From Governor's office

## IMPACT OF ELIMINATING NURSING HOME IGT PROGRAM IN NEW YORK STATE

- The Health Care Financing Administration (HCFA) is proposing a technical regulatory change to the Upper Payment Limit (UPL) methodology that will reduce Federal funding to public nursing homes by $475 million annually in New York State. HCFA is proposing this technical rule change because they claim some states are abusing a financing mechanism known as the Intergovernmental Transfer payment (IGT) by drawing down additional Federal Medicaid funds and using these dollars for purposes other than health care. The proposed change would greatly limit what HCFA believes is the inappropriate use of IGTs.

- In 1991, Congress reaffirmed states' use of IGTs to fund payments to Medicaid providers (Public Law 102-234 as it amends the Social Security Act). HCFA's proposed rule change effectively eliminates the IGT and circumvents the will and intent of Congress.

- HCFA has approved New York's related Medicaid state plans for the past five years. Unlike the alleged abuses HCFA claims are occurring in other states, HCFA officials have publicly indicated that New York uses these funds appropriately. Securing these funds have enabled the State to expand health care coverage to low-income children and adults consistent with the objectives of the Clinton Administration:

  - The Child Health Plus Program -- a national model adopted by the Federal government -- provides insurance coverage to approximately 500,000 children;

  - The recently enacted Family Health Plus and Healthy New York Programs will provide Medicaid coverage to approximately one million parents and other low-income adults;

  - IGTs provide a vital source of funding to County nursing homes that serve the poorest and most vulnerable senior citizens and disabled persons; and

- New York is a national health care leader with the finest teaching facilities in the world despite having the lowest Federal Medical Assistance Percentage (FMAP) in the nation.

- President Clinton recognizes that New York is disadvantaged under the current FMAP formula. In 1994 he stated that:

> "... there's no question that the formula should be changed, and that states like New York with high per capita incomes but huge numbers of poor people are not treated quite fairly under a formula that only deals with per capita income."

HCFA officials have raised the possibility of re-investing savings from eliminating IGTs into an FMAP increase.

For your IGT files

IGT

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To: Melanne Verveer

Date: June 27, 2000

From: Liz Robbins

Pages: 13 + cover

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Attached please find:

**P.1**= Explanation of impact of eliminating IGT Program in NY State
**P. 2&3**= Q&A about New York IGTs
**P.4**= Chart showing Federal Medicaid Matching Rates by State and how most all of the big states who get around a 50% Matching Rate have to use IGTs as a way to fund their health services for the poor
**P.5-8**=Copy of Feb. memo to Melanne on the Medicaid formula
P.5=Soundbite suggestions
P.6-8= Shorter version of backgrounder on the Medicaid Matching Rate formula and its inequities that was sent to HRC July 99*.
**P.9**= Outline of proposal to stem abuses in IGT program in a way that would not hurt the NY and Illinois type States who are in fact using it for health purposes and not supplanting state and local dollar.

This proposal was developed by Cook County with the Illinois Hospital Association. New York has signaled that it would work for them as have almost all of the 50ish reimbursement rate states using IGTs. Pennsylvania, (Spector) which they are pretty sure will agree it worked for them have not yet responded in full. Ditto for **West Virginia** who also are not happy about a possible cut.

According to the lawyers used to develop this rule(all of whom have great experience with the Social Security Act) HHS does have the authority to sculpt a proposal like the one included here that would cut off the people who want to abuse the IGT and maintain funds for those who are using them for health care for low income persons.

You didn't hear it from me but I assume to respond to HCFA's concern about escalating costs(mostly I would guess related to states using IGT to balance their budgets or fund highways etc.) one could even freeze future federal reimbursements even to those states using them for bonifide health costs at this year's level.

**P. 10&11**=Draft of actual rule that would have to be promulgated to implement the above described alternative to the rule HCFA sent to OMB
**P. 12** = One pager on impact of HCFA proposed rule (cutback) on Illinois
**P. 13**= One pager on impact of IGT on Cook County

*Will fax copy of complete memo/charts sent HRC (15pgs) later today.

N.Y.

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# IMPACT OF ELIMINATING NURSING HOME IGT PROGRAM IN NEW YORK STATE

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# New York IGTs Q+A

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This document responds to questions about the NY IGT program under the Medicaid program. Information was derived from phone conversation with Ray Sweeney, EVP for Hospital Association for New York State (HANYS).

**Q: What are the specifics of the New York program?**

A: IGT Payments are made through NY's nursing homes. (Illinois uses its hospitals.) Payments total roughly $950 M annually and yield $475 M federal matching funds. These matching funds are distributed to 51 counties ($95M annually; $15M goes to NY City public nursing homes) and the state Medicaid program ($380M annually; I assume $380 M additional federal funds are drawn when additional payments are made through the Medicaid program. All or virtually all of the $95 million received by counties are retained by public nursing homes to support operations. Funds received by the state have permitted NY to create or expand programs for the uninsured such as Child Health Plus and Family Health Plus.

**Q: How would cuts in these payments affect NY?**

A: According to HANYS publications, cuts would adversely effect the state's ability to provide expanded coverage---healthcare for uninsured children and seriously and chronically ill seniors and the disabled. They also stress the strain these cuts would have on the county level nursing facilities who serve the poorest and most vulnerable senior citizens and disabled persons. They highlight that these county level funds comprise 13% of the total funding available for these providers. In addition, the cuts would precipitate a new round of proposed Medicaid cost containment measures.

**Q: How are hospitals affected? Why are NY hospitals not affected like they are in Illinois?**

A: NY uses its DSH program to pay for uncompensated care. Total hospital DSH/IGT payments in NY are $1.58 billion--distributed to all public and private hospitals (minimum 0.5% uncompensated care). Public hospitals receive $870 million of that total; nearly 80% of the total DSH payments are paid to public and private hospitals in NYC, reflecting their substantial levels of uncompensated care. Hospitals would be affected by the elimination to covered populations, not in payment cutbacks.

**Q: What solutions could Illinois and NY suggest / support?**

A: Our understanding of HCFA's concerns center on answering two questions: (1) how are monies generated through IGTs spent? and (2) how can the total amount of federal spending be curtailed?

Our primary solution would be to "grandfather in" existing programs while developing rules for expansions or changes.

If HCFA feels that it must modify its existing rules to answer these questions now, Illinois and NY have several suggested approaches.

"How are monies generated through the IGT spent"

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Modify the rules to: (a) restrict how states use the FFP they receive to covering only healthcare services for low-income persons; (b) require states to establish identifiable funds for the FFP from IGTs so that states and HCFA can track how monies were spent and (3) require states to maintain their non-IGT support when they use IGTs as a Medicaid funding source.

"How can the total amount of federal spending be curtailed?"

It is our position is that states should be free to use IGTs to support their healthcare programs. HCFA is currently banned from affecting how states use IGTs. Since all state payments are subject to the aggregate payment upper limit test, HCFA already has its cap on federal spending exposure. As long as the monies, generated via the IGT are spent on healthcare services as described above, we feel that appropriate federal safe-guards in this area are already in effect.

If additional safeguards are needed, we have developed/explored several with little overall success because we find ourselves essentially attempting to redefine the entire matching structure used to finance the Medicaid program including the establishment of FMAP percentages. A solution of this type will take enormous efforts and time to be accomplished equitably which leads us back to our initial approach of grandfather with additional study being the preferred approach at this time.

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FE MATCHING RATES Cas of '98) ((1 time reduce every 2 years))

| ENHANCED FMAPS UNDER SECTION 2105 | |
|---|---|
| A STATE | B FEDERAL MEDICAL ASSISTANCE PERCENTAGES FY 1998 |
| ALABAMA | 69.32% |
| ALASKA(1) | 59.80% |
| AMERICAN SAMOA | 50.00% |
| ARIZONA | 66.33% |
| ARKANSAS | 72.84% |
| CALIFORNIA | 51.23% |
| COLORADO | 51.07% |
| CONNECTICUT | 50.00% |
| DELAWARE | 50.00% |
| DISTRICT OF COLUMBIA(1) | 70.00% |
| FLORIDA | 55.65% |
| GEORGIA | 60.84% |
| GUAM | 50.00% |
| HAWAII | 50.00% |
| IDAHO | 69.59% |
| ILLINOIS | 50.00% |
| INDIANA | 61.41% |
| IOWA | 63.75% |
| KANSAS | 59.71% |
| KENTUCKY | 70.37% |
| LOUISIANA | 70.03% |
| MAINE | 66.64% |
| MARYLAND | 50.00% |
| MASSACHUSETTS | 50.00% |
| MICHIGAN | 53.58% |
| MINNESOTA | 52.14% |
| MISSISSIPPI | 77.08% |
| MISSOURI | 60.88% |
| MONTANA | 70.58% |
| NEBRASKA | 61.17% |
| NEVADA | 50.00% |
| NEW HAMPSHIRE | 50.00% |
| NEW JERSEY | 50.00% |
| NEW MEXICO | 72.61% |
| NEW YORK | 50.00% |
| NORTH CAROLINA | 63.08% |
| NORTH DAKOTA | 70.43% |
| NORTHERN MARIANA IS. | 50.00% |
| OHIO | 58.14% |
| OKLAHOMA | 70.51% |
| OREGON | 61.66% |
| PENNSYLVANIA | 53.38% |
| PUERTO RICO | 50.00% |
| RHODE ISLAND | 53.17% |
| SOUTH CAROLINA | 70.23% |
| SOUTH DAKOTA | 67.75% |
| TENNESSEE | 63.36% |
| TEXAS | 62.28% |
| UTAH | 72.58% |
| VERMONT | 62.18% |
| VIRGIN ISLANDS | 50.00% |
| VIRGINIA | 51.49% |
| WASHINGTON | 52.15% |
| WEST VIRGINIA | 75.87% |
| WISCONSIN | 58.84% |
| WYOMING | 59.82% |
| Footnote: | |
| (1) FMAP as specified in Section 4725 of the Balance | |

✓ = some of the states using IGTs (FOR MEDICAID PURPOSES).

the big State users

NOTE that the states that have been @ or hovered around 50% matching rate for the last 40+ years are the big IGTS users FOR MEDICAID purposes — because of course Federal help for them poor until Congress updates the formula.

This was the only way to get

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To: Melanne Verveer
Date: February 10, 2000
From: Liz Robbins
Title: The Mother of All UNfair Shares: The Medicaid Formula

Melanne, here are some thoughts for a sound bite. You can rearrange the thoughts anyway you want, you might even want to start out with the fact that the Medicaid program costs the New York taxpayer nearly $13 bil/year. If I had to guess, I'd guess that the mayor never even asked the delegation to change the formula, maybe somebody can dig up copies of his Federal agenda that I assume he presented to the delegation each year or ask Senator Moynihan about it. The estimates below re: how much NY income and sales tax could be cut if we updated the formula were developed at my request by Jim Wetzler, the former NY state tax commissioner.

Attached is a chart showing the percentages each state is reimbursed under the formula and a three page background memo FYI (again).

I can be reached 24 hours a day through my Washington office (202) 544-6093.

The Federal formula that reimburses NY for its biggest Federal program, Medicaid, treats NY worse than all but 6 states (NY ranks 44th among states on how much of its Medicaid costs are reimbursed by Washington). Under the formula NY gets paid only $.50 of every dollar it spends while other states can get up to $ .80 on the dollar. NY spends nearly $25 bil/year (1997 dollars) on these Federally reimbursable health costs. Under the way the formula works in NY state the tab for the non Federally reimbursed share is split between the counties and the state each paying around $ 7 bil/year. To put this in perspective, UT and NM get $.73 on the dollar. If NY could get $.73 on the dollar the tax burden on our county and state could each be reduced by nearly **$3 billion/year**. For that much money the state could enact a nearly 10% across the board tax cut or reduce the sales tax by nearly 1%.

This formula was created over 50 years ago. Factors were inserted in the formula to make sure that the poorer states- - then the south and sw- - would get enough reimbursement to compensate for their lack of financial resources. It has never been updated since then. In the '70's when these states were doing fine and NYC was broke and NY state was suffering we still ranked 44th in reimbursements. Clearly NY doesn't get its fair share. I will make updating the formula my crusade.

I've talked to some of the Senators in the other states, like CA and NJ who also get $.50 on the dollar from the Federal government, they are my friends. We can work well together to fix this.

Senator Moynihan has done some excellent research on this ancient of formulas he has helped raise our consciousness. I will build on his work and get a better deal for New Yorkers.

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## The Mother of All Fair Shares: The Medicaid Matching Rate

To give you an idea of how much even the slightest change in the fifty year old formula on which federal payments for Medicaid, AFDC (TANF) and foster care are based, note that in 1997 (the latest figures available), the federal payments to New York for these programs were over 15 billion dollars! (Medicaid $12.4 billion, TANF[1] $2.4 billion, foster care $700 million.[2]) And, keep in mind that since in New York, counties (like New York City's five counties) pay twenty-five per cent of Medicaid, foster care (and I believe TANF still), to counties (think property tax!) any savings generated by formula updates would accrue!

Under these formulas, developed in the forties for the Hill-Burton hospital construction program and the National School Lunch Act, each state receives a national federal allotment that was inversely related to its per capita income with no state receiving less than 50 cents on the dollar and no more than 80 cents on the dollar. (Look right, and see Tab A for federal $ payments by state) In addition to this, the relationship between the state's per capita income and the national federal allotment was squared in both formulas as a mechanism that would assure that even greater federal assistance would go to those states with a "limited fiscal potential".

Per capita income was not only used as a proxy for state fiscal capacity, as Wilbur Cohen explained, but it was also thought to bear reasonable relevance to the variable – tax capacity – to which the reimbursement formula was *supposed* to be sensitive. (see Tab B – description of formulas)

When these formulas were first designed, per capita income may well have been the best available indicator of both states' ability to finance

B-115-N

ENHANCED FMAP UNDER SECTION 2105

| A STATE | B FEDERAL MEDICAL ASSISTANCE PERCENTAGES FY 1998 |
|---|---|
| ALABAMA | [illegible] |
| ALASKA[1] | [illegible] |
| AMERICAN SAMOA | [illegible] |
| ARIZONA | [illegible] |
| ARKANSAS | [illegible] |
| CALIFORNIA | [illegible] |
| COLORADO | [illegible] |
| CONNECTICUT | [illegible] |
| DELAWARE | [illegible] |
| DISTRICT OF COLUMBIA[1] | [illegible] |
| FLORIDA | [illegible] |
| GEORGIA | [illegible] |
| GUAM | [illegible] |
| HAWAII | [illegible] |
| IDAHO | [illegible] |
| ILLINOIS | [illegible] |
| INDIANA | [illegible] |
| IOWA | [illegible] |
| KANSAS | [illegible] |
| KENTUCKY | [illegible] |
| LOUISIANA | [illegible] |
| MAINE | [illegible] |
| MARYLAND | [illegible] |
| MASSACHUSETTS | [illegible] |
| MICHIGAN | [illegible] |
| MINNESOTA | [illegible] |
| MISSISSIPPI | [illegible] |
| MISSOURI | [illegible] |
| MONTANA | [illegible] |
| NEBRASKA | [illegible] |
| NEVADA | [illegible] |
| NEW HAMPSHIRE | [illegible] |
| NEW JERSEY | [illegible] |
| NEW MEXICO | [illegible] |
| NEW YORK | [illegible] |
| NORTH CAROLINA | [illegible] |
| NORTH DAKOTA | [illegible] |
| NORTHERN MARIANA IS | [illegible] |
| OHIO | [illegible] |
| OKLAHOMA | [illegible] |
| OREGON | [illegible] |
| PENNSYLVANIA | [illegible] |
| PUERTO RICO | [illegible] |
| RHODE ISLAND | [illegible] |
| SOUTH CAROLINA | [illegible] |
| SOUTH DAKOTA | [illegible] |
| TENNESSEE | [illegible] |
| TEXAS | [illegible] |
| UTAH | [illegible] |
| VERMONT[1] | [illegible] |
| VIRGIN ISLANDS | [illegible] |
| VIRGINIA | [illegible] |
| WASHINGTON | [illegible] |
| WEST VIRGINIA | [illegible] |
| WISCONSIN | [illegible] |
| WYOMING | [illegible] |
| FOOTNOTE[1] | [illegible] |

(1) FMAP as provided in Section 4725 of the Balanced

see back for enlarged chart

[1] Although TANF is a block grant, the original grant was based on the states' federal share payment of the previous year, which was, in turn, on the basis of the matching formula.

[2] Educated guess.

[3] No doubt there are other proposed modifications of the formula or even corrections to these as the data they are based on is also out of date – the deal is to pick one that is comfortable for the campaign (a high ball and a low ball.)

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program benefits and the incidence of poverty. In the intervening fifty years, however, more direct and more accurate measures of the states' financing capacities and poverty rates have become available. (See Tab C – other various critiques of this per capita based formula.)

And yet, not only have these formulas never changed, they were so unresponsive to actual circumstances that when New York City was broke, (try that for "limited fiscal potential!!"), New York's share didn't go up one penny.

Updating these formulas --- using better means of measuring a state's fiscal capacity — would mean hundreds of millions, if not billions to New Yorkers annually. According to one of the alternative formulas recommended by the U.S. General Accounting Office in a 1990 study (Tab D), New York State's federal Medicaid payment would have increased by 12 %, or by approximately $1.5 billion dollars in 1997, half of which would go to the counties.

Under another GAO alternative recommendation or by simply eliminating the squaring part of the ~~formula (irrelevant for so long)~~ New York's Medicaid matching rate would increase by three per cent. (Tab E) In 1997, that would have meant over a $700 million dollar increase in New York's treasuries.

Given the amount of additional federal funds that flow to New York under these formulas, one could argue that New York might not have gone broke, had this formula originally developed in the forties just been kept up to date. The fact that "it hasn't even been updated" (the sexiest way to express all of the formulas' inadequacies) makes a great fair share argument.

The thing to do, of course, is to translate this into sound bytes. We need to have someone do a chart that shows what updating the formula would have added each year to New York coffers since 1970, absent finding other alternatives already developed. three per cent (unsquaring) and twelve per cent (GAO) increases each year would do.[3] Then we need to get a laundry list of the most popular programs and institutions (by county!) and their costs or funding needs, so you can point out in local terms what a little – or years of – updating could buy. These potentially or previously foregone dollars could finance all sorts of educational reform. We could even show how updating the formula could finance all kinds of tax reductions should you update the formula the year you get to the Senate. The piece de resistance, of course, since ½ the savings would accrue to the counties, you could talk about how updating the formula could have (would?) finance property tax or NYC sales tax relief. Using the alternative suggested by GAO New York would probably make enough money in the first year at the state level to enact across the board 5% tax cut or reduce the sales tax by a ½% .

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Now, for another really good sound byte, look at the chart Tab F developed in 1980 that shows the "effective" federal matching rate for welfare, i.e. the federal rate when you consider the interplay with the 100 % federally funded food stamp program. As the chart shows, once food stamp "reimbursement" is understood as a potential proxy for a larger welfare benefit, it is clear just how New York was truly cheated.

The lower the per capita income and/or the lower the welfare benefit, the greater the amount of food stamp eligibility per public assistance recipient. The greater the portion of public assistance provided through the 100 % federally funded food stamp program, the more federal dollars make up the total amount of assistance per recipient. In Mississippi in 1980, for example, the chart shows that food stamps made up 64 % of a recipient's public benefits. As a result, the effective rate the state paid per recipient became the product of a 0 cents contribution on the food stamp portion, and 22 cents on the welfare grant portion, or just 6 cents on the dollar for each public assistance recipient. Conversely, as the chart shows, in New York, where our high cost of living meant our 50 % federally reimbursed welfare benefit levels disqualified our recipients from all but a few one hundred per cent federally paid food stamps, we paid 46 cents per dollar per welfare recipient. South Carolina spent only 11 cents, Alabama 12 cents, Georgia 15 cents, Louisiana 15 cents, Texas 17 cents, et cetera.

Now, even though the AFDC program has been block granted (except for foster care) into TANF, this is still a powerful story for a number of reasons. First, it explains how the block grant was established, i.e. it shows how our block grant amount, by being based on our previous federal share, was based on an amount equal to no more than fifty per cent of our caseload costs versus a much higher base percentage for other states. It also shows how you can still make the case that the combination of the federal TANF welfare reimbursement with the Food Stamp payments either per recipient or per state or county (as a percentage of assistance payments per caseload) that will resonate. Imagine telling someone that the block grant amount for other states means some states only spend six cents per tax dollar on poor people! Thirdly, I think it shows how we need to translate the inequities in the non-blocked granted programs like foster care and Medicaid. We need to take a program people don't mind hearing about as much as welfare, like adoption subsidy, New York State home health program, or a popular hospital (depending on what county you are in) and show how much more the Feds would pay if it were in another state or, conversely, how few of our tax dollars we would pay if the formula were just updated.

**Draft:** June 27, 2000

9

# MEDICAID IGT RULE:
## Alternative To HCFA Proposal

HCFA has proposed to modify the Medicaid "upper limit" rule to restrict intergovernmental transfer programs (IGTs). An IGT is where a local governmental unit, e.g., a county, provides the non-federal share of funding needed to attract federal Medicaid matching funds. An alternative to HCFA's proposal merits consideration.

**HCFA's Proposal.** Current federal rules restrict state Medicaid payments, in the aggregate, to no more than what Medicare would pay for similar hospital or nursing home services. Additionally, aggregate payments to state-operated hospitals or nursing homes may not exceed what would be paid under Medicare. HCFA is proposing that aggregate Medicaid payments to other government (e.g., county, city) operated hospitals or nursing homes may not exceed what would be paid under Medicare.

**HCFA's rationale for the proposal?** HCFA is proposing this rule change because:

1. Alleged abuses of IGTs, i.e., using federal funds for non-health care purposes.
2. IGTs are increasing federal Medicaid spending.
3. Current law limits HCFA's ability to restrict IGTs.

**Alternative Proposal.** The following alternative should be considered to preserve IGT programs that are being used to provide health care to low-income persons:

- **Separate Fund.** Require states to maintain a separate fund for all federal funds claimed based on expenditures made using monies from local governmental units.
- **Health Care Only.** Funds from the separate fund may only be used to provide health care to low-income persons.
- **Maintenance of Effort.** Local government funds may not be used to reduce the amount of State funds used to pay for Medicaid below the amount of State funds expended in the 12-month period ending on September 30, 2000.

**Advantages of the Alternative Proposal.**

- It limits the use of IGT derived funds to health care for low-income persons.
- It prohibits states from replacing state funds with IGT funds beyond the current level.
- It enables HCFA to audit the use of IGT derived funds, by requiring a separate fund.
- It permits HCFA to prevent abuses of IGT funding.

**Draft: 6/27/00 10:25 AM**

10.

**Medicaid: Alternative to HCFA Draft Upper Limit/IGT Rule.**

This alternative is intended to make the States accountable to HCFA for the use of IGT derived funds by providing for necessary assurances and a separate accounting of the funds.

PART 433 – STATE FISCAL ADMINISTRATION

Subpart A – Federal Matching and General Administration Provisions

Sec. 433.32 Fiscal policies and accountability.

A State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will –

(a) Maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements;

(b) Retain records for 3 years from date of submission of a final expenditure report;

(c) Retain records beyond the 3-year period if audit findings have not been resolved; ~~and~~

(d) Retain records for nonexpendable property acquired under a Federal grant for 3 years from the date of final disposition of that property; and

(e) Maintain a separate distinguishable account –

(1) Into which Federal funds, claimed as a result of expenditures for institutional services made, in whole or in part, with local public funds, are deposited, and

(2) From which funds are disbursed only for expenditures related to the health care needs of low income individuals,

(3) Transition. This paragraph (e) shall be effective no later than the beginning of the State fiscal year following the convening of the first regular session of the State legislature subsequent to adoption of this provision.

[44 FR 17935, Mar. 23, 1979]

Subpart B – General Administrative Requirements State Participation

Sec. 433.53 State plan requirements.

11.

A State plan must provide that –

(a) State (as distinguished from local) funds will be used both for medical assistance and administration;

(b) State funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; and

(c) State and Federal funds will be apportioned among the political subdivisions of the State on a basis that assures that –

(1) Individuals in similar circumstances will be treated similarly throughout the State; and

(2) If there is local financial participation, ~~lack~~

(i) Lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State.

(ii) Funding from local sources for services subject to the aggregate payment limitations specified in sections 447.272 and 447.321 of this *Code* have not been used to reduce the amount of State funds used to pay for the non-Federal share of total expenditures under the plan below the level of State funds so expended in the twelve-month period ending September 30, 2000.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993]

Q:\USERS\galtrule2.doc

12 Sent to AHA by Perlin

**Impact of Upper Limit / IGT Rule on Illinois**

- Since 1991 Illinois and Cook County have utilized IGTs to preserve the health care safety net.

- The payments associated with Illinois' IGTs with Cook County were thoroughly reviewed by HCFA and each time (1991, 1995, 1998) received HCFA's approval.

- The current IGT agreements between the State and Cook County are beneficial to both parties. The County receives stable reimbursement for their services at levels to help offset the substantial cost of indigent care borne by the County. The State receives additional funds from the arrangement that are used to pay for medical services to low-income families and to elderly and disabled persons throughout the state.

- IGTs are not used to finance anything other than health care. Furthermore, IGTs are not used to replace state Medicaid funding, rather, IGT monies combined with additional state funds facilitate rate increases for all providers and the expansion of Medicaid eligibility for the aged, blind, and disabled populations. Cook County has used IGT funding to open more than twenty outpatient clinics and re-opened a shuttered hospital on the south side of Chicago.

- Maintenance of effort: Illinois has consistently increased state support for the Medicaid program. On a percentage basis, Illinois financial commitment to the Medicaid program has exceeded the growth in state general revenue for 6 of the last 10 years.

- Restrictions in Illinois ability to utilize IGTs could significantly harm access to care for Illinois' neediest citizens and communities. In FY2001 it is estimated that IGTs will be used to cover more than $600 million in program spending. Areas affected may include, but are not limited to the following:

| | |
|---|---|
| Expanded eligibility for the Aged, Blind, and Disabled | $60 million |
| Fund payments to high volume uncompensated care hospitals | $30 million |
| Continuous 12-month eligibility for children | $22 million |
| Expanded services to immigrants / adults | $25 million |
| Coverage for working disabled indivuals | $10 million |
| Reform hospital ambulatory care program | $110 million |
| Hospital tertiary care adjustments | $35 million |
| Physician rate increases | $60 million |
| LTC and other provider increases | $140 million |
| Growth in prescribed drugs | $130 million |

- Elimination of programs funded by IGTs could create access and delivery system problems that will result in increased federal spending because care would be provided in more costly settings.

# COOK COUNTY IGT AGREEMENTS

| | (FFP) | Payments (Approp) | Cook County Benefit | Illinois Benefit |
|---|---|---|---|---|
| 1991 Agreement | $ 225.0 | $ 468.9 | $ 225.0 | $ - |
| 1996 Agreement | $ 214.5 | $ 429.0 | $ 62.1 | $ 152.4 |
| 1999 Agreement | $ 132.7 | $ 265.4 | $ 40.0 | $ 92.7 |
| Total From Agreements | $ 572.2 | $ 1,163.3 | $ 327.1 | $ 245.1 |
| Minus: Normal Payments | | | $ 125.1 | $ (64.9) |
| **Total Net Benefit** | | | **202.0** | **$ 310.0** |

1. **IGT revenue has been used exclusively to add funds to the State Medicaid program.**
2. **IGT revenue has funded about the same percentage amount of the Medicaid Program base (12%) in the past several years.**
3. **Of the $15.6 billion General Fund increase in the Illinois Medicaid program from 1990 - 2001, approximately one quarter was funded from IGT revenue.**
4. IGT revenue has permitted expanded access to health care for Illinois' neediest families:
   a. Due to outreach efforts, the **Department now covers an additional 80,000** individuals under Medicaid over the previous year (FY99-FY00).
   b. Beginning in FY00, continuous eligibility and de-linking efforts will result in the coverage of an additional 30,000 children and 10,000 adults under Medicaid. Additionally, the program expanded its services package to include adults.
   c. Beginning in FY'01, the Medicaid program will expand coverage to an additional 60,000 aged, blind and disabled individuals, as well as expand coverage for people with disabilities who work.
5. **The cooperation of state, federal and local officials, including Cook County, in designing critical health care programs has resulted in a Medicaid program that has passed the required upper limit tests since 1992.**

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