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RHODE ISLAND'S GLOBAL WAIVER NOT A MODEL FOR HOW STATES WOULD FARE UNDER A MEDICAID BLOCK GRANT

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In recent months, proponents of converting Medicaid into a block grant have cited a Medicaid waiver demonstration project in Rhode Island as evidence that a block grant would produce substantial federal and state savings while giving states greater flexibility over their Medicaid programs.[1] These claims, however, are off the mark. The Rhode Island waiver was a "sweetheart deal" between the Bush Administration — in its final week of office — and the Republican governor of Rhode Island, in which the federal government effectively unloaded additional federal money on the state and gave Rhode Island federal funds *beyond* what it would receive under the regular Medicaid program, in return for the state accepting a cap on its Medicaid expenditures at an inflated level that it never expected to reach anyway. Such a deal would be impossible to replicate under proposals to convert the Medicaid program to a block grant; such proposals are designed to *cut* federal Medicaid funding by tens or hundreds of billions of dollars, the opposite of what happened in Rhode Island.

Those who tout the Rhode Island waiver as a model for other states have also exaggerated the state savings that Rhode Island secured under the waiver. First, they have misleadingly counted savings to the state that resulted from the infusion of added federal Medicaid funding under the Recovery Act as though those savings were due to the Rhode Island waiver. Second, they have failed to acknowledge that the cost-containment measures which the state instituted under the waiver could have been instituted *without* capping Medicaid funding; other states can — and many have — instituted similar measures without a "global waiver" like Rhode Island's.

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[1] These claims are based on a paper written by Gary Alexander, the former secretary of the Rhode Island Executive Office of Health and Human Services and director of the Department of Human Services, for the Galen Institute, a conservative policy organization that favors converting Medicaid to a block grant. See "Rhode Island Medicaid Reform Global Consumer Choice Compact Waiver," January 28, 2011, available at http://www.galen.org/fileuploads/RIMedicaidReform.pdf.

An example of how the Alexander paper is being used to promote Medicaid block grants and funding caps is a paper written by Douglas Holtz-Eakin, president of the American Action Forum (a conservative policy group closely tied to the American Action Network, which seeks to elect more Republicans to office), which recommends that states seek waivers with capped financing such as Rhode Island's global waiver. See "Sustainability of Medicaid: Action Steps for Governors to Achieve Meaningful Reform," American Action Forum, February 28, 2011.

The Rhode Island Deal

The Bush Administration approved Rhode Island's project, commonly referred to as a "global waiver," on January 16, 2009, four days before President Bush left office. The state agreed to accept a cap on the amount of federal Medicaid funding it could receive for the next five years (and a cap on total federal and state Medicaid expenditures combined), set at levels well *above* what the federal government otherwise was expected to spend. The state received increased flexibility over such matters as how it contracts for covered Medicaid services and provides long-term care. Of particular importance, the global waiver also allowed Rhode Island to receive federal Medicaid funding to help pay for certain health services for adults who are *not* eligible for Medicaid under federal law; these were costs the state previously covered entirely at its own expense. The global waiver thereby allowed the state to shift some of these costs from itself to the federal government.

Those who claim that the Rhode Island global waiver is a model for other states and for the Medicaid program generally have made a number of claims about the Rhode Island experience and its applicability elsewhere. Close examination reveals, however, that these claims generally do not withstand scrutiny.

- The federal-state spending cap that the global waiver placed on Rhode Island's Medicaid program was set at a level far above what the state projected it would spend on Medicaid in the *absence* of the waiver. Moreover, because the state was allowed to claim additional federal Medicaid funds for services that the state previously covered on its own, federal costs *increased*. In contrast, any block grant proposals that Congress is likely to consider would provide states with substantially *less* federal funding than they otherwise would get; such proposals would be designed to produce sizeable federal savings.

- Rhode Island's Medicaid director has questioned the accuracy of claims made by the former state political appointee who has been promoting the global waiver as a model and claiming it has saved Rhode Island over $100 million, and whose statements and paper are the basis for the recent swell of interest in the global waiver. Referring to a report written by this former Rhode Island official for a conservative policy organization that has long advocated block-granting Medicaid, the current Rhode Island Medicaid director has said there is little in the report that is accurate.[2]

- Rhode Island could have instituted the cost containment measures authorized under its global waiver — such as adopting competitive contracting for various goods and services reimbursed by Medicaid and shifting more people who need long-term services and supports from costly nursing homes to community-based care — under *current* Medicaid rules and more limited waivers, without a global Medicaid expenditure cap. States do not need to agree to a global cap to get the flexibility to institute these measures.

[2] Megan Hall, "Former DHS director published unauthorized report on global waiver," *The Pulse,* WRNI Health Care blog, 20 January 2011, available at http://wrnihealthcareblog.wordpress.com/2011/01/20/what-happened-to-gary-alexander/.

Background on the Rhode Island Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the authority to conduct Medicaid demonstration projects and waive certain provisions of the Medicaid statute that otherwise would stand in the way of such projects.[3] Demonstrations must have the broad goal of furthering the objectives of Medicaid. They must also be budget neutral for the federal government —that is, the federal government cannot approve waivers that increase federal costs relative to what they would have been in the absence of the waiver.[4]

States can seek waiver authority to cover more health services or to extend coverage to groups of people that Medicaid otherwise is precluded from insuring, if the added costs are fully offset. For example, a state can seek a waiver to cover non-disabled childless adults and pay for those costs through other changes in its Medicaid program so that its total Medicaid expenditures are no higher with the waiver than without it. Over the past two decades, a number of states have sought and received waivers for such purposes as extending coverage to particular groups of low-income individuals and have offset the resulting costs through such means as greater use of managed care.

Rhode Island's global waiver, called the Global Consumer Choice Compact, merged a number of waivers the state already had received from the federal government (such as to help Medicaid-eligible people enroll in employer-based coverage and to expand the use of home- and community-based services for people needing long-term care) with new waiver initiatives. The new initiatives include allowing the state to establish a waiting list for long-term care services and supports while according priority to people with the highest need for such care, and allowing the state to contract on a competitive basis with a limited number of suppliers of medical equipment and other services in order to lower costs.

Where the global waiver differed dramatically from the state's earlier waivers, and from waivers granted to other states, was in its financing structure. The global waiver capped combined federal and state Medicaid spending at $12.075 billion for the waiver's five-year duration (2009-2013). The federal government would continue to pay a fixed percentage of Rhode Island's Medicaid costs up to the cap. The global waiver also allowed Rhode Island to claim millions of dollars in federal matching funds for health care services that previously had been provided entirely at state expense to certain groups of people who are not eligible for Medicaid under federal law; the state would not have received federal matching funds for those costs without the global waiver.

Rhode Island Waiver Increased Federal Costs; Block Grant Would Shrink Them

Current proposals to convert Medicaid to a block grant or otherwise cap federal Medicaid funding are designed to give states significantly *less* federal funding than they would otherwise receive, in

[3] Provisions that are often waived include freedom of choice of provider, the offering of comparable benefits across populations, and the offering of comparable benefits across geographic areas. Medicaid's matching structure cannot be waived.

[4] For more information about Section 1115 waivers, see Cynthia Shirk, "Shaping Medicaid and SCHIP Through Waivers: The Fundamentals," National Health Policy Forum, July 22, 2008.

order to cut federal Medicaid expenditures.[5] Under a block grant, the federal government would provide each state with a fixed dollar amount, usually based on a state's current expenditure level, and states would have to pay 100 percent of any costs that exceed these amounts. Federal allotments to the states would grow at an annual rate that is *slower* than the rate at which federal Medicaid funding otherwise would be expected to rise (as a result of increases in Medicaid enrollment due to normal population growth and the continued erosion of employer-based coverage, increases in health care costs throughout the U.S health care system, and the aging of the population). Because the level of block grant funding would not keep pace with these factors, federal Medicaid funding for states would — with each passing year — fall farther behind the levels of funding that states would have received under the current Medicaid program.[6]

The Rhode Island global waiver differs fundamentally from these block grant proposals:

- **The global waiver's spending cap of $12.075 billion over five years was set at a level *far above* the state's projection of Medicaid costs.**[7] In its initial request for a waiver, Rhode Island asked for a $12.386 billion spending cap but said it anticipated spending only $10.761 billion during the five-year period. By setting the cap more than $1 billion, or 12 percent, above what the state expected to spend — while allowing the state to shift certain state health costs to Medicaid and to secure federal matching funds for them — the Bush Administration gave the state a sweetheart deal.[8]

- **Under the global waiver, Rhode Island has received millions of dollars in federal reimbursements for health care costs previously funded by the state, and federal spending has *increased* relative to what it otherwise would have been.** Under virtually all block grant proposals, by contrast, states would receive significantly less federal funding than under the current Medicaid program and either would have to come up with additional state funds to replace the lost federal funds or to institute cutbacks. (Most block-grant proposals

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[5] Rep. Paul Ryan (R-WI) and Alice Rivlin of the Brookings Institution submitted a plan to the president's fiscal commission that included a proposal to convert Medicaid to a block grant. The Congressional Budget Office estimated that this proposal would reduce federal Medicaid funding by $180 billion over the next ten years. For more information, see Congressional Budget Office, "Letter from Douglas W. Elmendorf to the Honorable Paul D. Ryan," November 17, 2010; and Edwin Park, "Medicaid Block Grant or Funding Caps Would Shift Costs to States, Beneficiaries, and Providers," Center on Budget and Policy Priorities, January 6, 2011.

[6] For a more detailed discussion of block grants and their potential effects on states, see Edwin Park and Matt Broaddus, "Medicaid Block Grant Would Shift Financial Risks and Costs to States," Center on Budget and Policy Priorities, February 23, 2011.

[7] Judith Solomon, "Rhode Island's Medicaid Proposal Would Put Beneficiaries at Risk and Undermine the Federal-State Partnership," Center on Budget and Policy Priorities, September 4, 2008. During the negotiations, the state conceded that it was seeking a cap that would exceed what the state would need based on historical data, but argued that a higher cap was needed because of the increased costs of an aging population, a weak economy, and the risk the state was assuming. Steve Peoples, "Governor seeks waiver to cap Medicaid at $12.4 billion," *Providence Journal,* July 30, 2008.

[8] The Bush Administration had previously been criticized by the Government Accountability Office (GAO) for approving waivers that likely would *not* be budget neutral for the federal government. The GAO found that in approving waivers for Florida and Vermont, the Bush Administration likely inflated what those states' Medicaid costs would be in the absence of the waivers, by assuming (without supporting documentation) rates of cost growth under the states' existing Medicaid programs that exceeded HHS' own benchmarks. Government Accountability Office, "Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns," January 2008.

would eventually cut federal funding by amounts well beyond what states can accommodate through economies and efficiencies that don't cause more people to become uninsured or underinsured or reduce access to care.[9])

- **Furthermore, Rhode Island can terminate the global waiver at any time**; if it does so, its federal Medicaid funds will no longer be capped.[10] In other words, if at any point, Rhode Island concludes it is getting less federal money under the global waiver than under the regular Medicaid program, it can opt back into regular Medicaid. This is a "no lose" situation for the state, at the federal Treasury's expense. In contrast, proposals to convert Medicaid to a block grant generally alter the structure of the program on a permanent basis, terminating Medicaid as it exists today.

Even before the waiver, Rhode Island spent more per Medicaid beneficiary than any other state in the nation. The waiver has enabled the state to increase its Medicaid costs further, by shifting some previously state-funded costs into Medicaid, and is vastly more generous than what other states could expect from a federal block grant.[11]

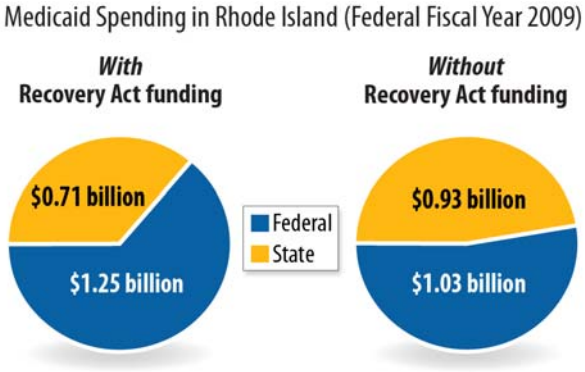
Claims of Savings Under the Global Waiver Are Heavily Exaggerated

Proponents claim that Rhode Island has gleaned significant Medicaid savings as a result of the global waiver. State Medicaid officials, however, have expressed strong skepticism about these assertions,[12] and careful analysis of the state's Medicaid spending demonstrates that the claims of large savings are highly misleading:

- **The claimed state savings largely reflect the receipt by the state of large amounts of additional federal Medicaid funds under the Recovery Act, which had nothing to do with the Rhode Island global waiver.** Like all states, Rhode Island

Figure 1

Rhode Island Saved More Than $200 Million in Medicaid in Federal Fiscal Year 2009 Due to Recovery Act Funding



Source: CBPP analysis of spending data from Rhode Island's CMS Form-64 submissions to the federal government.

[9] See Park, *op cit.*

[10] Rhode Island would have to submit a phase-out plan to CMS at least six months in advance, unless circumstances made a shorter time period necessary.

[11] Kaiser Family Foundation, Medicaid Payments Per Enrollee, 2007 at www.statehealthfacts.org. A federal block grant would likely lock in state variations in spending, with higher-spending states like Rhode Island faring better than states that now have lower Medicaid expenditures. Edwin Park and Matt Broaddus, Medicaid Block Grant Would Produce Disparate and Inequitable Results Across States, Center on Budget and Policy Priorities, March 11, 2011.

[12] See Marc Levy, "RI officials dispute Corbett nominee's claims," *Associated Press*, February 1, 2011, for more information. Available at http://www.ydr.com/politics/ci_17262346?source=rss.

received enhanced federal matching funds under the Recovery Act; the share of Rhode Island Medicaid costs that the federal government pays rose from 53 percent to 64 percent. The state has received $400 million in additional federal Medicaid funds as a consequence, a level that will reach about $470 million by June 30, when this temporary federal aid ends. These additional federal matching funds — not any savings attributable to the waiver — are the reason that Rhode Island's *state-funded* Medicaid expenditures declined in 2009. Rhode Island would have benefited from these savings whether it had a global waiver or not (see Figure 1).

- **Claims that Rhode Island's Medicaid program accrued $850 million in "surpluses" or "savings" in its first year are specious.**[13] To monitor Rhode Island's progress toward achieving budget neutrality over the five-year waiver period, the Centers for Medicare and Medicaid Services at the U.S. Department of Health and Human Services gave the state a spending ceiling for each year; if Rhode Island spends more than the ceiling in a given year, it must submit a plan for corrective action to CMS showing that the global waiver will be budget neutral to the federal government over the waiver's five-year life. Anticipating higher costs associated with the transition to the global waiver, CMS gave Rhode Island an extremely generous first-year spending ceiling of $2.6 billion, far above what the state expected to actually spend that year. During that first year (calendar year 2009), Rhode Island spent $1.75 billion on Medicaid costs that count against the ceiling.[14] To call the $850 million difference a "surplus" or "savings" that the global waiver produced is patently false. This difference is nothing more than an expected result, given the very high first-year ceiling that CMS allowed.

- **Rhode Island's Medicaid expenditures grew more slowly than other states *before* as well as after the global waiver went into effect, because enrollment in the program has not increased.** In the five years *preceding* the start of the global waiver, combined federal and state spending on Rhode Island's Medicaid program grew at an average annual rate of only 2.2 percent, according to reports the state submitted to the Centers for Medicare & Medicaid Services (CMS). In federal fiscal year 2009, which includes the first three quarters that the waiver was in effect, Rhode Island's spending increased by 3.3 percent over the prior year.[15] According to the state's quarterly waiver reports to CMS, Medicaid spending increased by 2.3 percent in federal fiscal year 2010.[16]

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[13] As the Rhode Island media have reported, many of the financial claims that former state DHS director Gary Alexander makes in his report cannot be corroborated by current DHS officials. See Levy, *op cit.* Despite this, some proponents of converting Medicaid to a block grant have cited Alexander's report as a primary source when making claims about savings under the global waiver. As an example, see John R. Graham, "In the Nick of Time: Rhode Island's Medicaid Waiver Shows How States Can Save their Budgets from Obamacare," Pacific Research Institute, January 2011.

[14] Some Medicaid spending categories, such as that on Disproportionate Share Hospitals (DSH), Local Education Agencies (LEA), and other adjustments, do not count against the spending targets that are part of Rhode Island's global waiver. These expenditures are included in the CMS-64 data reports.

[15] The Rhode Island Medicaid program's low rate of spending growth, both before and during the global waiver, is attributable in large part to the fact that enrollment actually *declined* slightly between June 2004 and June 2010, from 169,600 to 166,500. Nationally, Medicaid enrollment grew during the same time period from 41 million to 50 million. Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment: June 2010 Data Snapshot," February 2011.

[16] Since Rhode Island has only submitted global waiver reports to CMS through June 2010, we calculated federal fiscal year 2010 spending by taking the reported expenditures for the first three quarters of federal fiscal year 2010 and estimating costs for the fourth quarter based on the rate of growth in program costs under the global waiver.

Cost Containment Measures Could Have Been Instituted Without Global Waiver

There are several areas where Rhode Island may have achieved some savings under its global waiver — rebalancing long-term care, placing greater emphasis on selective, competitive contracting, and improving care coordination. A state can institute all of these cost-containment measures, however, *without* a waiver that caps overall Medicaid spending, and in some cases, without a waiver at all. For example, Rhode Island achieved savings by negotiating a rate reduction with its existing contractors; yet many other states, as well, have pursued these and other contracting reforms. In addition, Rhode Island could have applied for existing state options or more limited waivers (including waivers under section 1915(b) of the Social Security Act[17]) that would have enabled it to pursue its selective contracting initiatives without placing a cap on overall program expenditures.

Conclusion

Claims that Rhode Island's global waiver has produced savings for the federal government and the state do not withstand scrutiny. The federal government is actually spending somewhat *more* on Rhode Island's Medicaid program than it would in the absence of the global waiver. That is the opposite of what would occur under a Medicaid block grant, where states would be provided with significantly less federal funding than they would receive under current law.

In addition, the state's own savings since the start of the global waiver reflect not the waiver itself, but federal Recovery Act funding and the shifting to the federal government of some health care costs that the state previously paid for in full. Finally, the cost-containment mechanisms that the state has adopted under the global waiver could have been instituted without such a waiver, as other states have done.

[17] Section 1915(b) waivers allow states to restrict the freedom of an individual to choose his or her provider. Under such waivers, states can require beneficiaries to enroll in managed care plans or require them to select providers or suppliers from lists that the state provides.