



State Mandated Increases in Capitated Managed Care Will Jeopardize Billions of Dollars in Federal Medicaid Funds

To help solve the current state budget crisis, some have suggested that Illinois law should be changed to force significantly more Medicaid beneficiaries into HMOs. While examining all options for savings is prudent, expanding capitated managed care in Illinois will not save the state money, but will cost the state money.

Under a complex financing strategy known as the Hospital Assessment Program, Illinois hospitals pay a tax to the State of \$900 million per year (for FY 09 – FY 13) that is then used to bring in federal matching funds to pay for health care services provided to Medicaid beneficiaries. Of this \$900 million in hospital tax dollars, \$610 million is used to draw down \$930 million in federal matching funds, to make \$1.54 billion dollars in payments to hospitals¹. The remaining \$290 million in hospital tax dollars are, due to the enhanced matching rate under the federal stimulus law, able to draw down \$445 million in federal matching funds. This combination of funds is then used to make \$735 million in payments for other non-hospital Medicaid health services, such as long term care and developmental disabilities. Thus, in FY 09, this program creates over \$2 billion in health care funding -- all from sources other than the state's general revenues.

Any change in state law to require a significant increase in the number of persons enrolled in capitated managed care, such as HMOs, will jeopardize the current Hospital Assessment program. This means that either Medicaid HMOs will have to save the state over \$2 billion per year or the state will have to find a way to replace these funds.

How will the proposal to increase capitated Medicaid managed care jeopardize the current Hospital Assessment Program?

To answer this question it is necessary to understand the federal regulatory framework that governs the Hospital Assessment Program. One of the key federal Medicaid payment rules is the “upper payment limit” or “UPL”. The UPL is the ceiling on the State’s Medicaid expenditures that are eligible for federal matching funds. For hospital services, the UPL is the amount that the federal Medicare program would pay for the same services. In Illinois, the existing Medicaid payments to hospitals (i.e., the payments that are not funded by the Hospital Assessment) are far below the UPL. Through the Hospital Assessment Program, hospitals pay a tax to the state, which the state uses to draw down federal matching funds. The combination of those hospital tax dollars and the new federal dollars are then paid back to the hospitals to fill in the “UPL gap” – that is, the shortfall between the UPL and the existing Medicaid payments.

Example of a Hospital Assessment Program within the UPL:

Existing Hospital Payments	\$100
UPL	\$200
New Hospital Tax	\$50

¹ Because Illinois’ federal matching rate has been temporarily increased from 50% to about 60% under the federal stimulus law, only \$610 million is needed to draw down the federal funds needed to make the required payments to hospitals.

New federal funds	\$50
New Hospital Payments	\$100 (limited to the size of the (“UPL gap”))

Under this example, the hospitals receive a new payment of \$100, that consists of \$50 from a tax on the hospitals and \$50 in new federal matching dollars. The total payments to hospitals are still within the UPL of \$200, so the program qualifies for federal matching funds.

Medicaid HMOs are relevant in this analysis because in calculating the UPL, only services used by Medicaid beneficiaries that are paid on a fee for service basis are counted. Services provided to Medicaid beneficiaries enrolled in capitated HMOs are NOT counted in establishing the UPL. This means that if you reduce the UPL, the payments to hospitals under the Assessment Program will violate the UPL rule and therefore no longer qualify for federal matching funds – the Assessment Program, as it currently exists, will be null and void.

The following table contains hypothetical scenarios to illustrate how shifting a significant number of Medicaid beneficiaries from the traditional fee for service system to capitated HMOs will invalidate the Hospital Assessment Program.

Scenario	Beneficiaries in FFS	Average Existing Payment Per Beneficiary	Existing Aggregate Payments	Average UPL Per Enrollee	Aggregate UPL	UPL Gap
A	150	\$10	\$1,500	\$20	\$3,000	\$1,500
B	100	\$10	\$1,000	\$20	\$2,000	\$1,000

Scenario A: A hospital assessment program was designed under the facts contained in Scenario A from the above table. New payments to hospitals of \$1,500 were established to take advantage of the existing UPL Gap of \$1,500 – the difference between the “Existing Aggregate Payments” and the “Aggregate UPL”. These new payments were financed by a tax on hospitals of \$750, which would be used to draw down an additional \$750 in federal matching funds.

Scenario B: Now, consider Scenario B where as the result of a change in state law, the number of Medicaid beneficiaries in the fee for service system is reduced from 150 to 100 because 50 are assigned to a capitated HMO. The UPL Gap is thereby reduced to \$1,000 because of the fewer beneficiaries. Consequently, the new payments to hospitals created under the Hospital Assessment Program for the facts contained in Scenario A, now exceed the UPL by \$500. Therefore, those payments are not eligible for federal matching funds. In short, the state has changed the fundamental premises upon which it received approval from the federal government for its assessment program. The hospital assessment program is now invalid under federal Medicaid rules.

Thus, the present 5-year Hospital Assessment Program that has already been approved by the federal government and that will generate over \$6 billion for health care for Illinoisans from non-state sources would be invalid. All parties would have to come to the table, negotiate a new assessment, if that is possible, then seek approval from the federal government. None of these steps are easy, none are simple and nothing guarantees federal approval – this process took over a year to complete for the current assessment program and even longer than that for the prior one.

All of this time, effort and significant dollar loss would be incurred when there is no concrete evidence that expanding Medicaid HMOs in Illinois will save one dollar, much less save over \$6 billion to compensate for the loss of the Hospital Assessment Program.