CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

INSTRUCTIONS FOR COMPLETING MEDICAID REPORT ON PAYABLES AND RECEIVABLES (FORM CMS-R199)

June 2005

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I. Purpose

The purpose of this document is to identify reporting requirements by State Agencies for the Medicaid Report on Payables and Receivables (Form CMS-R199), also known as the Medicaid Incurred but Not Reported (IBNR) Survey.

II. Background

Medicaid

Established under Title XIX of the Social Security Act, Medicaid is the primary source of health care for a large population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. The Medicaid program is jointly funded by a cooperative venture between the Federal and State governments.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled and elderly population), low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups, covering at least ten services mandated by law, including hospital and physician services, laboratory tests, family planning, nursing facility services, and health screening for children under the age of twenty-one. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States.

Although the Medicaid programs are administered by the States, each State must operate its program under a State Plan, submitted to and approved by CMS, detailing eligibility, benefits, payment rates, and other program features. Under Medicaid, State payments for both medical assistance (MA) and administrative (ADM) costs are matched with Federal funds. The Federal government matches the state MAP expenditures using a rate called Federal medical assistance percentage (FMAP). The FMAP rates are determined annually for each State by a formula based upon the relationship of the State's average per capita income level to the national income level. The FMAP is limited to a minimum of fifty percent and a maximum of eighty-three percent – with the exception of higher matching rates for MAP expenditures related to Indian Health Facility (one hundred percent), family planning (ninety percent) services and enhanced FMAP rates for breast and cervical cancer and for the State Children's Health Insurance Program (SCHIP). The basic Federal matching rate for State Medicaid ADM expenditures is fifty percent. Higher rates ranging from seventy-five percent to one hundred percent may apply to certain other ADM costs such as Medicaid automated claims processing systems, skilled professional medical personnel, family planning, and immigration status verification status systems. The Federal share of State Medicaid expenditures for both MAP and ADM is referred to as Federal Financial Participation (FFP).

Incurred but Not Reported (IBNR) Costs

IBNR costs result from Medicare or Medicaid medical services incurred but not paid as of September 30, the Federal Government's fiscal year end. The Medicaid amount is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of

Medicaid funds to providers, anticipated rebates from drug manufactures, settlements of probate and fraud and abuse cases, and anticipated recoveries from other liable parties such as other health or liability insurance or via medical liability lawsuits (third party liabilities).

The Chief Financial Officer (CFO) Act of 1990, as amended by the Government Management Reform Act (GMRA) of 1994, requires government agencies to produce auditable financial statements. Because CMS fulfills its mission through its contractors and the States, these entities are the primary source of information for the financial statements. There are three basic categories of data: expenses, payables and receivables. The Form CMS-64 is used to collect data on Medicaid expenses. The Form CMS-R199 is used to collect Medicaid payable and receivable accounting data from the States.

III. Due Date for Submission of the Form CMS-R199

The CMS requests that States complete and return the IBNR survey by **September 15** for the current fiscal year.

Since most of the States and Territories operate on a June 30 fiscal year-end and the Form CMS-R-199 is due before most State Comprehensive Annual Financial Reports (CAFRs) are audited, States are instructed to submit their best estimate on the IBNR survey. Based upon the need to have the best estimate for the Medicaid IBNR, the CMS also requests that States submit ***updated IBNR Surveys no later than April 30.***

Note: If the September 15 and/or April 30 due dates occur on a holiday or a weekend, the report is due the following Federal workday.

IV. Certification

Certification of the Form CMS-R199 by the State Chief Financial Officer (CFO) or designee is required. The CFO or designee certifies that the IBNR data submitted has been reviewed, is based on or in agreement with the amounts verified by State auditors, and is the best available estimate for the reporting period. The name of a contact person is also required in the event that CMS has questions concerning the submitted data.

V. Form CMS-R199 Line Item Descriptions

The Form CMS-R199 consists of three sections: Section I – Medicaid Accounts Payable; Section II – Medicaid Accounts Receivable; and Section III – Average Days. Sections I and II require that the States identify the CAFR period that the data is based upon. Sections I and II also require that States report the latest CAFR data as well as CAFR data for the previous year. For each reporting requirement in Sections I and II, States are required to enter total costs as well as the portion known as Federal Financial Participation. Refer to the following formula when reporting costs in Sections I and II:

Total =State Portion +Federal Financial Participation.

Medicaid Accounts Payable

Medicaid Accounts Payable represents amounts owed by the State to providers for services rendered and for State and local administrative expenses as of the dates indicated below, but excluding amounts paid and reported on the Quarterly Medicaid Statement of Expenditures, (Form CMS-64) for the quarter ending as of the dates indicated on the survey.

Line 1, *Total Medical Assistance Accounts Payable,* equals claims that have been incurred by providers but not yet submitted to the State; claims submitted by providers but not yet processed or paid by the State; cost report settlements; and provider underpayments.

Line 2, *Payments Owed by the State for Medicaid State and Local Administrative Expenses,* equals Medicaid State and local administrative expenses owed by the State.

Line 3, *Other Accounts Payable,* equals any payables that have not been captured in Lines 1 or 2. If an amount is entered on Line 3, the State must identify the nature of the payable.

Medicaid Accounts Receivable

Medicaid Accounts Receivable represents amounts owed to the State form various sources **excluding the Federal Government** and any amounts received and reported on the Form CMS-64 for the quarter ending as of the dates indicated on the survey.

Line 1, *Medical Assistance Accounts Receivable*, consists of the following items:

Third Party Liabilities	Amounts billed and expected to be recovered from other medical or liability insurance programs (including Medicare) and amounts expected to be recovered through medical liability lawsuits.
Probate Court Cases	Receivables resulting from cases involving wills and estates. Probate court is a specialized court or division of a state trial court that considers only cases concerning the distribution of deceased persons' estate.

Fraud and Abuse Cases	Receivables due because it has been determined that there was fraud and/or abuse on the part of a physician/provider/supplier. Fraud is an intentional misrepresentation or deception which could result in an unauthorized benefit to a person or persons and usually comes in the form of a false statement requesting payment under the Medicare/Medicaid program. Abuse usually involves payment for items or services where there was no intent to deceive or misrepresent but the outcome of poor inefficient methods results in unnecessary costs to the Medicare/Medicaid program.
Provider Overpayments	Overpayments a provider has received in excess of amounts due and payable under the statute and regulations.
Audits of Annual Cost Reports	Receivables resulting from annual cost report audits.
Drug Rebates	States, CMS and drug manufacturers have an agreement whereby if a State's Medicaid population (according to data the States provide to the drug manufacturer) uses a specific drug above a predetermined threshold, the drug manufacturer will provide a rebate within 30 days to the State.
Other	Any receivables not captured on the above lines.

Line 2, *Allowance for Uncollectible Amount for Above Accounts*, is an estimate of receivables not likely to be collected.

Line 3, *Total Net Accounts Receivable*, is the sum of amount reported on Line 1 minus the allowance amount on Line 2.

Line 4, *Other Receivable not in CAFR*, is used to record any receivables not captured or reported in the Comprehensive Annual Financial Report. If an amount is entered on Line 4, the State must identify the nature of the receivable.

Average Days

The CMS also uses an alternative methodology based on average days to calculate the IBNR estimate. This methodology estimates the length of time from when services are provided to a Medicaid beneficiary until reimbursement by the State to the provider is made. The average days provided is multiplied by the average daily claims volume to arrive at a year-end payable estimate. The result is compared to amounts reported in the IBNR survey for reasonableness.

VI. Work Paper Standards

States must document its process for identify IBNR costs. Work papers should be used to document and support any decisions drawn relating to the process used and the costs reported on the IBNR survey. Work papers should be prepared in a uniform, clear and concise manner.

Work papers prepared by the States must be available upon request in the event that CMS Regional Office staff, or other parties on behalf of CMS, comes onsite to review State Medicaid IBNR documentation.

Appendix

(Medicaid IBNR Survey - Form CMS-R199)

MEDICAID INCURRED BUT NOT REPORTED (IBNR) SURVEY

I. MEDICAID ACCOUNTS PAYABLE

Medicaid amounts owed by the State to providers for services rendered and for State and local administrative expenses as of the dates indicated below, but excluding amounts paid and reported on the CMS-64 for quarter ending as of the dates indicated below. (TOTAL =STATE +FEDERAL FINANCIAL PARTICIPATION (FFP))

	Latest CAFR (9/30/XX or prior) as of _____		Previous CAFR (9/30/XX or prior) as of _____	
	Total (Whole dollars)	**FFP**	**Total** (Whole dollars)	**FFP**
1 - Total medical assistance accounts payable [1]				
2 - Payments owed by the State for Medicaid State and local administrative expenses				
3 - Other accounts payable (define)				

STATE _____ **CONTACT PERSON** _____
PHONE _____ **FAX** _____

ADDRESS _____

I hereby certify that I have examined the data reported for the periods ending as indicated above, and that to the best of my knowledge and belief, it is based on and in agreement with, amounts verified by the State Auditor.

Signature _____
Name (Printed) _____
Title _____ **Date** _____

Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0697. The time required to complete this information collection is estimated to average 3 hours per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21244 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

[1] Includes Claims incurred by Providers - not yet submitted to the State, Claims submitted by Providers - not yet processed or paid by the State, Cost report settlements, and Provider underpayments

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