DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

MAR 22 2001

Memorandum

Date

From Michael F. Mangano
Acting Inspector General

Subject Review of Illinois' Use of Intergovernmental Transfers to Finance Enhanced Medicaid Payments to Cook County for Hospital Services (A-05-00-00056)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Illinois' Use of Intergovernmental Transfers to Finance Enhanced Medicaid Payments to Cook County for Hospital Services." This is one in a series of reports on enhanced payments made in six States. At the completion of all the reviews, we will issue a summary report to the Health Care Financing Administration (HCFA) that will consolidate the results of our reviews in the six States and will include additional recommendations addressing enhanced payments financed through the intergovernmental transfer (IGT) process.

The objectives of our review were to analyze the use of IGTs by the Illinois Department of Public Aid (IDPA) to finance enhanced payments to county-owned hospitals, as part of its compliance with Medicaid upper payment limit regulations, and to evaluate the financial impact of these transfers on the Medicaid program. Under the upper payment limit rules, States have been permitted to establish payment methodologies that allow for enhanced payments to non State-operated government providers, such as county hospitals. Unlike other States that we have reviewed, enhanced payments in Illinois included both regular payments for Medicaid services and a supplement, which was in addition to the normal payment level.

In Illinois, we found that the enhanced payments applied only to three hospitals (Cook County Hospital, Oak Forest Hospital, and Provident Hospital) and associated clinics administered by Cook County. During the period from July 1, 1991 through June 30, 2000, IDPA made about $5.9 billion of enhanced payments to Cook County for inpatient, outpatient, and clinic services under the Medicaid program. About $3.0 billion of the $5.9 billion represented a payback of funds that were initially transferred as IGTs from Cook County to IDPA. The remaining $2.9 billion represented the Federal share of the payments. About $866.6 million of the $2.9 billion was returned by Cook County to IDPA and deposited to the State's General Revenue Fund.

During our review, the upper payment limit regulations included a separate, aggregate upper payment limit requirement for inpatient services in State-operated facilities. The lack of a similar limit for both inpatient and outpatient services for local government facilities

allowed Cook County and the State of Illinois to reap windfall revenue. Some of our observations about the enhanced payments to Cook County follow:

- If a separate upper limit requirement was applied for inpatient and outpatient services for local government facilities, the enhanced payments to Cook County during the State's Fiscal Year (FY) 2000 would have exceeded the upper limit by $748 million.

- For Cook County's FY 1999, the Medicaid enhanced payments made to the three applicable hospitals and associated clinics were about $244.2 million more than the total operating expenses of these facilities.

- Cook County used the enhanced payments to cover costs that would not otherwise qualify for Medicaid funding. Recent reports show that about 55 percent of the inpatient days and about 87 percent of the outpatient visits at Cook County Hospital were for individuals who did not qualify for Medicaid services.

- Since the enhanced IGT funding mechanism began, Cook County has opened Provident Hospital and several new clinics. Without the enhanced payments, the County would have been required to allocate additional tax-supported revenue to these operations. Meanwhile, the annual level of tax-supported revenue was reduced by $49 million compared with the level of 9 years ago.

Regarding the revenue that Cook County returned to the State, we could not confirm the contention that IDPA used the funds for health-related services. Traceability was lost when the funds were deposited directly to the State's General Revenue Fund.

Due to the significance of the funding levels, the enhanced payment mechanism threatens the fiscal integrity of the Medicaid program. In an early alert memorandum to HCFA, dated September 1, 2000, that included our preliminary results in Illinois, we recommended that HCFA move quickly to revise the upper payment limit regulations to include a separate aggregate limit for local government-operated facilities. In our draft report, issued on November 2, 2000, we were pleased to note that a Notice of Proposed Rulemaking (NPRM) was issued by HCFA in October 2000. For Illinois, we estimated that a separate upper payment limit for inpatient and outpatient services for local government-operated facilities would result in an annual reduction to the Federal share of payments by $374 million.

In response to our draft report, HCFA agreed with our concerns about excessive payments and noted that the final regulation creating new payment limits for local governmental providers was published on January 12, 2001. The new limits will be phased-in according to a gradual transition policy and not become fully effective until October 1, 2008. The full text of HCFA's response is attached as APPENDIX B.

We commend HCFA for taking action to change the upper payment limit regulation. We estimate that this regulation will result in savings to the Federal Government of about $1.2 billion during the transition period. Once the regulatory changes are fully implemented, we estimate additional Federal savings of $374 million annually, totaling a savings of about $1.9 billion over 5 years. We, therefore, recommend that HCFA take action to ensure that Illinois complies with the phase-in of the revised regulations.

We also recommend that HCFA require State plans to contain assurances that enhanced payments will be retained by the providers and used to provide services to Medicaid-eligible individuals.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at 410-786-7104.

To facilitate identification, please refer to Common Identification Number A-05-00-00056 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF ILLINOIS' USE OF INTERGOVERNMENTAL TRANSFERS TO FINANCE ENHANCED MEDICAID PAYMENTS TO COOK COUNTY FOR HOSPITAL SERVICES

MARCH 2001
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To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of Illinois' use of intergovernmental transfers (IGT) to finance enhanced Medicaid payments to Cook County hospitals. This is one in a series of reports on enhanced payments made in six States. At the completion of all the reviews, we will issue a summary report to the Health Care Financing Administration (HCFA) that will consolidate the results of our reviews in the six States and will include additional recommendations addressing enhanced payments financed through the IGT process.

The objectives of our review were to analyze the use of IGTs by the Illinois Department of Public Aid (IDPA) to finance enhanced payments to county-owned hospitals, as part of its compliance with Medicaid upper payment limit regulations, and to evaluate the financial impact of these transfers on the Medicaid program. Under the upper payment limit rules, States have been permitted to establish payment methodologies that allow for enhanced payments to non State-operated government providers, such as county hospitals. Unlike other States that we have reviewed, enhanced payments in Illinois included both regular payments for Medicaid services and a supplement, which was in addition to the normal payment level.

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allowed Cook County and the State of Illinois to reap windfall revenue. Some of our observations about the enhanced payments to Cook County follow:

- If a separate upper limit requirement was applied for inpatient and outpatient services for local government facilities, the enhanced payments to Cook County during the State's Fiscal Year (FY) 2000 would have exceeded the upper limit by $748 million.

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INTRODUCTION

BACKGROUND

The Medicaid Program

Title XIX of the Social Security Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with broad Federal requirements. Each State's rules may differ as to financial eligibility and medical services provided. To qualify for assistance, individuals must show that their income and assets conform to the State's Medicaid limits. Medicaid covers both needy elderly people and needy younger people, mostly unwed mothers and their children. In Illinois, IDPA administers the Medicaid program. The IDPA operates under the State Fiscal Year (SFY) basis which ends on June 30th.

Although Medicaid programs are administered by the States, they are jointly financed by the Federal and State Governments. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid eligible individuals. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula which yields the Federal medical assistance percentage. This percentage ranges from 50 percent to 77 percent, depending upon each State's relative per capita income. In Illinois, the Federal medical assistance percentage is 50 percent and the State's share is 50 percent.

IGTs as Source for State's Share

In certain circumstances, public funds may be used as the State's share of financial participation under the Medicaid program. According to 42 CFR 433.51, public funds may be considered as the State's share if they are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies to the State or local agency and under its administrative control. Since IGTs represented funds transferred by Cook County to IDPA, the funds (notwithstanding other requirements) qualified as a source for the State's share.

Upper Payment Limits Requirement

The HCFA has given State Medicaid programs considerable flexibility in determining payment rates for Medicaid providers. State Medicaid agencies have been allowed to pay different rates to the same class of providers, as long as the payments, in the aggregate, did not exceed the upper payment limits (what Medicare would have paid for the services). Federal regulations at 45 CFR 447.272, in effect during our review, provided that aggregate payments to each group of health care facilities, such as hospitals or nursing facilities, may not exceed the amount that could reasonably be estimated would have been paid for those services under Medicare payment principles.

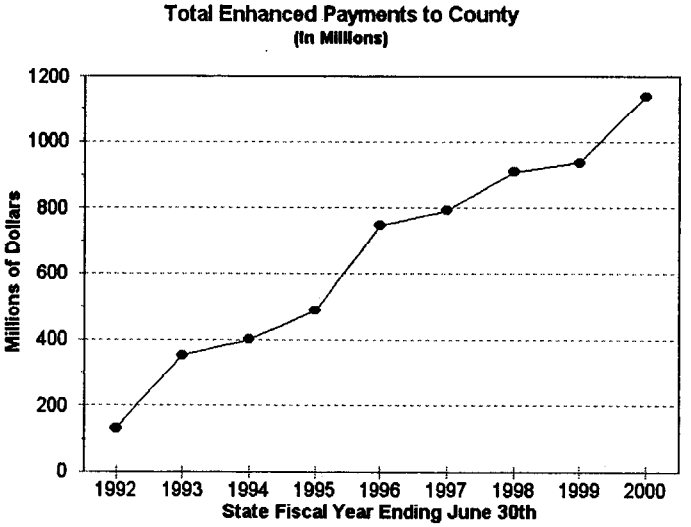
Revised final regulations at 42 CFR 447, published by HCFA on January 12, 2001, established separate aggregate upper limits for both inpatient and outpatient services on payments made to (i) State-owned or operated facilities, (ii) non-State government facilities, and (iii) privately-owned facilities. Previous to these changes, the regulations placed an upper limit on overall aggregate payments to all facilities for inpatient and outpatient services. In addition, a separate aggregate upper payment limit also existed for inpatient services provided by State-operated facilities. Because there was not a separate aggregate limit that applied to local government-operated facilities before the changes, these types of facilities were grouped with all other facilities when calculating aggregate upper payment limits. This allowed the State Medicaid agency to make enhanced Medicaid payments (payments at levels above reasonable costs) to city and county-owned providers, without violating the upper payment limit regulations.

Cook County Operated Hospitals

Illinois' Cook County, which includes the city of Chicago and several of its suburbs, owns and operates three hospitals (Cook County Hospital, Oak Forest Hospital, and Provident Hospital) and associated clinics. The largest of the three hospitals, by far, is Cook County Hospital. Built in the early 1900s, Cook County Hospital has a capacity of about 900 beds, and is currently staffed for about 600 beds. During 1996, construction began on a new facility to replace this worn-out structure. The cost of the facility, estimated at $551.6 million, is being financed with the issuance of Cook County General Obligation Bonds. The facility is expected to open in 2002. Oak Forest Hospital is primarily responsible for the treatment, rehabilitation, and long-term care of adult patients with chronic illnesses, while Provident Hospital is an inner city hospital that provides a wide range of services. Also, through the County's Ambulatory and Community Health Network (ACHN), Cook County operates neighborhood clinics that provide medical care, diagnostic screening, and pharmacy services to its residents.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to analyze IDPA's use of IGTs to finance enhanced payments to Cook County hospital providers as part of its compliance with Medicaid upper payment limit regulations, and to evaluate the financial impact of these transfers on the Medicaid program. Our review covered enhanced payments made by IDPA to Cook County during the period from July 1, 1991 to June 30, 2000 for services provided by Cook County Hospital, Oak Forest Hospital, Provident Hospital, and the ACHN clinics. Cook County Hospital and Oak Forest Hospital were county-operated during our entire review period. Provident Hospital officially opened in August 1993 as Provident Hospital of Cook County.



Our review was made in accordance with generally accepted government auditing standards. To accomplish our objectives, we (i) reviewed State statutes, Medicaid State plan material, and interagency agreements; (ii) examined calculations and financial records that established the amounts of the IGTs and accounted for the transfers; (iii) traced amounts claimed for Federal reimbursement back to original source documentation; (iv) reviewed the audited financial statements, Medicaid cost reports, and budget reports for the providers; and (v) examined documentation for the upper payment limits demonstration.

Our review was conducted at the central office of IDPA in Springfield, Illinois and at the offices of the Cook County providers in Chicago, Illinois between June and August 2000.

RESULTS OF REVIEW

Over the past 9 years, IDPA's use of IGTs to finance Medicaid enhanced payments to Cook County for inpatient and outpatient hospital services has increased significantly. During the first year of the IGT funding mechanism (SFY 1992), IDPA made enhanced payments of about $133 million to Cook County. Use of these payments continued to increase to the current level where they have recently exceeded $1.1 billion during SFY 2000. For the 9-year period, the payments have totaled about $5.9 billion.

Of the $5.9 billion, about $3.0 billion represented a payback of funds that were initially transferred as IGTs from Cook County to IDPA. The remaining $2.9 billion represented the Federal share of the payments. Under the agreements between IDPA and Cook County, about $866.6 million of the $2.9 billion was returned by Cook County to IDPA.

Although IDPA has demonstrated its compliance with the upper payment limit requirements, the enhanced payments have markedly exceeded the actual costs incurred by Cook County in providing inpatient and outpatient services to Medicaid beneficiaries. Using data from IDPA's upper payment limit calculations, we estimate that if a separate upper limit was applied to inpatient and outpatient services at local government facilities, the enhanced payments to Cook County during SFY 2000 would have exceeded the upper limit by $748 million. Such a level of enhanced funding amounts to a windfall in revenue to both Cook County and IDPA.

Cook County used the revenue to cover the inpatient and outpatient costs for individuals who did not qualify for Medicaid assistance. It also used the funds to operate a network of neighborhood clinics that serve a high proportion of non-Medicaid eligible persons. At the same time, the amount of Cook County tax revenue support for its hospitals was reduced. Based on the Cook County budget for the year ended November 30, 2000, about $247 million in tax revenues went toward meeting operating costs for its hospitals and clinics. This was $49 million less than the $296 million funding level of 9 years earlier for the year ended November 30, 1991 (prior to enhanced payments).

At the State level, we could not determine how the windfall revenues were used. The $866.6 million returned to IDPA by Cook County was deposited directly to the State's General Revenue Fund and traceability of these funds was lost. Although IDPA staff strongly contend that the deposits to the General Revenue Fund resulted in corresponding increases in spending for health care programs, there was no assurance that the funds were used in this manner.

Regardless of health care needs or other worthy projects that may have been funded with the enhanced payments, Cook County and IDPA profited by the use of the IGT funding mechanism under the Medicaid program. The upper payment limit regulations included a separate, aggregate upper payment limit requirement for inpatient services provided by State-operated facilities, including hospitals. This separate limit prevented the States from profiting through enhanced payments for their own facilities. However, we believe the lack of similar limits for inpatient and outpatient services for local government-operated facilities allowed the enhanced payment mechanisms and ensuing windfall revenue to continue at the significant funding levels that we identified.

INTERAGENCY AGREEMENTS

Through HCFA-approved Medicaid State Plan Amendments (SPA), IDPA specifically targeted counties in Illinois with populations greater than three million residents as the counties eligible to receive enhanced payments. Since Cook County was the only Illinois county of that size, the SPAs applied (and were intended to apply) only to Cook County. To implement the SPAs, IDPA entered into interagency agreements with Cook County whereby terms and conditions of the payments for the hospital services were identified.

Primary Agreement

The primary interagency agreement between IDPA and Cook County became effective on July 1, 1991 and, subject to minor formula revisions, is still ongoing. The agreement initially covered Cook County Hospital, Oak Forest Hospital, and associated clinics. In 1993, coverage for Provident Hospital was added. Under the primary agreement, Cook County makes a monthly IGT to IDPA. The IDPA then combines the IGT with the Federal Medicaid share and returns the funds to Cook County as payment for monthly Medicaid claims. To provide for quick 24 hour turn-around of the payments, these transfers between Cook County and IDPA are made electronically (wire transfers). The payments under the agreement are for reimbursements at enhanced rates for hospital inpatient, outpatient, and provider-based clinic services. For inpatient services, the rates were set at a level that was over one and one-half times the reasonable cost of the services. For outpatient and clinic services, the rates covered the full costs of the services.

The primary agreement was amended effective April 1, 1998 to require Cook County to return funds to the State for SFY 1998 and SFY 1999 only. These transfers back to the State's General Revenue Fund were not to exceed $40 million for SFY 1998 and $41 million for SFY 1999.

Secondary Agreement

Although the primary agreement provided for Medicaid payments to Cook County that exceeded the reasonable costs of the services, IDPA entered into a secondary interagency agreement, effective July 1, 1995, calling for further payments to Cook County. The maximum annual amount for these payments was set at $429 million. Under the agreement, Cook County is required to make IGTs to IDPA amounting to one-half the sum of the total payments (about $214.5 million annually). Wire transfers are made by Cook County to IDPA on a quarterly basis. The IGTs, along with the Federal share received by IDPA, are then wired to Cook County by IDPA. Upon receipt of payments, Cook County makes a secondary transfer of funds back to the State's General Revenue Fund. Under this agreement, the annual Federal share is approximately $214.5 million. About $62 million of the $214.5 million is retained by Cook County, and about $152.5 million is returned to the State.

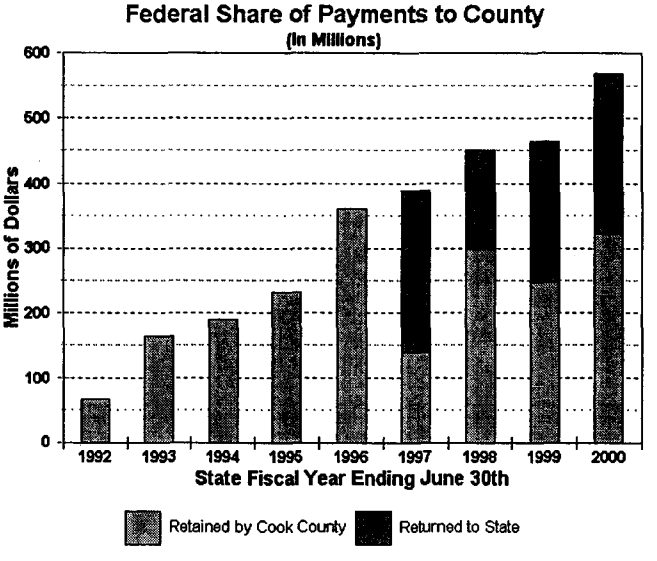
Under an amendment effective October 1, 1999 to the secondary interagency agreement, IDPA initiated additional payments of $266 million annually. To fund these payments, Cook County made additional IGTs on a quarterly basis. Annually, the IGTs equal one-half the sum of the total payments, or $133 million. Upon receiving payment from the IDPA that includes the quarterly IGTs plus the Federal share, Cook County made a secondary transfer back to the State's General Revenue Fund. Under this amendment, the annual Federal share is about $133 million. Cook County retains $40 million of the $133 million and returns $93 million to the State.

ENHANCED PAYMENTS UNDER THE AGREEMENTS

For SFY 2000, IDPA paid over $1.1 billion to Cook County under the two agreements, as amended. About $572 million represented Cook County funds received by IDPA under the IGT agreements, and about $567 million was the Federal share. Of the $567 million in Federal share, about $322 million was retained by Cook County and about $245 million was returned to the State's General Revenue Fund.

Of the $1.1 billion, about $445 million was paid by IDPA under the primary agreement, and about $694 million was paid under the secondary agreement, as amended.

Since the inception of the IGT funding mechanism, about $2.9 billion in Federal Medicaid funds was paid to Cook County. About $2.0 billion of the $2.9 billion was retained by the County, and about $866.6 million was returned to the State. Although, according to the agreements, transfers to the State's General Revenue Fund were to begin with SFY 1996, the actual transfers were not made until SFY 1997. Transfers during SFY 1997 covered seven quarters of data.



UPPER PAYMENT LIMIT DEMONSTRATION

To demonstrate compliance with the upper payment limit requirement, each year IDPA prepared a separate inpatient hospital and outpatient hospital upper payment limits calculation. Each year's calculation applied to the next year's payments. For example, the calculations made in SFY 1999 applied to the actual payments for SFY 2000. The upper

limits (what Medicare would pay for the services), were estimated using base year 1992 actual cost data trended forward. These upper limits, in the aggregate for all hospitals in the State, were compared to the projected payments based on payment rates applied to the anticipated number of services. The calculations have demonstrated compliance with the upper limit requirements. To illustrate, the following table shows the results of the calculations made by IDPA applicable to the payment year SFY 2000:

SFY 2000 - All Hospitals

	Upper Limits	Projected Payments	Below Limit
Inpatient	$2,301.3M	$2,123.1M	$178.2M
Outpatient	$ 623.5M	$ 551.7M	$ 71.8M
Total	$2,924.8M	$2,674.8M	$250.0M

Combining the inpatient and the outpatient calculations, the projected Medicaid payments to all hospitals in the State were about $250 million below the upper limits. By separating from the above data the amounts for the Cook County hospitals, one can clearly see the effect of the enhanced payments under the IGT funding mechanism:

SFY 2000 - Inpatient & Outpatient

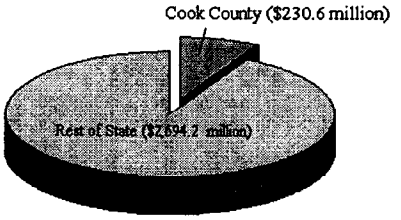
	Upper Limits	Projected Payments	Below (Above) Limits
Cook County	$ 230.6M	$1,164.6M[1]	$ (934.0M)
Rest of State	$2,694.2M	$1,510.2M	$1,184.0M
Total	$2,924.8M	$2,674.8M	$ 250.0M

Payments to Cook County hospitals were projected to exceed the individual Cook County upper limits by $934 million. The projected payments of $1,164.6 million were more than five times greater than the upper limits of $230.6 million based on Medicare payment principles. At the same time, payments to all other hospitals in the State were projected to be under their limits by about $1.2 billion ($1,184 million).

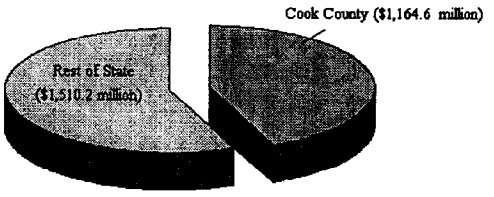
[1]The actual payments for SFY 2000 will vary somewhat from the projected payments used in the calculations. For Cook County, the projected payments were $1,164.6 million, while the actual payments totaled $1,138.9 million. This does not materially affect the upper payment limits demonstration.

This disparity between Cook County and the rest of the State illustrates the extent that the payments exceeded the reasonable costs of the services. The enhanced funding for Cook County amounts to a windfall in revenue from the Federal share of the payments.

How the Upper Payment Limits are Established ($2,924.8 million):



How the Payments are Made ($2,674.8 million):



According to IDPA's cost reporting records, there were 31 local government hospitals in Illinois (the 3 Cook County hospitals plus 28 other hospitals). For the other 28 local government hospitals, we noted that the upper limit calculations exceeded the payments by about $22.2 million. However, using the data compiled by IDPA for the upper payment limit demonstration for SY 2000, aggregate payments for the 31 local government hospitals exceeded the upper limit calculations by $886.1 million ($903.8 million for the 3 Cook County hospitals, using actual payments, offset by $22.2 million for the other 28 hospitals). Consequently, a separate limit for local government-operated facilities (capped at 150 percent of the upper payment limit) would have resulted in a Federal savings of $374 million.

USE OF FUNDS AT COOK COUNTY AND STATE

Cook County

The total Medicaid enhanced payments (Federal share and non-Federal share) increased annually to the point where they are now more than sufficient to cover the entire operations of the three Cook County hospitals and the ACHN clinics. For example, Cook County operates on a County Fiscal Year (CFY) basis which ends on November 30th. For

CFY 1999, the enhanced payments received by Cook County from IDPA totaled about $858.5 million. (This amount is the total Medicaid expenditures included within expenditure reports filed by IDPA for purposes of claiming the Federal share of the payments.) One-half of the payments represented a return of Cook County's own IGT funds, and one-half represented the Federal share. For CFY 1999, the total operating expenses of the three hospitals and the ACHN clinics were about $614.3 million, or about $244.2 million less than the total Medicaid enhanced payments:

Enhanced Payments & Operating Expenses for CFY 1999

Medicaid Enhanced Payments		$858.5 million
Expenses:		
Cook County Hospital	$364.4 million	
Oak Forest Hospital	99.7 million	
Provident Hospital	68.6 million	
ACHN Clinics	81.6 million	$614.3 million
Difference		$244.2 million

As previously shown for the upper payment limits, the total enhanced payments significantly exceeded what Medicare would pay for the services provided to the Medicaid beneficiaries. A large part of the enhanced payments was therefore being used by Cook County to cover the inpatient and outpatient costs for individuals who did not qualify for Medicaid assistance.

According to reports filed by Cook County Hospital for CFY 1999, about 55 percent of the inpatient days of stay and about 87 percent of the outpatient visits were for individuals who did not qualify for Medicaid services. Some of these individuals qualified for Medicare, some were covered by private insurance, and many were uninsured.[2] We also noted that reports filed for the clinics included in the ACHN showed that about 80 percent of the clinic visits were made by non-Medicaid patients.

For CFY 1999, the Federal share of the enhanced payments to Cook County was about $429.3 million. Of this amount, $177.8 million was transferred back to IDPA by Cook County, and about $251.5 million was retained. The retained Federal share funded about 41 percent of the operations ($251.5 million of $614.3 million).

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[2]Federal Medicaid assistance to hospitals for compensation for serving large numbers of uninsured patients is normally available under what is referred to as disproportionate share hospital (DSH) payments. Since the needs of the Cook County hospitals were being met with the enhanced payments, IDPA elected not to allocate DSH funds to the Cook County hospitals. Instead, the DSH funds were distributed to other hospitals within the State. For the Federal FY 1999, the total DSH allotment for Illinois was $199 million.

The Federal share of the payments retained by Cook County over the 9-year period amounted to about $2.0 billion. These funds were deposited to the Cook County Health Fund and used to finance the operating expenses of the three hospitals and related clinics. As the level of Federal funding continued to climb over the last several years, there were noticeable increases in operational spending by Cook County from the Health Fund. Aside from inflationary increases, these increases included the addition of Provident Hospital in August 1993 and growth for the County's ACHN clinics. At the same time, however, Cook County did not maintain the level of county tax revenue support for its Health Fund that was provided before the enhanced payments began.

On August 17, 1993, about 2 years after the start of the IGT funding mechanism, Cook County opened Provident Hospital with an initial operating budget of about $60 million annually. It also opened several new clinics within its ACHN over the last several years, to where they now number about 30. Today's annual budget for the ACHN clinics is about $46 million higher than it was 6 years ago. Based on the Cook County budget for CFY 2000, about $247 million in tax revenues will go toward meeting Health Fund expenses. This is $49 million less than the $296 million funding level of 9 years earlier. Clearly, without the enhanced Medicaid payments, Cook County would have been required to allocate additional tax-supported revenue to the Health Fund in order to finance these new openings.

State Level

We could not similarly determine how the State used the revenues that were transferred back to it by Cook County. During the last 4 years of our 9-year review period, Cook County returned a total of $866.6 million to the State. The receipts were deposited directly to the State's General Revenue Fund. As such, traceability of these funds was lost. Although IDPA staff strongly contend that the deposits to the General Revenue Fund resulted in corresponding increases in spending for health care programs in Illinois, there is no assurance that the funds were used in this manner. Furthermore, we could not assess the level of health care funding that the State might have given to IDPA's programs had the transfers not occurred.

CONCLUSIONS AND RECOMMENDATIONS

Regardless of health care needs at the County or State levels that may have been met with the enhanced payments, both Cook County and Illinois are profiting by the use of the IGT funding mechanism under the Medicaid program. Cook County was able to expand its health care delivery system without allocating additional tax revenue to its Health Fund. By using IGTs as the State's share of the enhanced Medicaid payments to Cook County, the State was able to free up State funds that otherwise would have been paid to Cook County.

We believe that these actions undermined a basic premise of the Medicaid program--the premise that the program operates under a joint State and Federal effort.

To prevent a State from profiting through enhanced payments to itself for facilities that it owns and operates, the upper payment limit regulations required a separate payment limit for inpatient services at State-operated facilities, including hospitals. We noted that during the period covered by our review, a separate upper payment limit requirement was also needed for inpatient and outpatient services for local government-operated facilities. Using the data compiled by IDPA for the upper payment limits demonstration for SFY 2000, we estimate that a separate limit for inpatient and outpatient services for local government-operated facilities would have resulted in aggregate payments exceeding the upper limit calculations by about $748 million (Federal share - $374 million).

Preliminary results of our review in Illinois were included in an early alert memorandum to HCFA dated September 1, 2000. In that memorandum, we recommended that HCFA move quickly to revise the upper payment limit regulations. Our work in Illinois further supported our contention that action was needed to help protect the fiscal integrity of the Medicaid program. In our draft report, we were pleased to note that HCFA issued an NPRM in October 2000 that, when implemented, would help limit the manipulation of the upper payment limit requirements.

Subsequent to the issuance of our draft report, final regulations were published on January 12, 2001. According to the regulations, the new upper payment limits will be phased-in over the next several years, not becoming fully effective until October 1, 2008. In addition, with respect to non-State government-owned or operated hospitals, the regulations provide that the aggregate Medicaid payments, calculated separately for inpatient and outpatient services, may not exceed 150 percent of the amount that Medicare would pay for the services.

We estimate that these changes will result in savings to the Federal government of about $1.2 billion during the transition period. Once the regulatory changes are fully implemented, we estimate additional Federal savings of $374 million annually, totaling a savings of about $1.9 billion over 5 years. See APPENDIX A for additional details.

We, therefore, recommend that HCFA take action to ensure that Illinois complies with the phase-in of the revised regulations. We also recommend that HCFA require State plans to contain assurances that enhanced payments will be retained by the providers and used to provide services to Medicaid-eligible individuals.

HCFA's Response to Draft Report

In written comments dated January 26, 2001, HCFA agreed that a separate upper payment limit requirement was needed for local government-operated facilities and referred to the final regulation for action taken on our recommendation. The HCFA indicated that the

gradual transition policy was instituted in order to help States that have relied on upper payment limit financing arrangements.

OIG's Comments

We commend HCFA for taking action to change the upper payment limit regulations. As our review has shown, funding for enhanced payments in Illinois was not traditional Medicaid funding. At Cook County, the funds were used to finance healthcare services that would not otherwise qualify for Medicaid participation. At the State level, the funds were a source for general revenue enhancements.

APPENDIX A

Schedule of Federal Savings in Illinois
Based on Implementation of Revised
Upper Payment Limit Regulations
(in millions)

Estimate of Federal Savings Based on
Medicare Payment Principles

SFY Ending June 30th	Capped at 150 Percent With Transition Period
2001	-
2002	$ 0
2003	0
2004	56
2005	112
2006	168
2007	225
2008	281
2009	365
Savings During Transition	$1,207 ($1.2 Billion)
2010	$ 374
2011	374
2012	374
2013	374
2014	374
Total 5-Year Savings After Full Implementation of Regulations	$1,870 ($1.9 Billion)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JAN 26 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Illinois' Use of Intergovernmental Transfers to Finance Enhanced Medicaid Payments to Cook County for Hospital Services," (A-05-00-00056).

Thank you for the opportunity to comment on the use of Medicaid upper payment limits (UPL). The information you have provided in the related draft reports is very useful to us as we develop new Medicaid payment policies. We look forward to receiving the audit reports regarding the remaining states and your summary report and recommendations.

In your memorandum and throughout the report, reference is made to the previous UPL regulations, which included a separate aggregate UPL requirement for state-operated facilities. This limit is applied to inpatient services furnished by hospitals, nursing facilities, and institutional care facilities for the mentally retarded. The language should be clarified to show that this limit is applied to inpatient services furnished by hospitals, and does not apply to outpatient services furnished by hospitals.

Also, throughout the report, there are references made to October 5, 2000, the date HCFA issued a Notice of Proposed Rulemaking (NPRM) on the issue. The proposed rule was actually published in the Federal Register on October 10, 2000, and the final regulation was published on January 12, 2001. You may want to reference these dates instead when making future references.

OIG Recommendation
A separate UPL requirement is also needed for local government-operated facilities.

HCFA Response
We concur. In July, we issued a letter to State Medicaid Directors outlining our concerns about excessive payments to public providers and setting forth our intent to propose new rules to address the issue. HCFA published an NPRM on the subject on October 10, 2000, followed by the publication of the final rule on January 12, 2001. The final rule precludes states from aggregating payments across private and public facilities to calculate UPLs. We further created a new payment limit for local governmental

providers, and in the case of outpatient hospital and clinic services, an additional UPL for state-operated facilities. These changes will significantly reduce the amount of excessive payments that were paid under the previous UPL regulations.

To help states that have relied on UPL financing arrangements, we have instituted a gradual transition policy. In addition, recognizing the need to preserve access by Medicaid beneficiaries to public hospitals, we have included provisions that would ensure adequate payment rates for such facilities.

OIG Recommendation
The aggregate upper payment limit for non-state public hospitals should be 100 percent of the amount that Medicare would have paid for services.

HCFA Response
We do not concur. We believe that allowing higher Medicaid payments will fully reflect the value of public hospitals' services to Medicaid and the populations it serves. Public hospitals are established to ensure access to needed care in underserved areas and often provide a range of care not readily available in the community, including expensive specialized services such as trauma, burn care, and outpatient tuberculosis services. They also provide a significant proportion of the uncompensated care in the nation.

The size and scale of public hospitals creates extreme financial stresses and uncertainties, especially given their dependence on public funding sources. We are concerned that these stresses may threaten the ability of public hospitals to fulfill their mission and to fully service the Medicaid population. While we received several public comments on this proposal, we did not receive any concrete information that justified an alternate limit. Therefore we have retained the 150 percent limit, as proposed in the NPRM on October 10, 2000.

OIG Recommendation
We also recommend that HCFA issue guidance that would address the method of calculation of the Medicare upper payment limit.

HCFA Response
We intend to issue revisions to the State Medicaid Manual to provide guidance regarding the states' calculation of the Medicare UPL.