CENTER FOR TAX AND BUDGET ACCOUNTABILITY

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The State of Illinois Shortchanges Cook County on Federal Medicaid Payments

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Executive Summary

Cook County, through its three hospitals and network of community clinics, is the largest provider of indigent health care in the state and the third largest provider of such care in the nation, caring for more than a million poor uninsured individuals every year.[1] The demand for the public sector to provide access to health care is only expected to increase as private coverage becomes less affordable for low-income, working families – over 40 percent of Illinois' workforce no longer receives employer-provided health insurance.[2] As a result, Cook County's role in caring for poor and low-income residents can be anticipated to increase in future years. Accordingly, it is imperative that all funding sources for the County's health care system be preserved.

Federal Medicaid funds are an essential revenue stream supporting the delivery of health care services provided by the County, funding nearly two-thirds of the County's health care budget.[3] In particular, a significant amount of the County's federal Medicaid revenue comes from a federal law entitled the "Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000," often referred to as "BIPA." Section 701(d) of BIPA requires states to pass certain federal Medicaid funds onto public hospitals serving a disproportionate number of low-income patients.[4] Because states are the primary administrators of state Medicaid programs, dedicated federal funds are distributed to each state, rather than the providers themselves. The state then distributes the federal funds to the appropriate health care providers. The statutory language in BIPA is clear: all federal funds distributed to Illinois must be paid to the qualifying County hospitals to help cover the cost of caring for Medicaid and other low-income patients.

The specific language of the §701(d) provides that "payment adjustments made…to a *hospital* described in paragraph (2) shall be made…"[5] (Emphasis added). The Cook County hospitals meet the requirements set forth in paragraph (2) of § 701(d) of BIPA. The plain language of the statute does not allow for states to retain a portion of the federal BIPA funds or permit states to require the local provider to return a portion of the federal payments by way of an intergovernmental transfer back to the state. The U.S. Supreme Court has declared the cardinal rule of statutory construction: it must be presumed Congress "says in a statute what it means and means in a statute what it says there."[6] Under well-settled Supreme Court rulings, if the statutory language is clear on its face, there is no room for interpretation or intent; the express language of the law must be enforced.[7]

The amount Cook County hospitals are eligible to receive under the federal BIPA provision is $375 million annually. However, contrary to federal law, the State of Illinois retains, in effect, fully 65 percent of the special federal BIPA funds intended for the County hospitals, or $243.8 million annually, to help fund state health care programs.[8]

A few states, including Illinois, have not been complying with the federal requirement that certain federal dollars, such as the BIPA funds, are to be distributed to specific safety-net providers, such as Cook County hospitals, rather than retained for state health care programs. In an effort to curb this practice, the federal government issued proposed regulations on January 17, 2007, prohibiting states from keeping a portion of federal Medicaid dollars appropriated specifically for local safety-net providers.[9] The proposed regulations eliminate any potential doubt regarding the interpretation that all federal funds distributed to Illinois under §701(d) of BIPA are required to be paid to Cook County. The proposed regulations require that, with respect to federal Medicaid funds "*providers receive and retain the full amount* of the total computable payment provided to them for services furnished…"[10] (Emphasis added). Accordingly, Illinois' retention of the

federal BIPA funds to which Cook County is entitled is contrary to the express language of both BIPA itself, and the proposed federal regulations recently issued commenting on intergovernmental transfers of Medicaid payments between state governments and public hospital providers generally.

Brief Summary of Medicaid Financing

Medicaid, the public health care program for impoverished children and their parents, the disabled and the poor elderly, is financed jointly by the federal government and the states. While each state administers its own Medicaid program, the federal government shares in the cost of each state's program. Generally, the federal government reimburses Illinois for half of its Medicaid expenditures (i.e., the state's federal Medicaid matching rate is 50 percent).[11]

Illinois finances its share of Medicaid costs through a variety of sources, including general state tax revenue, special hospital provider taxes, and contributions from specific local governments (e.g., Cook County) through intergovernmental transfer arrangements, as permitted by federal Medicaid law.[12] Because Medicaid is technically a reimbursement program, to trigger federal matching funds, the state must expend some combination of state and local funds on Medicaid first.

In Cook County, Medicaid is financed using a combination of local tax dollars and federal funds only – state funds are not used. Based on an arrangement with the State of Illinois, the County transfers local funds ("local participation fees") to the state. The County's contribution is determined by Medicaid expenditures it has already incurred. This then triggers a federal Medicaid match of 50 percent of such expenditures reported by the state to the federal government. The federal match is then paid to the state, which is then supposed to reimburse the County for the cost of the Medicaid services it has already provided.

It is important to note that, historically, Medicaid reimbursement rates set by states generally do not cover the full cost Medicaid providers incur in delivering Medicaid services.[13] Recognizing that Medicaid reimbursement rates do not cover the full cost of care for Medicaid patients, the federal government requires states to make supplemental payments to hospitals that care for a significant number of Medicaid beneficiaries as well as low-income, uninsured, non-Medicaid patients.[14] These supplemental payments are called "disproportionate share hospital" or "DSH" payments. Medicaid DSH payments are intended to help off-set the high cost of uncompensated indigent care. Despite DSH and other supplemental Medicaid payments, however, Medicaid has a long history of paying less than Medicare for the same services.[15] Medicaid reimbursement rates in Illinois are so much lower than the Medicare reimbursement rates that the state's differential ranks 42nd out of the 50 states.[16]

Medicaid Financing: Intergovernmental Transfers (IGTs) and the Upper Payment Limit (UPL)

As permitted under the Social Security Act, many states use contributions from local governments to draw federal Medicaid matching funds.[17] Illinois is no exception. This financing arrangement involves the interplay of "intergovernmental transfers" and the "upper payment limit."

An intergovernmental transfer, or "IGT," is simply a transfer of public funds from one level of government to another (e.g., the county to the state). IGTs have been an instrumental component of public finance for decades. So much so, that Illinois and many other states have come to rely on IGTs to fund a significant portion of their Medicaid programs, as permitted by federal law.[18] Illinois' most significant IGT agreement for Medicaid financing is with the Cook County Board of Commissioners (the Cook County IGT).

The upper payment limit, or "UPL," limits how much a state can reimburse Medicaid providers for health care services delivered to Medicaid beneficiaries. A state has considerable flexibility in determining how much of a provider's cost of delivering Medicaid services the state will cover through reimbursement rates. However, federal regulations impose a ceiling – the UPL – on Medicaid reimbursement rates. Under the

UPL regulations, a state may not pay providers more than what Medicare would have paid for the same service.[19] Since Medicaid has historically paid providers lower reimbursement rates than Medicare, there is often a "gap" between Medicaid and Medicare reimbursement rates.

Under the pre-2001 UPL regulations, a state would calculate its UPL for certain groups of providers serving Medicaid patients, and pay hospitals owned by local units of government, such as county hospitals providing large amounts of care to both Medicaid and uninsured patients, more than what the state would have paid if it used its usual Medicaid reimbursement rates. The enhanced payment is based on the "gap" between what the state's Medicaid reimbursement rate would have allowed, and the greater payment the UPL allows predicated on Medicare rates. The result is that county providers received greater payments for Medicaid services to cover a greater percentage of their actual Medicaid costs and the cost of providing services to low-income uninsured patients. In addition, using the IGT-UPL mechanism, the state, in effect, retains a portion of the enhanced federal Medicaid matching funds. This allows the state to fund delivery of needed health services to low-income and vulnerable populations. Without the use of enhanced reimbursement using the IGT-UPL strategy, Medicaid reimbursement rates do not cover the full cost of serving Medicaid and uninsured populations incurred by county providers.

The Cook County IGT draws a significant amount of federal Medicaid funds to the County annually, all of which are used to fund health care services provided to uninsured, indigent County residents.

Responding to its own increasing budget pressures, the federal government issued regulations in 2001 severely limiting the use of the higher Medicaid reimbursement rates under the UPL-IGT process, effectively cutting federal Medicaid funds to public providers like the Cook County hospitals.[20] The phase-out of this financing mechanism is being implemented over several years, ending in 2008. Accordingly, states and county providers can no longer take advantage of the old UPL regulations and will lose a significant amount of federal Medicaid funds following the full implementation of the new regulations.

Special Federal Medicaid Funds under "BIPA" Intended for Public Hospitals Like Cook County

Recognizing the devastating impact the curtailment of the UPL would have on certain public hospitals, § 701(d) of the federal Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, or "BIPA," provides for federal supplemental Medicaid payments to be made to certain public hospitals that serve a disproportionate number of Medicaid and low-income patients. The BIPA requires a state to distribute the special federal Medicaid payments dispersed by the federal government, to qualifying public hospitals that do not receive DSH payments. The language of the BIPA specifically provides that "payment adjustments made …to a *hospital* … shall be made…"[21] (Emphasis added). Nowhere in the BIPA is the authorization made for splitting the payments with any governmental entity or unit. The Cook County hospitals have met the statutory requirements identified for receipt of the special reimbursement payments every year since BIPA went into effect. Since the express language of the statute is unambiguous, Cook County is the sole entity eligible to receive the federal BIPA payments. However, rather than turning over to Cook County all federal Medicaid payments under BIPA, the state has been effectively retaining 65 percent of the funds.

This 35/65 split of federal Medicaid funds is based on an agreement between Cook County and the State of Illinois that grew out of the IGT-UPL Medicaid funding strategy. This law has now changed under proposed federal regulations, which no longer permit this splitting of federal Medicaid funds.[22]

It should be noted that states have discretion with respect to how they divide traditional DHS payments under the Social Security Act. However, § 701(d) of BIPA specifically requires payments be allocated to public hospitals meeting certain requirements, and mandates states to distribute all such amounts. The statutory language does not provide for state discretion in the distribution of the funds, or the option of keeping a portion of the dollars for state health care programs. Rather, Congress explicitly required the funds to be

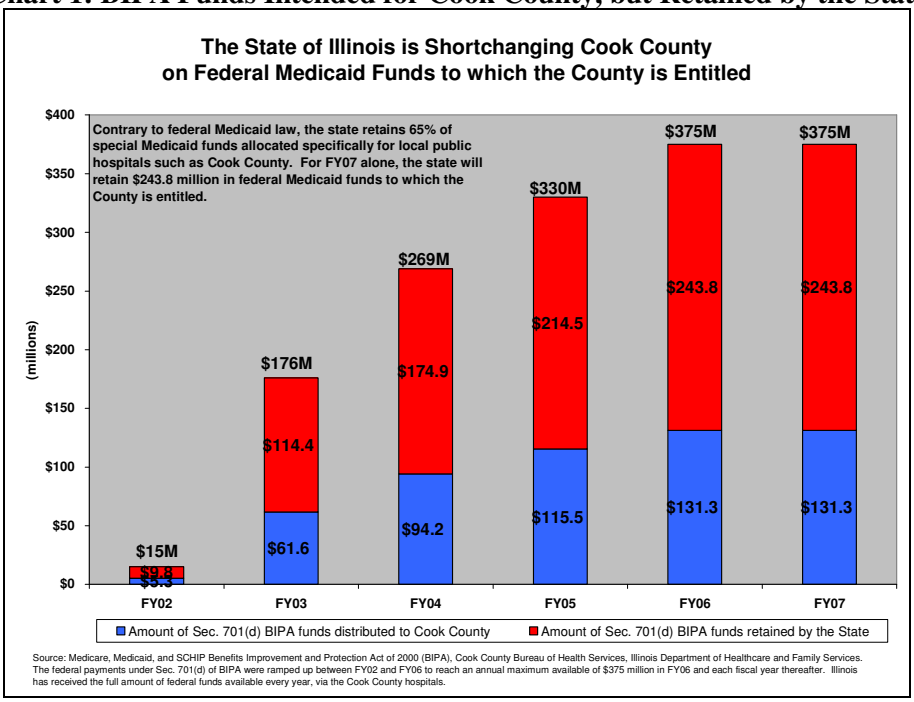
directed to public hospitals bearing a substantial financial burden in caring for low-income patients. Any doubt about Congressional intent was eliminated by the proposed federal regulations issued on January 17, 2007, which make clear that states are not permitted to keep any federal Medicaid funds Congress appropriated specifically for public safety-net providers.

The maximum amounts of federal BIPA funds that can be distributed by the federal government each federal fiscal year are $15 million in 2002; $176 million in 2003; $269 million in 2004; $330 million in 2005; and $375 million in 2006, and in each fiscal year thereafter.

Because the Cook County hospitals are the only hospitals in the nation that qualify for BIPA funds every year, the full statutory amount available under BIPA has been distributed to Illinois, for the state to reimburse Cook County. The reason federal Medicaid funds are not simply distributed directly to Cook County by the federal government is that states are the only permissible administrators of federal Medicaid funds, not local units of government. Accordingly, states often act as "pass through" entities for purposes of federal Medicaid funds directed to specific providers.

Chart 1 shows the current allocation of BIPA proceeds in Illinois, with the state in effect retaining 65 percent of the federal BIPA funds, while distributing the remaining 35 percent to Cook County.[23] For each federal fiscal year beginning in 2006, the state will keep $243.8 million out of $375 million.

Chart 1: BIPA Funds Intended for Cook County, but Retained by the State



Endnotes

[1] Cook County Bureau of Health Services.
[2] *The State of Working Illinois*, Center for Tax and Budget Accountability and Northern Illinois University (2005).
[3] Cook County Bureau of Health Services.
[4] § 701(d), Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.
[5] *Id.*
[6] *Connecticut National Bank v. Germain*, 112 S. Ct. 1146, 1149 (1992).
[7] *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241-242 (1989); *United States v. Goldenberg*, 168 U.S. 995, 102-103 (1897).
[8] Illinois Department of Healthcare and Family Services, Cook County Bureau of Health Services.
[9] 72 Fed. Reg. 2236 (January 19, 2007).
[10] *Id.*, at Retention of Payments (§ 447.207).
[11] 42 U.S.C. § 1396d(b).
[12] 42 U.S.C. § 1396a(a)(2).
[13] According to the Illinois Hospital Association, Illinois reimburses providers approximately 81.5 percent of cost for Medicaid services. Illinois Hospital Association, *Illinois Hospitals at a Glance*, August 10, 2005.
[14] *See* 42 U.S.C. § 1396r-4.
[15] *See* S. Norton and S. Zuckerman, "Recent Trends in Medicaid Physician Fees, 1993-1998," *Health Affairs,* 2000.
[16] Kaiser Family Foundation, Statehealthfacts.org, "Medicaid-to-Medicare Fee Index, 2003."
[17] 42 U.S.C. § 1396a(a)(2).
[18] 42 U.S.C. § 1396b(w)(6)(A) (IGTs from a local government may be counted as the state's share of Medicaid financing).
[19] 42 C.F.R. § 447.272(b).
[20] 42 C.F.R. § 447.422.
[21] § 701(d), Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.
[22] 72 Fed. Reg. 2236 (January 19, 2007), Retention of Payments (§ 447.207).
[23] Illinois Department of Healthcare and Family Services, Cook County Bureau of Health Services.