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Medicaid Block Grants: Lessons from Rhode Island's Global Waiver

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Introduction

Medicaid block grants have been a popular topic in the news and other public forums in the past several years. Representative Paul Ryan included provisions for block granting Medicaid in the 2012, 2013, and 2014 House budget proposals (Ryan 2011, 2012, 2014), and Mitt Romney drew from these proposals during his presidential campaign (Romney 2012). A number of governors have also asked the federal government to switch Medicaid funding from its current matching rate arrangement to a block grant structure. This request is predicated on the idea that block grants would give states more flexibility to run their Medicaid programs according to state-specific needs while reducing costs.

This brief provides the context for the Medicaid block grant debate and uses the Rhode Island Global Consumer Choice Compact Medicaid Waiver ("Global Waiver") as a case study. Specifically, this brief highlights several select findings regarding the structure and implementation of the Global Waiver relevant to the block grant debate and health reform generally.

Background

Traditional Medicaid Structure

Currently, Medicaid is an entitlement program, wherein the federal government has an open-ended commitment to match state governments' spending, and state governments must provide coverage to all who are eligible under state law until such time as state law is modified, albeit within limits established by federal statutes and regulations. The federal government provides a portion of the funding at a particular rate, determined on a state-by-state basis, and this federal match ("Federal Medical Assistance Percentage" or "FMAP") is guaranteed. For example, in Minnesota, the federal government covers 50 percent of total program costs; in Rhode Island, the federal matching rate is 52.12 percent; and in Mississippi, 74.18 percent.

In return for the federal contribution, states are required to cover certain groups of people and provide certain benefits. Mandatory populations include children, pregnant women, and parents with dependent children within specific income brackets. Mandatory benefits include services such as inpatient hospital care, nursing facility care,

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The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues at a state level, with a focus on state-level implementation of the Affordable Care Act (ACA) and other efforts designed to increase coverage and access. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.shadac.org/share.

prenatal care, laboratory services, and childhood vaccinations. States can also choose to cover a number of optional populations and services beyond federal minimums.

How Block Grants Would Change this Structure

Block grants would end the federal matching rate approach to Medicaid funding—and typically also its mandate to cover particular groups and benefits. Instead, states would be provided with an annual lump sum of federal money that they could use to structure Medicaid on their own terms, determining eligibility and benefits themselves. Some proposals call for a national Medicaid spending allotment that would be set each year, with a formula to determine each state's share of the allotment. Under other proposals, each state could be given a capped amount of funding based on a specified calculation or formula, with no predetermined national grant amount. Whether state or national, these funding allotments would be adjusted annually in order to reflect demographic and economic factors (e.g., size of the Medicaid population, GDP per capita, inflation) (Park & Broaddus 2011).

The Case for Block Grants

Block grant proponents cite several reasons for changing the Medicaid payment structure. First, supporters suggest that state governments are in a better position than the federal government to decide where to appropriate funds to create the greatest impact. Proponents also maintain that state governments can best meet people's needs when the states are free to experiment, innovate, and develop policy approaches without burdensome oversight from the federal government. Finally, block grant advocates argue that a benefit of a national Medicaid spending allotment is that the federal government would know with certainty the amount of money it would pay for Medicaid every year.

The Case against Block Grants

Opponents of block-granting Medicaid argue that it would make the program more financially unpredictable and risky for states, which would be on the hook for unanticipated Medicaid cost increases – such as those resulting from recession-related enrollment growth – after their block grant allocations are depleted. Currently, the federal government covers half to three-quarters or more of such unanticipated costs (depending on a state's matching rate) on an open-ended basis. Under a block grant scenario, the depletion of grant funds would force states to do one of two things: (1) contribute more state funding through tax increases or cuts to other programs; or (2) institute cuts in eligibility, benefits, and/or provider reimbursement rates. Block grant opponents also point out that states with lower FMAPs would receive less initial funding than other states under a block grant scenario, essentially locking in existing funding variations across state Medicaid programs. Lastly, opponents of block grants fear that states would loosen their benefit standards without federally-mandated minimums (a scenario sometimes referred to as a "race to the bottom"), contributing further to inter-state variation in people's ability to receive medical care.

Case Study: Rhode Island

Rhode Island is often viewed as the poster child for Medicaid block grant success (Alexander 2011). Like many other states, Rhode Island has experienced pressure from the size of its Medicaid program. In fiscal year 2006, more than one-fifth of the state's population was enrolled in Medicaid and the program cost about $800 million, or about one-quarter of the state's budget (Executive Office of Health and Human Services 2007). In an attempt to reign in state Medicaid costs, Republican Governor Donald Carciari pushed for an arrangement under which Rhode Island could operate its Medicaid program under one section 1115 demonstration waiver (Centers for Medicare and Medicaid Services 2011), claiming $67 million in potential savings in the first year alone. The waiver request Rhode Island submitted to the Centers for Medicare and Medicaid Services (CMS) asked that the state receive a fixed, up-front federal allotment without a required state match. In lieu of a state match, the waiver included a "maintenance of effort" provision, under which the state would allocate 23 percent of its general revenue budget to the Medicaid program each year. After several months of negotiations, CMS gave its official approval for the "Rhode Island Global Consumer Choice Compact" on January 16, 2009, albeit with a different financing structure than requested by the state.

The Rhode Island Global Consumer Choice Compact

The Rhode Island Global Consumer Choice Compact Medicaid Waiver ("Global Waiver") allowed Rhode Island to run its entire Medicaid program under a single 1115 demonstration waiver, rather than the eleven waivers under which the program had operated previously. Prior to 2009, administration of Medicaid was spread across five different state departments, and officials hoped that, by operating as a single, overarching waiver for Rhode Island's Medicaid program, the Global Waiver would reduce the number of silos under which the program operated (Executive Office of Health and Human Services 2008, Alexander 2011). The Global Waiver also implemented mandatory enrollment in Medicaid managed care for all those without third-party medical coverage. In addition, the waiver permitted Rhode Island to use different eligibility standards and, potentially, higher cost-sharing requirements than are typically allowed by CMS. Finally, the Global Waiver emphasized rebalancing long-term care and updating its provider payment methodology ("smart purchasing").

The following case study describes the final structure of Rhode Island's Global Waiver and identifies lessons learned from the waiver development and implementation process for the Medicaid block grant debate and health reform generally.

Methods

This study sought to characterize and assess the final structure and implementation of the Global Waiver. The Global Waiver was evaluated to judge its resemblance to typical block grant proposals and assess its financial and administrative impact. Stakeholder input and influence on the waiver, as well as factors that facilitated or impeded implementation, were also evaluated.

Twenty-six semi-structured key stakeholder interviews with thirty individuals were conducted from March 17 to May 28, 2010. Interview subjects were chosen through a combination of purposive and snowball sampling. Interviewees were recruited from different stakeholder backgrounds to ensure representation of varying viewpoints about Medicaid and the Global Waiver. Interview subjects included legislative staff (2 individuals), current and former officials within pertinent agencies (7 individuals), consumer advocates (10 individuals), provider representatives (8 individuals), and other knowledgeable observers (3 individuals). Each interview was initially coded to identify recurring themes and patterns, and then recoded after a full set of codes was developed and finalized. Information from more than 375 archival sources published between 2007 and 2013 was used to corroborate the descriptions and perspectives of key informants, as well as to provide historical background on Rhode Island's Medicaid program and the Global Waiver.

Findings

The Global Waiver Is Not a Block Grant

The results from Rhode Island's Global Waiver are often cited as evidence of the success of block-granting Medicaid, but the waiver does not stand as an example of an actual block grant. There are several key reasons for this.

First, the final waiver approved by CMS does not include the block grant structure. While the waiver does cap the federal government's funding commitment like a block grant, federal financing is not provided as a lump-sum allotment. Instead, Rhode Island's Medicaid program still uses an FMAP structure where the state has to spend the first dollar, drawing down over time against an aggregate state and federal funding cap of $12.1 billion over five years. Rhode Island also purposefully built a cushion into its fiscal projections and the Global Waiver was much more generous than typical block grant proposals.

Second, the waiver allows increased flexibility in some areas of the state's Medicaid program; block grants, on the other hand, would allow increased flexibility across the entire span of a state's Medicaid program. For example, the state arranged Special Terms and Conditions with CMS that specified what types of changes Rhode Island could make without requesting approval. If, however, the state wanted to make changes that were not listed in the Special Terms and Conditions, such changes would be subject to a new three-tier federal oversight system (CMS 2011). In addition, the state legislature increased its oversight role, and now all but simple administrative changes must be

reviewed by the legislature before moving forward for federal approval (Peoples 2009).

Finally, Rhode Island's waiver expires on January 1, 2014, though the state is currently applying for renewal, and Rhode Island can terminate the waiver at any time. In contrast, block grants are generally permanent with no state option to revert back to regular Medicaid (Cross-Call & Solomon 2011).

Savings Are Not Attributable to the Waiver

Rhode Island reduced its total spending by $65.7 million in the first two years of Global Waiver implementation (The Lewin Group 2011). The savings, however, are not necessarily the result of the federal cap itself, but a result of external funding and other changes that could have been instituted without the pseudo-block grant structure. Moreover, as part of the Global Waiver, CMS granted Rhode Island up to $22 million annually in federally matching funds, or Costs Not Otherwise Matchable (CNOMs), for populations and services previously covered just by the state. CNOMs were critical to maintaining services levels and benefits that would have otherwise been cut or eliminated due to budget constraints. Also important was the American Recovery and Reinvestment Act which substantially increased the federal government's payments to Rhode Island's Medicaid program from October 2008 to June 2011, ultimately contributing $523 million to the state. Between the federal stimulus, CNOM dollars, and a generous global cap, the federal government actually spent more money under the Global Waiver than it would have spent otherwise, allowing Rhode Island to reduce state spending primarily through an influx of federal dollars rather than through any programmatic cost-savings mechanisms established under the Global Waiver.

Lack of Transparency during Waiver Development Impeded Implementation

Rhode Island's Global Waiver was promoted as an efficient way to specifically target the needs of the state's population. Several study participants, however, reported very few opportunities for provider representatives, consumer advocates, and the general public to provide input during waiver development. When opportunities to comment on the waiver's design were provided, stakeholders found it difficult to offer feedback due to the lack of specifics. Respondents also expressed concern that decisions made about the Global Waiver were focused more on cutting costs than on achieving savings and improving care through programmatic changes. Ultimately, stakeholder concerns were deepened due to the perceived lack of community involvement and transparency, creating distrust that made for a more challenging implementation environment. For example, respondents indicated that this distrust helped to spur oversight legislation that requires state legislative review of most Medicaid program changes. Additionally, respondents reported that once the waiver was approved by CMS, lack of effective dialogue between community stakeholders and state officials continued to be an issue, a dynamic attributed, in part, to a short-handed state bureaucracy.

State Agencies Had Insufficient Administrative Resources for Implementation

Respondents from state agencies responsible for administering Medicaid expressed concern about lacking the necessary administrative resources to implement the Global Waiver. Between July 1 and December 31, 2008, the workforce of the five state agencies in charge of Medicaid fell by 426, largely due to changes in the state's retirement system. A number of senior administrators had also left the agencies, leaving a lack of experienced leadership, and state budget constraints impeded filling both new and old administrative positions essential to implementing the waiver. According to respondents, the shortage in administrative personnel increased stress among remaining staff, hampering their ability to complete even day-to-day functions, let alone the added burdens associated with the waiver.

State Agencies Had Insufficient Information Processing Capacity for Implementation

Interviewed stakeholders reported that Rhode Island lacked the information processing capacity to effectively administer the Global Waiver. Mainly, the agencies were using outdated technology that hampered program eligibility and quality assurance processes and did not allow for timely access to the data required to follow and evaluate progress on achieving program goals. The state needed to update its network and hardware and software resources; establish data-sharing

across agencies; introduce centralized monitoring and decrease redundancy; and institute a centralized portal for all health and human services programs. There was also dissatisfaction that the initial emphasis was on identifying spending and utilization trends and not on documenting the scope and quality of beneficiaries' experiences.

Discussion

The Global Waiver offers few insights to inform the greater Medicaid block grant debate. Rhode Island and several other states have utilized waivers that contain key elements of a block grant, but, as of this writing, no state has implemented a true block grant. Indeed, the Global Waiver is sufficiently different that it does not provide evidence to either support or oppose block-granting Medicaid. Financially, the Global Waiver is much more generous than a block grant would be and, as such, has failed to generate savings to the federal government which has, in fact, spent more during the time period in which the Global waiver has been in effect than spent previously. This is in marked contrast to most block grant proposals, which would substantially reduce the level of federal fiscal support (and without permitting states to back out of the waiver, as Rhode Island could have done).

What we do know about block granting Medicaid indicates that this strategy should be approached carefully, especially given the current state of the economy and pressure on state budgets. States have already pursued aggressive cost containment and delivery system reform within Medicaid, particularly in light of the recent recession and slow recovery. Because there is so little excess in the current system, the marked reductions in federal spending that would result from turning Medicaid into a block grant could have severe negative consequences, not only for state budgets but for provider reimbursement, beneficiary access and quality, and program benefits and eligibility. Reducing the funding commitment of the federal government could also lead to fewer states expanding the program to those with family incomes up to 138 percent of the Federal Poverty Level as allowed under the Affordable Care Act.

The question of block grants aside, this analysis of the Global Waiver offers several general lessons about the process of developing and implementing Medicaid waivers. The first lesson is that waiver development and implementation can benefit from a collaborative effort between stakeholders and the state. It is important that stakeholder input be integrated throughout the entire process – from the state's design of the waiver application through federal approval and implementation – to avoid generating stakeholder distrust and creating a more challenging implementation environment for program administrators. Community stakeholders have unique knowledge and expertise regarding the needs and preferences of Medicaid eligible populations and the providers that serve them. It is critical that state administrators draw upon this resource to further program improvement.

Another lesson that can be drawn from the Global Waiver process is that adequate state agency resources are important to successful implementation. In the future, states would benefit from assessing whether their agencies can take on new functions and responsibilities without harming existing programs, what types of new personnel and information processing capacity may be needed, and whether there are sufficient resources to fill in the gaps *before* instituting large program changes.

Conclusion

Rhode Island's Global Waiver excluded some key characteristics of a block grant. The waiver maintained the traditional FMAP structure, did not substantially increase the state's flexibility to administer the Medicaid program, and provided the option for the state to allow the arrangement to expire after five years or to withdraw at any time if the waiver became untenable. Like Medicaid block grants, however, Rhode Island's Global Waiver was promoted as an efficient way to specifically target the needs of the state's population. Yet key informants reported that state officials have largely focused on relieving the burden on the state treasury with significant programmatic improvement remaining elusive. Finally, in contrast to the Global Waiver, block grants would markedly reduce rather than increase federal Medicaid spending, suggesting even greater emphasis on financial retrenchment over programmatic improvement in Rhode Island and other states should the Medicaid program be

reformed along the lines favored by Congressman Ryan and other block grant advocates.

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