

# **CENTER FOR TAX AND BUDGET ACCOUNTABILITY**

70 E. Lake Street • Suite 1700 • Chicago, Illinois 60601

## **Illinois' Medicaid Program: Financing Challenges in the Face of Federal Medicaid Cuts and a Flawed State Fiscal System**

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## **Illinois' Medicaid Program: Financing Challenges in the Face of Federal Medicaid Cuts and a Flawed State Fiscal System**

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### **Introduction**

Medicaid is the nation's primary public health insurance program for low-income families, the disabled and the poor elderly, providing health care for over 55 million uninsured Americans.<sup>1</sup> It is also an essential part of Illinois' health care safety net. Medicaid provides health care coverage to more than two million Illinoisans per year, one million of which are children; pays for 40 percent of the state's births; and pays for two of every three nursing home days.<sup>2</sup> If anything, current economic factors such as the sluggish recovery in Illinois, the private sector trend to reduce health care benefits offered to workers, particularly in low wage jobs, and the skyrocketing growth in private health insurance costs which, according to the Kaiser Family Foundation are increasing at three times the rate of inflation, strongly indicate that Medicaid's role as the principal provider of health care coverage for the state's most vulnerable populations will only increase over time.

In addition to providing health care to poor and working-poor families, Medicaid plays a substantial role in the state's economy. Illinois hospitals, nursing homes and community health centers depend on Medicaid funds to keep their doors open. For example, in 2002 alone, more than \$3.2 billion in Medicaid funds flowed into Illinois' hospitals.<sup>3</sup> Medicaid now accounts for more than 13 percent of total patient revenue for Illinois hospitals.<sup>4</sup> Similarly, Medicaid is the primary payor for nearly two-thirds of Illinois nursing home residents and is the source of one of every five dollars spent for prescription drugs.<sup>5</sup> For these reasons, the state has much to lose if federal Medicaid funding cuts are implemented in Illinois. Indeed, any cuts in Medicaid funding would be detrimental to both Illinois' economy and the state's ability to provide necessary health care services to low-income children and families unable to afford private health insurance.

### **Executive Summary**

- Generally, Illinois and the federal government share equally in funding the state's Medicaid program as prescribed under the Social Security Act.
- Illinois' poor fiscal condition and skyrocketing health care costs have forced the state to use significant contributions from local governments to generate enough federal revenue to avoid painful cuts in the coverage provided by the Illinois Medicaid program. These "intergovernmental transfers" (IGTs) of local funds to the state have been an integral part of public finance for decades and are a permitted source of Medicaid financing under the Social Security Act.<sup>6</sup> Increasingly, Illinois, as well as numerous other states in similar situations, has come to rely on this particular Medicaid financing mechanism to fund a significant portion of the Medicaid coverage provided to poor and working-poor families. Although there are many methods used to maximize federal Medicaid funds, this report focuses specifically on one such method – the use of IGTs in combination with the "upper payment limit" (UPL).
- Due primarily to federal budget pressures, federal regulations were issued in 2001 that greatly restrict the use of the IGT-UPL funding mechanism.<sup>7</sup> As a result, it is estimated that Illinois will lose nearly \$1 billion in federal Medicaid funds over the eight-year phase-out of method used

under the old regulations.<sup>8</sup> Moreover, the proposed federal budget for fiscal year 2007 may foreclose the use of the UPL altogether by public hospitals.<sup>9</sup>

- Because Illinois' tax system will not be able to make up the difference, if Illinois loses the IGT-UPL funding stream, the state will be forced to cut either its existing Medicaid program or other essential human services the state provides.
- Cuts in Illinois' Medicaid program would push thousands of impoverished people onto the ranks of the uninsured, leaving them without access to health care. As a result, hospitals and other health care providers around the state would be forced to bear the cost of providing additional charity and uncompensated care to these newly uninsured families. In addition, Medicaid also supports costly but vital health care facilities, such as trauma, burn and neonatal intensive care units, the costs of which typically exceed the revenue generated. Without Medicaid, many health care safety net providers would not be able to maintain such facilities.
- The negative impact that would result from any reduction to the state's Medicaid program would be felt throughout Illinois' health care industry and economy. In essence, if the state were to cut its Medicaid program, it would reduce the flow of dollars to hospitals, clinics, nursing homes and pharmacies, which in turn would most likely reduce employment, income, state tax revenue and economic output.
- It is therefore imperative that the IGT-UPL Medicaid funding stream be preserved or fully replaced.

### **Medicaid Financing: The Entitlement Challenge**

Historically, there have been no caps on Medicaid spending at either the federal or state level because Medicaid is an entitlement program. This means the government must provide Medicaid health care benefits to everyone who is eligible for the program and enrolls, regardless of cost. The idea behind making Medicaid an entitlement was simple – low-income individuals who cannot afford private coverage should have access to basic health care services.

Funding an entitlement program, however, can be a challenge – particularly for programs like Medicaid. During difficult economic times, more families are eligible for Medicaid health care coverage due to job loss and the concurrent loss of employer-sponsored health insurance. Accordingly, the program's financing structure must be able to absorb all newly eligible participants who enroll during such times. This is difficult during economic contractions when program costs increase as tax revenues needed to fund the program decrease for both the federal and state governments, leaving less revenue to cover greater costs. This confluence of factors recently forced many states facing severe fiscal constraints to contain Medicaid costs by limiting eligibility, reducing the benefits offered, or a combination thereof, at a time when Medicaid coverage was needed most.

The public financing challenge presented by the frequent mismatch between increased demand for Medicaid coverage and falling tax revenue is exacerbated by skyrocketing health care costs which greatly outpace inflation. According to the Congressional Budget Office, federal Medicaid expenditures, which are estimated to total \$190 billion for fiscal year 2006, are expected to nearly double in the next ten years.<sup>10</sup> This continues a longstanding trend. Nationally, Medicaid spending has been growing at annual rates between 9 and 10 percent since 2002, and is projected to continue growing between 8 and 9 percent annually for the next decade.<sup>11</sup> While this is a slowdown from the average annual growth rate of 12 percent seen between 1975 and 2002, it is nevertheless unsustainable.<sup>12</sup>

At the state level the net result is that, overtime, Medicaid costs are consuming ever greater portions of Illinois' state budget. Medicaid spending is now one of the state's largest budget items, second only to education. From its total budget for fiscal year 2005, it is estimated that Illinois will spend nearly \$12 billion on Medicaid, which will account for more than 25 percent of the state's total expenditures.<sup>13</sup> This is up 69 percent from expenditures in fiscal year 2000, which totaled \$7.086 billion.<sup>14</sup>

In response to the rising cost of Medicaid and increasing budget pressures at both the federal and state levels, Congress recently passed the Deficit Reduction Act of 2005 (DRA).<sup>15</sup> The provisions of the DRA addressing Medicaid allow states to charge higher co-payments for medication and doctor and hospital visits in an effort to rein in Medicaid costs. The cost sharing measures are estimated to save the federal and state governments \$28.3 billion between 2006 and 2015.<sup>16</sup> In addition, the proposed federal budget for fiscal year 2007 would impose \$14 billion in further cuts in the Medicaid program over five years.<sup>17</sup>

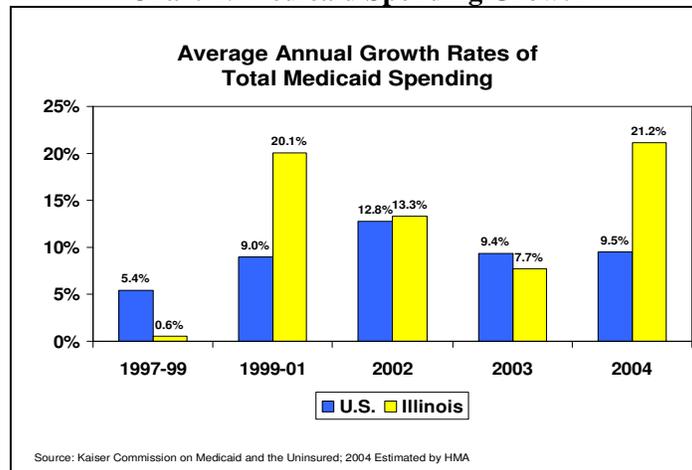
To date, Illinois has not opted to cut Medicaid through benefit reductions or eligibility restrictions, as many states have done in response to financial difficulties. However, as the program continues to absorb a growing portion of the state budget, Illinois will be under increasing fiscal pressure to cut Medicaid if the state's revenue system fails to generate sufficient revenue to cover increasing costs. This in turn would result in vulnerable, low-income Illinois families losing access to health care, an outcome that is both undesirable and difficult to justify, especially since U.S. Census data ranks Illinois as one of the ten wealthiest states in the nation.

## **Illinois Medicaid Spending**

Chart 1 below illustrates Medicaid spending growth in Illinois compared with the rest of the nation. On the whole, Illinois' Medicaid spending mirrors other states. However, Illinois experienced two periods in which its Medicaid spending outpaced other states: 1999 – 2001, and 2004. Between 1999 and 2001, a portion of the increased spending on Medicaid in Illinois was due to the implementation of Illinois' KidCare program. KidCare was implemented under the State Children's Health Insurance Program (SCHIP), which Congress passed in 1997. The goal of SCHIP is to provide health care coverage to millions of uninsured children living in poverty throughout the county. Illinois took more time than other states to implement its SCHIP program. As Chart 1 reveals, this also explains why Illinois' Medicaid spending between 1997 and 1999 lagged behind other states, as other states implemented their SCHIP programs immediately after passage of SCHIP. In simply catching up with the rest of the nation, Illinois' KidCare program grew substantially between 1999 and 2001.

The spike in Illinois' Medicaid spending in 2004 was not caused by explosive program growth. Rather, it was primarily due to Illinois taking advantage of both one-time federal fiscal relief and short-term borrowing to pay pre-existing Medicaid liabilities the state owed but failed to pay during the prior fiscal year, because of fiscal difficulties. Medicaid liabilities incurred in one fiscal year but which are paid in the following year are called "deferred Medicaid liabilities." Because Illinois' fiscal system cannot afford to pay providers for all Medicaid services delivered within a fiscal year, the state defers a significant amount of Medicaid liabilities from one year to the next.<sup>18</sup> Although constitutionally required to balance its budget every year,<sup>19</sup> Illinois has the flexibility to defer payment for certain obligations from the current fiscal year to the next.<sup>20</sup> This process is called "lapse period" spending, and allows Illinois to appear as if it balanced its budget when, in fact, its revenues are less than spending needs. Medicaid obligations are the most significant expenditures that may be deferred from one year to the next under this procedure. In an effort to reduce deferred Medicaid liabilities, in June 2004, the state borrowed \$850 million to avoid carrying over those Medicaid costs into the next fiscal year, resulting in increased spending in 2004 as Chart 1 reflects. Nevertheless, Illinois still deferred over \$1 billion in Medicaid liabilities to fiscal year 2005, delaying payment to providers for health care services rendered in 2004.

**Chart 1: Medicaid Spending Growth**



### **Measuring Actual Growth in Illinois' Medicaid Program: Medicaid Liabilities**

Focusing on Medicaid spending alone does not provide a complete picture of Medicaid program growth. The most appropriate measure of Medicaid expansion over time is program liability. The “program liabilities” are the amounts incurred for Medicaid services actually provided within a fiscal year. Tracking the total liability amount for a fiscal year eliminates the possibility of counting the unpaid, deferred obligations left over from the prior year. Between 2000 and 2004, Illinois' Medicaid liabilities increased at an average annual rate of 9.4 percent due primarily to rising health care costs in general, the cost of prescription drugs, the cost of covering the disabled and the elderly, and increased enrollment in KidCare.<sup>21</sup>

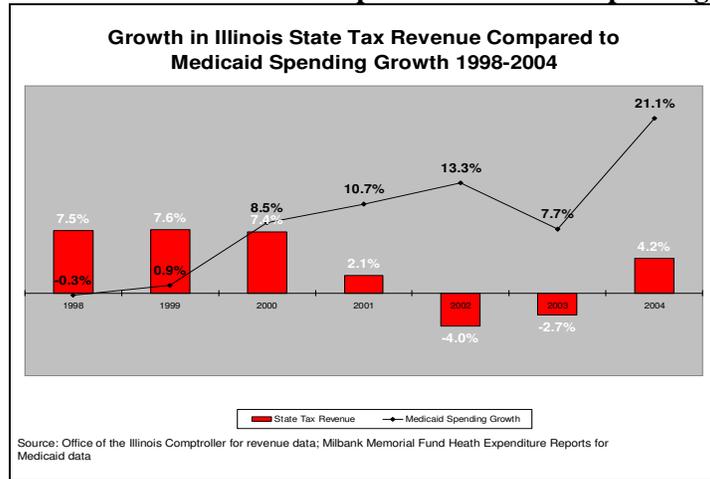
### **Illinois' Revenue System Cannot Keep Pace with the Rising Costs of Medicaid**

Medicaid spending and program liability increases have greatly exceeded both the rate of inflation and the rate of growth in Illinois state tax revenues over the last decade. The primary reason Illinois has annual budget deficits is due to revenue shortfalls caused by structural problems in the state fiscal system.<sup>22</sup> The flaws in Illinois' tax system are exacerbated during economic downturns, resulting in ongoing deficits. The severity of the problem is such that, under its current fiscal structure, Illinois does not raise enough revenue annually to finance the same level of public services it provided the prior year, adjusting solely for inflation. As a result, each year the state has a gap between estimated revenues and expenditures. The technical term for this is a “structural deficit,” which simply means that the state is insolvent. Because Illinois is constitutionally required to balance its budget, the decline in revenue often leads to cuts in essential public and human services or using debt to finance such services. Consequently, Illinois' antiquated fiscal system does not have the capacity to finance even the current level of state spending on Medicaid, much less keep up with the rising costs of Medicaid over time, without cutting other services the state provides.

Chart 2 below illustrates that Illinois' state tax revenue has not kept pace with Medicaid spending growth. Although, as mentioned above, Medicaid spending is not the best measure of program growth, it is nevertheless important when determining the state's spending needs to maintain the program. As Medicaid continues to consume more of the state's budget, continued growth in Medicaid spending effectively forces cuts in other essential human and public services the state provides. If the state's fiscal

limitations are compounded by federal Medicaid funding cuts, the state's balanced budget requirement will force it either to cut Medicaid or other essential programs vulnerable populations depend on.

**Chart 2: Illinois Tax Revenue Compared to Medicaid Spending Growth**



## Traditional Medicaid Financing: A Federal-State Partnership

### *The Federal Contribution to Medicaid Financing*

Medicaid is financed jointly by the federal government and each state participating in the Medicaid Program.<sup>23</sup> The federal contribution to each state's program is determined by a federal matching rate called the Federal Medical Assistance Percentage, or "FMAP." A state's FMAP rate is based on the state's per capita income, with the poorest states receiving a larger percentage of federal funding than wealthier states.<sup>24</sup> Under the Social Security Act, there is a ceiling and a floor placed on the federal government's contribution to a state's Medicaid program – a state's federal matching rate cannot exceed 83 percent or go below 50 percent of its Medicaid expenditures.<sup>25</sup> For fiscal year 2005, the FMAP ranged nationally from a low of 50 percent, to a high of 77 percent, with Mississippi receiving the highest federal match rate. Eleven states, including Illinois, receive the lowest federal match rate of 50 percent.<sup>26</sup>

There are two significant problems with the federal matching rate formula: (1) it does not take into account the percentage of the Medicaid population residing in a particular state, and (2) the mandatory 50-percent FMAP floor allows some states to receive significantly more in federal Medicaid funds than they otherwise would receive without the floor. As for the first concern, the FMAP formula only takes into account a state's overall per capita income while failing to consider the percentage of a state's population living in poverty. This is a problem because the percentage of Medicaid-eligible individuals living in a state directly correlates to the cost of a state's Medicaid program. Hence, the current system does not account for the fact that even states like Illinois that are relatively wealthy overall, may at the same time be home to a significant number of families who live in poverty. The end result is Illinois gets shortchanged in its federal Medicaid match. Currently, Illinois serves 4.5 percent of the total Medicaid population but only receives 3.6 percent of the total federal Medicaid dollars. As Chart 3 demonstrates, this effectively means the current system shortchanged Illinois to the tune of \$1.167 billion annually.

The second problem with the FMAP formula is the 50-percent statutory floor for the federal Medicaid contribution. This results in some states receiving a windfall of federal Medicaid funds. For instance, Connecticut's true FMAP rate is 15 percent, while New York's true FMAP rate is 37 percent. Accordingly, those states receive a substantial boost in federal funds due to the requirement that the

federal government bear at least 50 percent of a state’s Medicaid costs. Illinois, which has a true FMAP rate of 47 percent, does not benefit nearly as much from the FMAP floor as do other states. The result is that Illinois is under compensated by the federal government when it comes to Medicaid.

Chart 3 illustrates how the FMAP formula shortchanges Illinois in terms of receiving federal Medicaid funds:

**Chart 3: How the FMAP Formula Affects Illinois<sup>27</sup>**

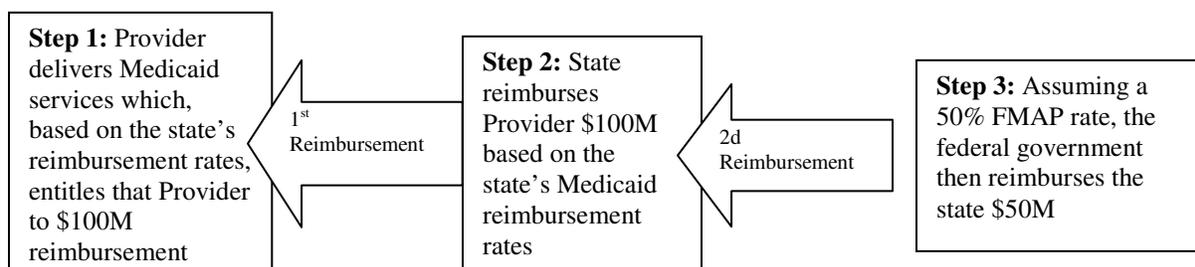
State	Percent of Medicaid Population	Percent of Federal Funding	(Cost) or Benefit
<b>Illinois</b>	<b>4.50%</b>	<b>3.61%</b>	<b>(\$1,167)</b>
Connecticut	1.00%	1.30%	\$ 391
New Jersey	2.12%	2.63%	\$ 670
Massachusetts	2.36%	2.69%	\$ 425
New York	9.27%	14.25%	\$ 6,498
Maryland	1.50%	1.48%	(\$ 24)
Delaware	.26%	.23%	(\$ 40)
Minnesota	1.73%	1.74%	\$ 11
New Hampshire	.24%	.40%	\$ 215
Colorado	.86%	.86%	\$ 6

***A State’s Contribution to Medicaid Financing***

A state has considerable flexibility with respect to how it finances its share of Medicaid. For instance, a state may use its own tax revenue or debt as permitted sources of Medicaid financing.<sup>28</sup> A state can also require local governments to contribute up to 60 percent of the state’s share of its Medicaid expenditures.<sup>29</sup> All funding, however, must come from state and local origins; federal funds may not be used as a source for a state’s share of Medicaid funding.<sup>30</sup>

Technically, Medicaid is a reimbursement program. To trigger federal Medicaid matching funds, a state must expend some combination of state and local funds on Medicaid first.<sup>31</sup> To illustrate, when a Medicaid recipient receives health care services, the provider incurs the cost, then requests reimbursement from the state. However, states generally do not cover the full cost of the Medicaid services providers deliver. Rather, the state sets reimbursement rates for Medicaid services, and providers are generally paid less than the actual cost of service delivery.<sup>32</sup> Once the state reimburses the provider, the state is then reimbursed by the federal government in an amount equal to that state's FMAP rate, multiplied by the state’s actual Medicaid expenditures from state and local sources. The following chart illustrates how the funding system works:

**Chart 4: The Flow of Money in Medicaid Reimbursement**



Recognizing that Medicaid reimbursement rates do not cover the full cost of caring for Medicaid patients, the federal government, in 1981, began requiring 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.<sup>33</sup> 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, the program has a long history of paying less than other payers.<sup>34</sup> Illinois’ Medicaid reimbursement rates are particularly low compared to the rest of the nation, ranking 42<sup>nd</sup> out of the 50 states when compared to Medicare rates.<sup>35</sup>

### **Special Medicaid Financing Mechanisms: Intergovernmental Transfers and the Upper Payment Limit**

Facing serious fiscal constraints and growing societal need for Medicaid coverage, states unwilling to reduce their Medicaid programs through eligibility cuts or benefit reductions use contributions from local governments, as permitted under the Social Security Act, to finance a portion of their Medicaid programs. Illinois is no exception. One such strategy Illinois utilizes involves the interplay of “intergovernmental transfers” and the “upper payment limit.” This financing mechanism, which was approved by the federal government, allows the state to obtain additional federal Medicaid matching funds.

As the name implies, 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) or between agencies at the same level of government (e.g., one state agency to another). 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.<sup>36</sup> Illinois has two main IGT agreements for Medicaid financing: one with the Cook County Board of Commissioners (the Cook County IGT) and one with the Board of Trustees of the University of Illinois (the University of Illinois IGT).

While IGTs involve transferring funds among different levels of government, 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.<sup>37</sup> 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, states were able to take advantage of UPLs for two different types of providers, state-owned and non-state owned, allowing reimbursement of the different types of providers at different rates.<sup>38</sup> Non-state-owned providers included both private hospitals as well as hospitals owned by local units of government (e.g., counties). The UPL for each of these two provider classes was based on the maximum amount that could be paid to the entire class as if every provider in the class received the higher Medicare rates for the services it provided to Medicaid beneficiaries, rather than the lower Medicaid rates the state would normally use.

A state would then calculate its UPL for all non-state owned providers that serve Medicaid patients, and pay hospitals owned by local units of government, such as county hospitals that provide large amounts of care to both Medicaid and uninsured patients, more than what the state would have paid if it just 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 larger payments for Medicaid services to cover a greater percentage of their actual Medicaid costs and the cost of covering low-income uninsured patients.

It is important to note that, historically, Medicaid reimbursement rates in Illinois are below the actual cost of providing the service.<sup>39</sup> Therefore, 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 providers.

Many states, including Illinois, used the IGT-UPL strategy to obtain additional federal Medicaid matching funds to supplement their Medicaid programs and the uncompensated care costs of covering the uninsured. In Illinois, the strategy was first used in 1992 and was approved by the Center for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration), the federal agency charged with Medicaid oversight and administration. Thereafter, the state's IGT-UPL arrangements were approved annually by CMS as a legitimate method of drawing federal funds to sustain the state's Medicaid program.

However, federal regulations issued in 2001 redefined the different classes of providers, and required states to phase out the use of the UPL based on the classification system under the old regulations.<sup>40</sup> The phase-out is being implemented over several years, ending in 2008. Accordingly, states can no longer take advantage of the old UPL regulations and will lose a significant Medicaid funding stream following the full implementation of the new regulations. Moreover, the proposed federal budget for fiscal year 2007 imposes further restrictions on the use of the UPL by public providers through administrative rulemaking.<sup>41</sup> It is essential to Illinois' Medicaid program that the IGT-UPL funding mechanism under the old regulations be preserved or replaced. Otherwise, Illinois may be forced to cut its Medicaid program due to its inability to replace the lost federal funds, thereby denying thousands access to health care.

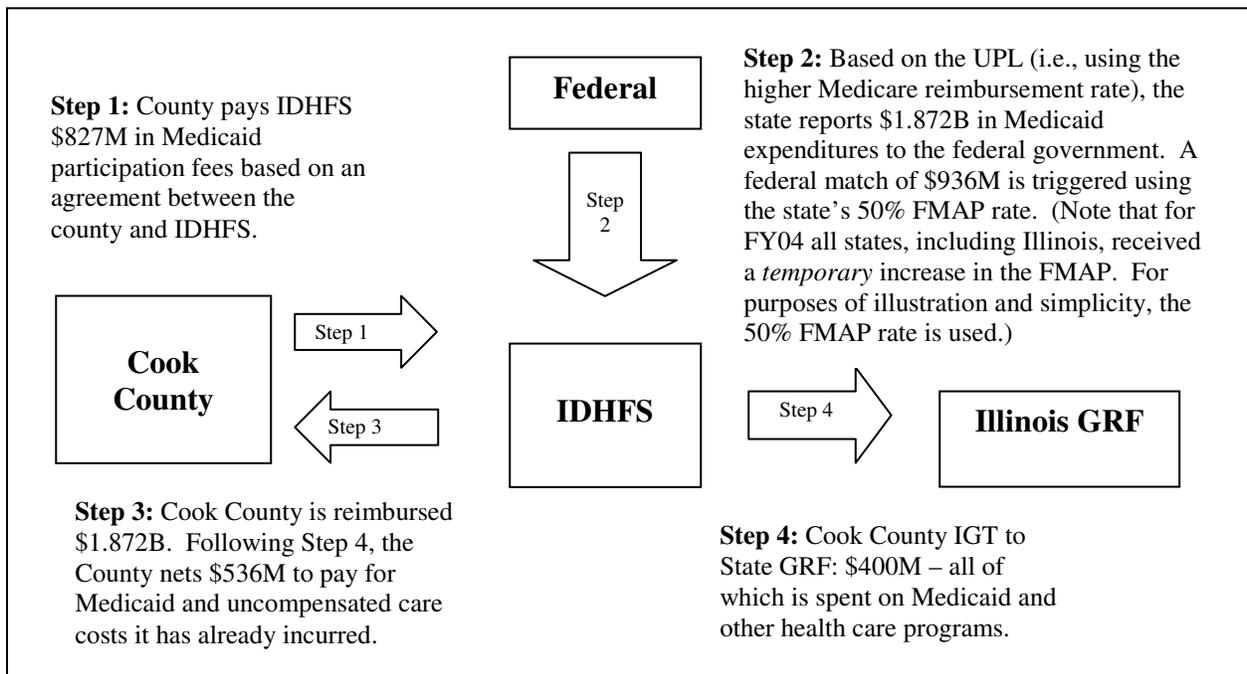
### ***The Cook County IGT***

Cook County, through its hospitals and clinics operated by the Bureau of Health Services, is the largest provider of Medicaid services and indigent care for the uninsured in Illinois, and is the third largest provider of uncompensated care in the nation.<sup>42</sup> Medicaid revenues are the lifeblood of Cook County's health care financial structure. For fiscal year 2005, Medicaid revenue funded approximately 63 percent of the county's Bureau of Health Services' budget.<sup>43</sup> The IGT-UPL funding is part-and-parcel of this Medicaid revenue.

Because Cook County plays a vital role in Illinois' health care safety net, the county has the state's most important IGT agreement with IDHFS, the state agency that administers the Medicaid program. Under this agreement, Cook County makes payments of an agreed upon amount to the state's County Provider Trust Fund. Such amounts count towards the state's share of Medicaid financing, triggering federal Medicaid matching funds at Illinois' FMAP rate of 50 percent. Following receipt of the federal match, the state then makes federally approved payments to the hospitals and other facilities operated by the Bureau of Health Services from the Trust Fund. During certain months, the County subsequently sends money to the state General Revenue Fund (GRF) by way of an IGT. The net amount retained by Cook County serves, in effect, as a repayment of the original local contribution, plus an additional amount to cover Medicaid and uncompensated care costs. However, the federal match and the payments to Cook County are not based on the customary Medicaid reimbursement rate Illinois generally pays, but are based on the greater payments permitted by the UPL. This strategy, approved by CMS, allows Illinois to leverage more federal dollars to cover a greater percentage of Cook County's actual Medicaid and indigent health care costs.

To illustrate, based on an agreement between Cook County and IDHFS, in fiscal year 2004, Cook County transferred \$827 million in health care participation fees to the state's County Provider Trust Fund. However, because the UPL allows Illinois to reimburse Cook County for these Medicaid services at the higher rates Medicare would have paid for the same bundle of services, Illinois reported Medicaid expenditures of approximately \$1.872 billion to the federal government. This generated a 50 percent federal match of \$936 million.<sup>44</sup> When the federal match of \$936 million was added to the \$827 million Cook County already transferred to the state, the total deposit in the County Provider Trust Fund grew to \$1.763 billion, all of which was then paid to Cook County providers. The county then transferred just over \$400 million to the state, which was credited to the GRF. The entire amount transferred to the state GRF was used to cover Medicaid and state health care expenditures according to the IDHFS.<sup>45</sup> The balance retained by Cook County – the remaining \$1.363 billion – resulted in a net of \$536 million (\$1.363 billion minus the \$827 million in local participation fees paid to the state) to cover Medicaid and uncompensated care costs already incurred by the county. Chart 5 illustrates the transaction.

**Chart 5: Cook County IGT, Fiscal Year 2004**



The Cook County IGT draws a significant amount of federal Medicaid funds annually. In fiscal years 2002 and 2003, the state received approximately \$600 million and \$700 million respectively in federal Medicaid matching funds through the Cook County IGT. Since its inception in 1992, the Cook County IGT has been instrumental in allowing the state to expand Medicaid coverage to children living in poverty. If Illinois were to lose this revenue stream, it could be forced to cut Medicaid health care coverage to such children and their families, or other vital public and human services the state provides. Due to the state's structural deficit and soaring Medicaid costs, Illinois simply cannot make up the difference in state revenue if federal funds are lost.

***The University of Illinois IGT***

The University of Illinois operates a state-owned hospital system that serves a large number of Medicaid beneficiaries. Under the University of Illinois IGT, the University contributes payments to the state's University of Illinois Hospital Services Fund. The state also annually deposits approximately \$45 million

from its GRF to the Hospital Services Fund. The state uses the balance in the Fund to reimburse, in part, the University of Illinois Hospital for hospital and pharmacy services. Subsequent to the payments to the University hospital, federal funds are claimed on the state expenditures and are deposited into the Hospital Services Fund. As with the Cook County IGT, the federal match and the payments ultimately made to the University of Illinois are greater payments based on the federally-approved UPL methodology, rather than payments determined at Illinois' usual Medicaid reimbursement rate.

In fiscal year 2004, the University made payments of \$77 million to the University of Illinois Hospital Services Fund while the state simultaneously transferred \$45 million from its GRF based on state law and an agreement between the University and IDHFS. Based on the higher reimbursement rate using the UPL, the state reported Medicaid expenditures of approximately \$250 million to the federal government. This then generated a federal match of \$125 million which was deposited into the University of Illinois Hospital Services Fund. The amount of funds to pass through the Fund then totaled \$247 million (\$77 million from the University, plus \$45 million from the state, plus \$125 from the federal government). Over the course of the year, the state reimbursed the University \$173 million in Medicaid payments based on the UPL and then transferred \$81 million back into the GRF, all of which was used for Medicaid and health care services.<sup>46</sup>

### ***The IGT-UPL Revenue Enables Illinois to Provide Health Care Coverage to Over Two Million of the State's Most Vulnerable Populations***

Illinois' IGT-UPL revenue is used to fund the state's Medicaid program and provide indigent health care to uninsured low-income families. According to IDHFS, this funding stream pays for a significant portion of Illinois' Medicaid program.<sup>47</sup> Specifically, the IGT-UPL revenue has permitted the state to:

1. Expand its KidCare program to cover over 1 million children living in poverty;
2. Expand coverage in fiscal year 2005 to low-income parents living below 133 percent of the federal poverty level, benefiting an additional 56,000 individuals.
3. Increase FamilyCare eligibility to 185 percent of the poverty level;
4. Implement Illinois Cares Rx (formerly SeniorCare), which now provides comprehensive drug coverage for 160,000 seniors; and
5. Cover more than 2 million individuals every year.

If Illinois were to lose its ability to leverage federal matching funds through the IGT-UPL funding mechanism, the state will be forced to cut back on the Medicaid health care coverage it currently provides to people living in, or just above, poverty. As national census data confirm, poverty is growing and incomes for most Illinois workers are declining. Any cuts to Medicaid would leave thousands of low-income children and families without health care coverage, and potentially force hospitals, clinics and nursing homes that rely on Medicaid funding to close their doors.

### **Illinois Loses IGT-UPL Medicaid Revenue under New Federal Regulations**

The new federal regulations passed in 2001 substantially constrain the IGT-UPL strategy. The regulations require that the use of the UPL to increase federal matching funds be phased out over a period of eight years.<sup>48</sup> For Illinois, the transition will be completed by September 30, 2008. In addition, the FY2007 proposed federal budget would further curb payments to public providers by limiting their reimbursement rates to cost, effectively eviscerating the UPL for such providers.<sup>49</sup>

Recognizing the devastating financial impact the new UPL regulations would have on states' Medicaid programs, Congress increased the amount of disproportionate share hospital (DSH) payments certain

public hospitals receive.<sup>50</sup> DSH payments are payments made to hospitals that serve a large number of Medicaid and low-income, uninsured non-Medicaid patients in an effort to alleviate their overall uncompensated care costs. Cook County's three hospitals began receiving DSH payments in 2003 under the new law to help offset the loss in federal matching funds caused by the phase-out of the UPL strategy. Estimates vary regarding the impact of new DSH payments, and whether they will fully make up for the loss of IGT-UPL funds. Nevertheless, DSH payments are intended to go only to DSH hospitals, rather than all Medicaid providers. In contrast, a portion of the IGT-UPL funds were used by the state to contribute to the cost of the state's overall Medicaid program.

Hence, preservation of the IGT-UPL revenue stream may be critical to Illinois' Medicaid program. The phase-out of the old UPL regulations will cost Illinois nearly \$1 billion in federal Medicaid funds.<sup>51</sup> When combined with escalating health care costs and the state's ongoing structural deficit, any cuts to Illinois' Medicaid program would result in an increased number of uninsured low-income families, while also having a potentially devastating impact on the state's health care industry. According to Families U.S.A., every \$1 million invested in Illinois' Medicaid program results in nearly \$2.4 million in new business activity and more than 20 new jobs.<sup>52</sup> Reducing the amount of federal Medicaid funds Illinois receives will reduce the flow of dollars to hospitals, nursing homes, home health agencies and pharmacies, and reduce the amount of money circulating through the state economy, affecting employment, income, state tax revenue and economic output.

### **Congress Should Increase Illinois' FMAP Rate**

The increased use of financing strategies that draw additional federal Medicaid funds such as the IGT-UPL mechanism suggests that the current Medicaid financing structure does not provide states with sufficient federal funds to support their Medicaid programs. To address this problem, the FMAP formula should be adjusted to increase the federal share of Medicaid spending, especially during economic downturns.

Currently, the FMAP rate formula does not take into account current economic conditions or the percentage of the overall Medicaid population a state serves. Both of these problems should be remedied. If more current information were used, federal matching payments may better reflect Illinois' economic condition and ease the fiscal pressures during recessions. Second, as demonstrated previously, because Illinois serves 4.5 percent of the Medicaid population but receives only 3.6 percent of federal Medicaid funds, Illinois loses nearly \$1.2 billion annually in federal revenue. The FMAP formula should be modified to take into account the percentage of the Medicaid population a state serves, as this directly relates to the cost of the program.

IDHFS has estimated that each percentage point increase in the FMAP rate would mean an additional \$120 million in federal Medicaid funding for the state. Simply increasing the FMAP floor from its current 50 percent to 53 percent would eliminate the need for the IGT-UPL funding strategy.

### **Conclusion**

Illinois' IGT-UPL revenue is essential to maintaining its Medicaid program. This revenue stream has allowed the state to expand health care coverage to over one million children living in poverty, their parents and seniors who would otherwise be uninsured and without access to affordable health care. If this funding stream is lost or reduced, it would have a devastating impact on Illinois' most vulnerable families and the state's economy as a whole.

## Endnotes

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- <sup>1</sup> Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance*, May, 2006.
- <sup>2</sup> See Illinois Department of Public Aid, *Illinois Medicaid: A Primer: FY2003*; Illinois Hospital Association, *Medicaid Overview* (presentation materials).
- <sup>3</sup> Illinois Department of Public Aid, *Illinois Medicaid: A Primer: FY2003*; American Hospital Association, *Annual Survey*, 2002.
- <sup>4</sup> Illinois Hospital Association, *Illinois Hospitals at a Glance*, August 10, 2005.
- <sup>5</sup> Illinois Hospital Association, *Medicaid Overview*.
- <sup>6</sup> See 42 U.S.C. § 1396b(w)(6)(A).
- <sup>7</sup> 42 C.F.R. § 447.272(e)(2).
- <sup>8</sup> State of Illinois Comptroller, “Medicaid Provider Assessments and Intergovernmental Transfers,” *Fiscal Focus*, (April 2003).
- <sup>9</sup> See *Budget of the United States Government, Fiscal Year 2007*, [www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf](http://www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf).
- <sup>10</sup> Congressional Budget Office, *Medicaid Spending Growth and Options for Controlling Costs*, July 13, 2006 (CBO Testimony, Statement of Donald B. Marron, Acting Director, before the Special Committee on Aging, United States Senate). (This amount includes DSH payments and administrative costs, but does not include federal expenditures for the State Children’s Health Insurance Program (SCHIP)).
- <sup>11</sup> *Id.* at 9, S. Heffler, et al., “U.S. Health Spending Projections for 2004-2014,” *Health Affairs*, (February 23, 2005).
- <sup>12</sup> Congressional Budget Office, *Medicaid Spending Growth and Options for Controlling Costs*, at 7.
- <sup>13</sup> National Association of State Budget Officers, *2004 State Expenditure Report*, (2005), Kaiser Commission on Medicaid and the Uninsured.
- <sup>14</sup> Milbank Memorial Fund, *State Health Care Expenditure Reports*.
- <sup>15</sup> S. 1932, 109<sup>th</sup> U.S. Congress, Deficit Reduction Act of 2005.
- <sup>16</sup> Congressional Budget Office, *Congressional Budget Office Cost Estimate: S. 1932, Deficit Reduction Act of 2005*, January 27, 2006.
- <sup>17</sup> See The Henry J. Kaiser Family Foundation, *The President’s FY 2007 Budget Proposal: Overview and Briefing Charts*.
- <sup>18</sup> According to Illinois State Comptroller data, deferred Medicaid liabilities more than tripled between 1997 and 2003, growing from \$560 million in FY1997 to over \$1.7 billion in FY2003.
- <sup>19</sup> Art. VIII, Sec. 2, Constitution of the State of Illinois.
- <sup>20</sup> 30 I.L.C.S. § 105/25.
- <sup>21</sup> State of Illinois Comptroller, “Medicaid Continues to Challenge State Budgets,” *Fiscal Focus*, May 2005.
- <sup>22</sup> Illinois’ structural deficit was identified in a study done for CTBA by economics professor, Dr. Fred Giertz, Executive Director of the National Tax Association at the University of Illinois Urbana. CTBA has identified the extent of the structural deficit problem in Illinois through modeling developed by Dr. Giertz.
- <sup>23</sup> Currently all states participate in the Medicaid program.
- <sup>24</sup> 42 U.S.C. § 1396d(b).
- <sup>25</sup> 42 U.S.C. § 1396d(b)(1).
- <sup>26</sup> Kaiser Commission on Medicaid and the Uninsured.
- <sup>27</sup> Illinois Department of Public Aid, *Illinois Medicaid: A Primer: FY 2003*.
- <sup>28</sup> See 42 C.F.R. § 433.51.
- <sup>29</sup> 42 U.S.C. § 1396a(a)(2).
- <sup>30</sup> *Id.*
- <sup>31</sup> See 42 U.S.C. § 1396b(a)(1).
- <sup>32</sup> 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.
- <sup>33</sup> See 42 U.S.C. § 1396r-4. (Supplemental DSH payments are subject to statewide and hospital-specific caps unlike traditional Medicaid payments).
- <sup>34</sup> See S. Norton and S. Zuckerman, “Recent Trends in Medicaid Physician Fees, 1993- 1998,” *Health Affairs*, 2000.
- <sup>35</sup> Kaiser Family Foundation, Statehealthfacts.org, “Medicaid-to-Medicare Fee Index, 2003.”
- <sup>36</sup> IGTs from a local government may be counted as the state’s share of Medicaid financing. See 42 U.S.C. § 1396b(w)(6)(A).
- <sup>37</sup> 42 C.F.R. § 447.272(b).
- <sup>38</sup> See 42 C.F.R. § 447.272 in effect prior to 2001.

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<sup>39</sup> 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.

<sup>40</sup> 42 C.F.R. § 447.422.

<sup>41</sup> See U.S. Department of Health and Human Services, *FY 2007 Budget in Brief, Centers for Medicare and Medicaid Services*, <http://www.hhs.gov/budget/07budget/centersformed.html#foot2>.

<sup>42</sup> Cook County Bureau of Health Services.

<sup>43</sup> *Id.*

<sup>44</sup> The FMAP rate was increased from 50 percent to 52.95 percent during this period to provide fiscal relief to the states. However, this was a *temporary* increase in the FMAP rate received by all states. For the sake of simplicity, a 50 percent FMAP rate is used to illustrate how the IGT-UPL works.

<sup>45</sup> Annual state Medicaid and health care expenditures increase more than the amounts transferred to the state's GRF through Medicaid-related IGTs.

<sup>46</sup> Because there are generally always funds in the Hospital Services Fund, the dollar amounts above do not total exactly.

<sup>47</sup> Illinois Department of Public Aid, *Illinois Public Aid Medicaid Funding History*.

<sup>48</sup> 42 C.F.R. § 447.272(e)(2).

<sup>49</sup> See *Budget of the United States Government, Fiscal Year 2007*, [www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf](http://www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf).

<sup>50</sup> Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, § 701(d).

<sup>51</sup> State of Illinois Comptroller, "Medicaid Provider Assessments and Intergovernmental Transfers" *Fiscal Focus* (April 2003).

<sup>52</sup> Families, U.S.A., *Medicaid Cuts are Bad Medicine*.

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