, which could then levy outgoing Medicare reimbursements for the tax debt amount.

CMS and Treasury also are working to address the concern that physicians with significant tax debts are retaining Medicare provider numbers. Current statutory authority does not allow CMS or its agents to deny or revoke provider enrollment for delinquent tax liabilities. While there is no system currently in place whereby IRS notifies CMS of such individuals before we process their enrollment, we are exploring regulatory options to build better checks into our systems.

Partnership Showing Promise: Los Angeles County Fraud Interdiction Program

The Los Angeles County Fraud Interdiction Program (Tax Project) is one of the best examples of ongoing collaborative work at the intersection of health care fraud and tax evasion. This collaboration is achieved through a partnership of more than ten State and Federal agencies including CMS, the HHS-OIG, the Federal Bureau of Investigations (FBI), major health insurance payers and other concerned organizations. Using available payment data, aberrant billing patterns and patient complaints, the partners identify questionable health care practitioners as potential suspects, whose information is then made available to the Tax Project's lead prosecutor. Accumulated payment information pertaining to the suspects is shared with a criminal investigations supervisor at the

California Franchise Tax Board (FTB), one of the Tax Project's partners, who then initiates a tax case when filing deficiencies are discovered. A substantial percentage of suspects are non-filers. Another substantial percentage of individuals involved in health care provider fraud grossly under report their incomes. Under either scenario, felony crimes have potentially been committed. Felony convictions that are within the past ten years may be used as a basis for CMS to revoke a physician's Medicare billing privileges, removing them from the Medicare program.

As a result of the Tax Project's efforts to date, three individuals have been convicted of tax fraud, with all convictions including prison sentences and restitution. Another two physicians have been arrested on suspected tax and health insurance fraud, and roughly 300 cases are under development by the Tax Project. Significantly, of these potential additional cases, CMS identified 50 Medicare physicians who were paid more than $100 million in program reimbursement, for which they failed to file a state income tax return for one or more tax years.

The District Attorney for Los Angeles County is sharing this model approach with other counties within the State of California and also with other states. Statute permitting, CMS would be interested in pursuing this on the federal level.

Conclusion

Responsible and efficient stewardship of taxpayer dollars is a critical goal of CMS and the entire Administration. The PMA and ongoing collaboration across government agencies are significant steps toward minimizing improper payments and collecting debts

owed. With respect to physician tax debt in particular, CMS is fully committed to exploring a deeper partnership with FMS and the IRS, building on current successes in applying tax levies and our participation on the FCTC Task Force.

Thank you. I would be happy to answer any questions.