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“Block Grant” Guidance Will Likely Invite Medicaid Waivers That Pose Serious Risks to Beneficiaries, Providers, and States

By Judith Solomon and Jessica Schubel

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma has said she wants to use Medicaid waivers to let states ignore various federal standards and beneficiary protections — and avoid federal oversight — in exchange for agreeing to caps on the federal Medicaid funding they receive. As explained below, such “block grant” waivers would pose serious risks to beneficiaries, health providers, and states.

In 2017, the Trump Administration and congressional Republicans attempted and failed to make sweeping changes in Medicaid and cut the program over time by capping and reducing federal Medicaid funding for seniors, people with disabilities, and families with children and by repealing the Affordable Care Act (ACA)’s expansion of Medicaid to low-income adults. Since then, the Administration has pursued similar goals through Medicaid waiver authority, encouraging states to propose restrictive waiver policies that would cause thousands of people to lose coverage or access to key health care benefits.

New CMS guidance that reportedly would provide a framework for states to seek and implement block grant waivers currently is under review at the federal Office of Management and Budget.¹ Several states are also drafting or considering waivers along these lines.² Utah has already proposed a per-person cap on the federal Medicaid funding that it receives for low-income adults, coupled with unprecedented eligibility restrictions.³ Tennessee recently enacted legislation directing its Medicaid

¹ HHS-CMS, State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity, June 4, 2019, <https://www.reginfo.gov/public/jsp/EO/eoDashboard.jsp>.

² Rachana Pradhan and Dan Diamond, “Trump wants to bypass Congress on Medicaid plan,” *Politico*, January 11, 2019, <https://www.politico.com/story/2019/01/11/trump-bypass-congress-medicaid-plan-1078885>.

³ Judith Solomon, “Utah’s Proposed Medicaid Waiver Would Deny Medicaid to Tens of Thousands of Low-Income Utahns, Drive More Cuts in the Future,” Center on Budget and Policy Priorities, June 12, 2019, <https://www.cbpp.org/blog/utahs-proposed-medicaid-waiver-would-deny-medicaid-to-tens-of-thousands-of-low-income-utahns>

agency to pursue federal block grant funding for its entire Medicaid program.⁴ And Alaska has hired a consultant to develop a waiver concept paper analyzing the potential for a block grant among other options.⁵

Many questions will remain unanswered until CMS issues the guidance. But Administrator Verma's comments and the waivers that CMS has already approved signal that the guidance will likely invite waivers that would undermine Medicaid's guarantee of coverage and beneficiary protections and shift financial risk to states.

- **The guidance will likely invite waivers that undercut Medicaid's guarantee of comprehensive coverage to low-income people who meet the program's statutory eligibility criteria.** Administrator Verma has described the forthcoming waiver policy as giving states capped federal funding "in exchange for more flexibility and less oversight." But Medicaid already provides states with numerous options to customize their programs, while requiring that states provide coverage that meets basic affordability and benefit standards to all low-income people who qualify under Medicaid eligibility criteria. "Flexibility" is likely code for allowing states to abrogate these standards.

For example, the Administration has already approved a waiver allowing Utah to flatly deny coverage to eligible low-income adults who apply, in order to keep the state's share of Medicaid costs for this group within a budget cap that the state sets. Extending such authority to other states or other groups of Medicaid enrollees would amount to ending Medicaid's coverage guarantee for many people in those states.

- **While CMS can't require states to accept deep federal funding cuts, the guidance will likely invite waivers that put states at greater financial risk.** Block grant waivers likely won't entail the deep cuts that were included in the legislative block grants and per capita cap proposals Congress considered but failed to pass in 2017. That's because the Trump Administration can't force states to agree to a waiver, and states are unlikely to accept waivers with federal funding caps far below the level of federal Medicaid funding they otherwise expect to receive. Nonetheless, any waiver that imposes a rigid cap on federal funding would shift significant risk to states, since it would put them on the hook for unexpected costs that the federal government otherwise would help pay. That could include costs for new drugs that represent health care breakthroughs but are expensive, a public health emergency like the opioid epidemic, or in the case of an aggregate cap on total federal Medicaid funding for a state (as distinguished from a per-person cap), increases in Medicaid enrollment during a recession when people lose jobs and the health coverage that often comes with them.

In addition, some state policymakers appear to be under the mistaken impression that under a block grant waiver, a state could receive a specified amount of federal funding *regardless* of its own level of Medicaid spending, or that a state could receive *more* federal dollars under such a waiver. But Medicaid's funding structure cannot be changed using waiver authority. That means states would still have to put up their own funds to draw down federal dollars. Meanwhile, Medicaid waivers can keep federal costs the same or reduce them, but waivers

⁴ Harris Meyer, "Tennessee will test CMS' willingness to block-grant Medicaid," *Modern Healthcare*, May 7, 2019, <https://www.modernhealthcare.com/payment/tennessee-will-test-cms-willingness-block-grant-medicaid>.

⁵ Elwood Brehmer, "State awards contract for Medicaid block grant study," *Alaska Journal of Commerce*, June 5, 2019, <http://www.alaskajournal.com/2019-06-05/state-awards-contract-medicaid-block-grant-study>.

cannot increase federal costs. That means a waiver could not increase federal funding for a state.

- **Measuring health outcomes won't protect enrollees from the harmful effects of taking away coverage or making coverage less adequate or less affordable.** Administrator Verma has said the new waiver authority would substitute a new form of state accountability for producing desired health outcomes for the current accountability for states to comply with federal Medicaid standards and for some of CMS' current oversight. Such a substitution, however, is both unworkable and based on a mistaken premise. In practice, it's very difficult to reliably establish whether Medicaid changes as a result of implementing a waiver are worsening health outcomes. And it's virtually impossible in a short period of time: it often takes many years for the loss of access to care to lead to measurable deterioration in a person's health. In addition, as a federal court recently reminded CMS, the purpose of health insurance is *both* to improve access to care and health outcomes *and* to improve households' financial security. Tracking health outcomes sheds no light on whether changes made under a waiver are making it harder for low-income families to pay rent or put food on the table or are leaving them burdened by medical debt.

Moreover, abundant evidence has already established that letting states take coverage away from eligible people or make coverage less affordable worsens access to care and health outcomes. And procedural protections for beneficiaries and federal oversight are key to ensuring that states actually meet eligibility, affordability, and benefit standards.

- **Waivers approved based on the forthcoming guidance are likely to face legal challenges.** A federal court recently rejected two restrictive waivers approved by the Trump Administration, finding the Administration had not shown how the waivers would advance Medicaid's central objective: providing health coverage to low-income people. Given that, waivers that allow states to undermine Medicaid's coverage guarantee in exchange for agreeing to capped federal funding would almost certainly be subject to legal challenge.⁶ While the Administration may still approve such waivers, states could expend substantial effort and resources developing them, negotiating them with the Administration, and redesigning eligibility or other systems around the new waiver authorities, only to have the waivers struck down in court (or reversed by a subsequent Administration).

The combination of eligibility restrictions, weaker beneficiary protections, greater financial risk for states, and reduced federal oversight threatens the well-being of both low-income and vulnerable Medicaid beneficiaries and those who provide their care. Medicaid's coverage guarantee means that coverage is there when it's needed: people who lose their jobs or get sick can enroll when they qualify and receive a core set of health care services that all states must cover. Ending that guarantee — or eliminating the federal oversight that ensures that states, health plans, and providers comply with it — would worsen access to care, health, and financial security for Medicaid enrollees and very likely increase uncompensated care costs for hospitals and other providers.

⁶ *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018).

Guidance Will Likely Invite Waivers That Undermine Coverage and Do Not Improve Health Care

In making its case both for legislative proposals to overhaul Medicaid in 2017 and for the forthcoming waiver guidance, the Administration has repeatedly claimed that federal standards and oversight are standing in the way of state efforts to improve the quality and efficiency of care.

While CMS could encourage more state proposals that improve the delivery of care to Medicaid beneficiaries, this isn't likely to be the focus of the new guidance. Rather, discussion of new state flexibility is more likely to turn out to be code for offering states unprecedented authority to limit eligibility or offer skimpier or less affordable coverage, and for limiting or eliminating federal oversight that ensures basic standards are met.

Medicaid Delivers Quality Care, Already Offers States Considerable Flexibility

The Trump Administration has provided few, if any, specific examples of federal authorities that impede state innovation in care delivery. That's not surprising, for two reasons.

First, Medicaid already delivers quality care at lower cost than private insurance. "Spending per enrollee is lower for Medicaid compared to private insurance after controlling for differences in socio-demographic and health characteristics between the two groups," Kaiser Family Foundation and Urban Institute researchers concluded, based on a comprehensive literature review. *Cost growth* in Medicaid has also been slower than in private insurance or Medicare.⁷

Yet people covered by Medicaid obtain care at rates similar to people with private insurance and report high satisfaction with their coverage. And gaining Medicaid coverage improves access to care, financial security, and health outcomes (as discussed below).⁸ Medicaid provides more comprehensive benefits than private insurance at significantly lower out-of-pocket cost to beneficiaries, and its lower payment rates to health care providers and lower administrative costs make the program very cost effective.⁹

Second, states already have many opportunities to innovate in their Medicaid programs, both with and without waiver authority. The federal government pays a significant share of the program's costs, and states agree to follow federal rules that set minimum standards for the people and benefits states must cover, as well as beneficiary protections, provider payments, and how benefits are delivered. But within those rules, every state designs its Medicaid program to fit its needs and

⁷ Lisa Clemans-Cope, John Holahan, and Rachel Garfield, "Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence," Kaiser Family Foundation, April 13, 2016, <https://www.kff.org/report-section/medicaid-spending-growth-compared-to-other-payers-issue-brief/>.

⁸ Hannah Katch, "Medicaid Works, in 5 Charts," Center on Budget and Policy Priorities, May 12, 2017, <https://www.cbpp.org/blog/medicaid-works-in-5-charts>; Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, "Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?" Commonwealth Fund, September 2017, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_sara_collins_2017_aca_tracking_survey_ib_v2.pdf.

⁹ Edwin Park *et al.*, "Frequently Asked Questions About Medicaid," Center on Budget and Policy Priorities, updated March 29, 2017, <https://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid>.

environment, with significant flexibility to decide whom it covers, what benefits it provides, and how it delivers health care services. For example, some states have large public hospital systems; others have largely private systems of care. Some states rely heavily on managed care organizations to deliver care, while others use provider-sponsored organizations or pay providers on a fee-for-service basis.¹⁰

A number of states are already taking advantage of Medicaid's flexibility to experiment with different methods of paying for and delivering care. Similar to the experimentation occurring in Medicare and among private payers, state Medicaid programs are experimenting with value-based payment models that require providers to accept some financial responsibility for the cost and overall outcomes of patients' care. For example, in Oregon, partnerships between health plans and providers — which receive a per-enrollee rate to provide all medical, mental health, and dental care services for their members — have reduced spending by \$2.2 billion between 2012 and 2017 and substantially reduced avoidable use of the emergency department.¹¹ Such models also have shown promise in Medicare for reducing costs without harming the quality of care.

States also use Medicaid's flexibility to respond to health issues as they arise. Numerous states have created evidence-based systems of care as part of their efforts to address the opioid epidemic or to improve behavioral health care. Michigan is using Medicaid to help address the lead crisis in Flint.¹²

Guidance Likely to Let States Limit Eligibility and Weaken Coverage

Utah's recently approved Medicaid waiver indicates where some states and the Administration may be headed in exchanging caps on federal funding for authority to limit coverage. The waiver gives Utah unprecedented authority to close enrollment and deny coverage to eligible low-income adults if Medicaid costs exceed the state's budget targets — in effect, whenever it chooses. If allowed on a widespread basis, enrollment caps would convert Medicaid from a program that provides coverage when people need it to one that provides coverage only when states opt to dedicate resources to health coverage for low-income people, rather than to other parts of their budgets or tax cuts.

Capping enrollment is just one of the ways CMS could allow states to deviate from Medicaid rules in exchange for accepting caps on their federal funds. The Trump Administration has already approved waivers that lock people out of coverage if they don't meet work requirements, pay premiums that many Medicaid beneficiaries may have difficulty affording, or fill out paperwork on time, as well as approving waivers that erode Medicaid's affordability protections. For example, Kentucky has secured a waiver under which it doesn't have to seek further CMS approval if it decides to increase premiums on low-income adults, as long as the state keeps the premiums below

¹⁰ Judith Solomon, "Caps on Federal Medicaid Funding Would Give States Flexibility to Cut, Stymie Innovation," Center on Budget and Policy Priorities, January 18, 2017, <https://www.cbpp.org/research/health/caps-on-federal-medicaid-funding-would-give-states-flexibility-to-cut-stymie>.

¹¹ For additional examples, see Hannah Katch, "Restrictive Medicaid Policies Will Impede Innovation to Improve Care and Reduce Costs," Center on Budget and Policy Priorities, March 14, 2019, <https://www.cbpp.org/sites/default/files/atoms/files/3-14-19health.pdf>.

¹² Solomon, 2017.

4 percent of their income (a prohibitive level for some families that already face considerable difficulty paying rent, putting food on the table, and providing other necessities). And Michigan's approved waiver will allow it to impose premiums set at 5 percent of a person's income on some adults, the highest amount ever authorized. Premiums at this level are certain to decrease participation, research shows.¹³ New waiver guidance could allow states to impose still higher premiums and cost-sharing and lock out those unable to afford these costs, or simply invite more states to implement these harmful provisions.

Holding states to a lesser standard of oversight, as Administrator Verma has suggested, also would harm beneficiaries. An example is states' responsibility to oversee their managed care contracts to ensure that beneficiaries are getting the care they need. Nationally, over two-thirds of all Medicaid beneficiaries were enrolled in comprehensive managed care in 2016. Some states are now enrolling beneficiaries who need long-term services and supports into managed care, in addition to large numbers of children and other adults who are already enrolled.¹⁴ Recent news reports from Texas and Iowa illustrate the harm that can occur under managed care arrangements when beneficiaries don't get the care they need and states and the federal government don't fulfill their oversight responsibilities.¹⁵ Now, Utah is seeking waiver authority that would relax federal oversight of the state's managed care program, including CMS' oversight of how the state sets rates, CMS' review of Utah's contracts with health plans, and how the state demonstrates it is meeting the appropriate standards for access to care and the availability of services.

Cutting Medicaid enrollment would also have a significant impact on providers, increasing uncompensated care costs. Research shows that the ACA's Medicaid expansion has led to reductions in uncompensated care and improved operating margins in hospitals, especially rural hospitals, in states that have expanded Medicaid.¹⁶ Under the type of waivers CMS is now contemplating, the expanded flexibility and diminished federal oversight that states would receive in exchange for accepting capped federal funding would likely reverse some of this progress.

¹³ Laura Snyder and Robin Rudowitz, "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings," Kaiser Family Foundation, February 2013, <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings>.

¹⁴ As of 2016, 20 states had begun using managed care for beneficiaries needing long-term services and supports. Centers for Medicare & Medicaid Services, "Medicaid Managed Care Enrollment and Program Characteristics, 2016," Spring 2018, <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf>.

¹⁵ Tony Leys, "Paralyzed Iowan Wins Second Fight with Medicaid Managed-Care Company UnitedHealthcare," *Des Moines Register*, July 20, 2018, <https://www.desmoinesregister.com/story/news/health/2018/07/20/privatized-iowa-medicaid-paralyzed-iowan-jamie-campbell-wins-second-fight-against-unitedhealthcare/804117002/>; "Pain and Profit: Investigating Medicaid managed care in Texas," *Dallas Morning News*, June 20, 2018, <https://www.dallasnews.com/news/medicaid-managed-care/collection/pain-profit-investigating-medicaid-managed-care-texas>.

¹⁶ Jessica Schubel and Matt Broaddus, "Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect," Center on Budget and Policy Priorities, May 23, 2018, <https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage>.

Guidance Will Likely Invite Waivers That Increase States' Financial Risk

As explained above, block grant waivers are unlikely to feature the deep federal funding cuts that have been included in legislative proposals to convert Medicaid to a block grant or per capita cap. But even without those cuts, the waivers would likely be damaging to state budgets. That's because any waiver that imposes a rigid cap on federal funding will likely shift costs to states, making them solely responsible for unexpected costs that exceed the cap instead of sharing those costs with the federal government as they do today.

Administrator Verma has argued that block grant waivers won't hurt states, saying that a governor wouldn't agree to terms that put his or her state in a dire budgetary situation. But that doesn't mean that a waiver won't leave a state in a situation where it exhausts its federal funds and must cover — entirely on its own — significant health care costs that the federal government otherwise would share in, especially when the state experiences unexpected costs. Under a waiver with capped federal funding, a state may be quite limited in its ability to renegotiate with CMS if its Medicaid spending increases because of higher-than-anticipated costs for health care such as when new blockbuster prescription drugs like Sovaldi come to market, or because of a public health emergency, environmental disaster, or economic downturn. While states may seek to minimize their risk, CMS will likely push states to agree to rigid caps in exchange for new authorities.¹⁷

And capping federal funding would heighten the risks that would come from giving states new authority to restrict eligibility, cut benefits, or eliminate important affordability protections — since states will be more likely to use this authority if they face budget pressures from reduced federal funding. Federal funding caps also would exacerbate the risks to health providers, since states approaching their federal funding caps would likely cut provider payment rates, as well as eligibility, benefits, and/or important beneficiary protections.¹⁸

Waivers Can't Convert Medicaid Funding to Lump-Sum Block Grants

Some state policymakers appear to be under the misimpression that waivers could convert Medicaid funding into a traditional block grant, with the state receiving a specified amount of federal funding *regardless* of its own Medicaid spending. Tennessee's legislation, for example, proposes to convert federal funding into an "allotment," and Alaska policymakers appear to see a block grant as an opportunity to increase the state's federal funding.

But Medicaid waiver authority, as allowed in section 1115 of the Social Security Act, is not unlimited and does not authorize the Secretary to waive the requirement for states to provide their share of Medicaid funding. Under section 1115, the Secretary of Health and Human Services can only waive provisions in section 1902 of the Social Security Act. That section sets out the requirements and options that states must address in their Medicaid state plans, which provide the blueprint for the operation of state Medicaid programs. Section 1902 defines whom states must

¹⁷ Utah's waiver requesting a per capita cap illustrates how states may seek to limit their risk. There is no guarantee, however, that the Trump Administration will agree to the terms Utah is proposing, and even under Utah's proposal, the state would be taking on more financial risk than without the cap. See Solomon, 2019.

¹⁸ Because waivers are voluntary, a state can discontinue its waiver at any point as long as it provides CMS at least five months' notice and receives approval of a phase-out plan. In the event that a state is close to reaching its cap, it could simply end the waiver, at which point the cap would no longer apply. However, the state would likely have to give up other features of its waiver that it received in exchange for agreeing to a cap on federal funds.

cover and whom they can opt to cover, what benefits they must provide (and what benefits they can opt to provide), the processes for determining eligibility, various beneficiary protections, and various requirements and options for the delivery of health care services.

But to alter Medicaid’s financing structure — including the requirements for state funds — the Secretary would have to waive a provision in *section 1903* of the Social Security Act, which governs how Medicaid is financed and which requires the federal government to pay states (on a quarterly basis) a fixed percentage of the amount the state spends to provide health care services to eligible beneficiaries. And the Secretary *cannot grant waivers of section 1903* and hence can’t approve waivers that alter Medicaid’s basic financing structure. (Section 1903 of the Act is not among the enumerated sections that can be waived under section 1115 demonstration authority.)

In addition, longstanding policy requires that Medicaid waivers be budget neutral to the federal government; they cannot cost the federal government more than it would have spent without the waiver. This means the federal government cannot agree to provide a state with higher-than-anticipated funding over the life of a waiver, only the same or lower funding.

Measuring Health Outcomes Won’t Protect Beneficiaries From Loss of Coverage and Services

Administrator Verma has said the new waiver authority would substitute state accountability for health outcomes for state accountability for complying with Medicaid standards and CMS oversight of states’ adherence to those standards. Yet measurement of health outcomes is no substitute for Medicaid standards and protections and CMS oversight of state programs.

First, it’s challenging to reliably establish whether Medicaid changes as a result of implementing a waiver are worsening health outcomes. That’s especially true when people have gaps in their health coverage, since quality measures generally only include the assessment of the health care delivered to people who are enrolled for an entire year or most of the year. Moreover, even if it were possible to measure everyone’s health outcomes, results wouldn’t be available on a timely basis, so beneficiaries could experience significant harm while the outcomes were being evaluated. CMS’ evaluation guidance includes a timeline for an interim evaluation three years after waiver approval and a final evaluation at the end of five years.¹⁹ Moreover, as noted earlier, changes in health outcomes that may result from gaining or losing access to care can take years or even decades to manifest themselves and thus wouldn’t show up in these evaluations.

On top of that, Verma’s apparently singular focus on health outcomes ignores the fact that, as Congress intended, Medicaid also provides families with financial security. In overturning Kentucky’s CMS-approved Medicaid waiver, a federal district judge pointed out that “promoting health is not the only reason Congress wanted to provide health insurance to needy populations. It also had an interest in making healthcare more *affordable* for such people.”²⁰ Survey respondents in

¹⁹ Centers for Medicare & Medicaid Services, “Section 1115 Demonstrations: Developing the Evaluation Design,” <https://www.medicare.gov/medicaid/section-1115-demo/downloads/evaluation-reports/developing-the-evaluation-design.pdf>.

²⁰ *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018).

Medicaid expansion states reported having fewer debts and better credit than respondents in states that hadn't expanded.²¹ Medicaid expansion also reduced the rate of evictions, according to a recent study.²²

Finally, a large body of research showing the benefits of Medicaid coverage has already refuted the claim that health outcomes would improve or stay the same for beneficiaries who lose coverage or are offered worse or less affordable coverage; this doesn't need to be tested through new waivers. For example, research finds that having Medicaid coverage improves access to care, including access to preventive services and treatment.²³ Access to preventive care leads to earlier diagnosis of chronic conditions like cancer, diabetes, and mental illness. In addition, access to physicians, prescription drugs, and other services makes treatment and better outcomes more likely.²⁴ Making it harder for people to access coverage by imposing premiums or high cost sharing on low-income people would reduce their participation in health coverage and their use of necessary health care services, reversing the positive outcomes of having affordable health coverage.²⁵

“Block Grant” Guidance Will Likely Raise Legal Issues

Contrary to what some have argued, there's no precedent for a block grant waiver. Proponents of block grants and per capita caps often cite Medicaid waivers in Rhode Island and Vermont as precedents for Medicaid block grants that saved both the state and the federal government money without hurting beneficiaries. But these claims are misguided. While these waivers used varying approaches to lower state Medicaid spending, *neither* waiver (1) created a block grant; (2) included a reduction or rigid constraint on federal funding; or (3) gave the state new authority to cut eligibility or benefits (see box).

The statute states that section 1115 waiver authority is for demonstration projects that “assist in promoting the objectives of [Medicaid].” This statutory requirement is more subjective than the statutory restriction limiting waiver authority to provisions in section 1902, and it is the section 1115 authority that the Trump Administration is trying to leverage as justification for unprecedented waiver approvals that take coverage away from people who do not comply with work requirements, pay premiums, or renew their coverage on time. But the only federal court that has ruled to date on

²¹ “Chart Book: The Far-Reaching Benefits of the Affordable Care Act’s Medicaid Expansion,” Center on Budget and Policy Priorities, October 2, 2018, <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid>.

²² Heidi Allen, Tal Gross, and Naomi Zewde, “Health Insurance and Housing Stability: The Effect of Medicaid Expansion on Eviction,” January 19, 2019, <https://sswr.confex.com/sswr/2019/webprogram/Paper35675.html>.

²³ “Chart Book”; Larisse Antonisse *et al.*, “The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review,” Kaiser Family Foundation, March 28, 2018, <https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/>.

²⁴ Julia Paradise, “Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid,” Kaiser Family Foundation, March 23, 2017, <https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/>.

²⁵ Snyder and Rudowitz.

these new types of restrictive waiver proposals has disagreed with the Trump Administration's attempt to justify coverage losses as being consistent with the Medicaid program's objectives.²⁶

Despite this federal court ruling, the Administration has made clear that it plans to continue approving waivers that include restrictive policies that jeopardize Medicaid's coverage guarantee.²⁷ CMS' approval of Utah's waiver, with its unprecedented authority to deny coverage to eligible people based on a state-set budget target, is the latest example. Waivers that jeopardize Medicaid's coverage guarantee by denying coverage based on funding caps or targets, allow states to deny coverage or health benefits that federal Medicaid law mandates, or eliminate important beneficiary protections (as part of a deal to cap federal funds) almost certainly will also be subject to legal challenge.

²⁶ The court twice vacated approval of a waiver that CMS granted to Kentucky, which included a work requirement and other restrictions on coverage, and also struck down CMS' approval of Arkansas' work requirement. The federal government and both states have appealed these decisions.

²⁷ Michelle Stein, "Verma: Court, GAO 1115 Concerns Won't Change Policy Direction," *Inside Health Policy*, May 27, 2019, <https://insidehealthpolicy.com/daily-news/verma-court-gao-1115-concerns-won%E2%80%99t-change-policy-direction>.

Medicaid Waivers in Rhode Island and Vermont Didn't Include a "Block Grant"

During the George W. Bush Administration, CMS approved waivers in Rhode Island and Vermont that tested new approaches in operating their Medicaid programs. These new approaches did not include a "block grant."

First, neither state received authority to change Medicaid's basic financing structure. The Rhode Island waiver is most likely described as a block grant because the state's waiver *application* included a request to "deviate" from the traditional open-ended Medicaid financing approach and to "receive federal financial participation through a fixed allotment ... based on projected Rhode Island Medicaid costs."^a Rather than approving this request, however, the Bush Administration made clear in the waiver's terms and conditions that it would continue to provide federal matching funds at the applicable rate for Rhode Island's Medicaid costs.^b

Moreover, neither Rhode Island nor Vermont accepted a reduction or rigid constraint on its federal funds. Rhode Island and Vermont were never at risk of incurring unanticipated state costs, because the aggregate cap that each state negotiated with CMS was set at a level far above what each state would have spent on Medicaid in the absence of the waiver.^c

Finally, neither state was given the authority to keep eligible people out of the program or cut their benefits. In fact, both states used their Medicaid waivers to *expand* coverage and health care services that wouldn't otherwise be available. Vermont said its waiver was "specifically designed to put in place a series of health coverage options to achieve the goal of universal access to health care in Vermont."^d

^a State of Rhode Island, "Application for the Rhode Island Consumer Choice Global Compact Waiver," August 7, 2008, <http://www.ohhs.ri.gov/medicaid/pdf/TheRIGlobalConsumerCompactGlobalWaiverFinal082808.pdf>.

^b Centers for Medicare & Medicaid Services, "Special Terms and Conditions: The Global Consumer Choice," January 16, 2009, <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-stc-01162009-12312013-amended-122009.pdf>.

^c United States Government Accountability Office, "Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency," June 2013, <https://www.gao.gov/assets/660/655483.pdf>.

^d State of Vermont, Global Commitment to Health application, April 15, 2005, http://dvha.vermont.gov/global-commitment-to-health/vermontfinalwaiver_041505.pdf.