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Implications of Rhode Island's Global Consumer Choice Compact Medicaid Waiver for Block Granting Medicaid and Other Retrenchment[1]

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Abstract

On January 16, 2009, the Federal government approved Rhode Island's application for a Global Consumer Choice Compact Medicaid Waiver whereby the state became the first granted permission to operate its entire Medicaid program under the state plan and a single 1115 "research and demonstration" waiver. The Global Waiver has been implemented in the context of Republican proposals to turn Medicaid into a block grant which would give states substantially more flexibility administering the program in exchange for receiving an upfront allotment from the Federal government. Proponents have held up the Global Waiver as a successful example of what might be achieved nationally if all states received block grants to run their Medicaid programs. This study draws lessons from Rhode Island's Global Waiver for the Medicaid block grant debate. Data derive from 325 archival sources and 26 semi-structured interviews. Results indicate that the Global Waiver is not a block grant but a capped federal match where the state is required to spend its own money before receiving the federal contribution. Moreover, the state did not receive unlimited discretion to administer Medicaid under the Global Waiver nor achieved nearly as much savings as has been claimed. Indeed, most savings obtained by Rhode Island during this time period derive not from efficiencies stemming from the Global Waiver but from increased federal spending and from measures the state could have implemented independently of the waiver. The generosity of the Global Waiver is in marked contrast to most block grant proposals which would substantially reduce the level of federal fiscal support. In the near future, turning Medicaid into a block grant is not going to occur in light of President Obama's reelection. Identifying the implications of RI's experience for Medicaid retrenchment and the block grant debate is important, however, as some states eschew expanding the program under the Affordable Care Act and as proponents continue to propose block grant approach to Medicaid reform, both in future budget proposals and presidential party platforms.

Introduction

Medicaid is the jointly funded federal-state health insurance program for the poor and disabled. Although administered by the states, the federal government matches state Medicaid spending at a rate determined by the Federal Medical Assistance Percentage (FMAP), which currently ranges from 50.0% to 73.4%, and is dependent on state per capita income (Snyder et al. 2012). Medicaid provides coverage for more than 62 million low income individuals or approximately one in five Americans (Kaiser Family Foundation May 2012). As the largest federal grant-in-aid program, total expenditures reached $389 billion in 2010 (Centers for Medicare and Medicaid Services [CMS] 2011). Medicaid is also the largest fiscal item in state budgets, accounting for 21.8% of total spending (National Association of State Budget Officers 2010). Annual growth in states' Medicaid expenditures has exceeded growth in revenues, thereby causing Medicaid to consume increasingly larger proportions of state budgets. This has forced a tradeoff with other priorities since all states but Vermont must balance their budgets.

Like other states, Rhode Island (RI) has faced considerable pressure to restrain Medicaid spending. In state fiscal year (FY) 2006, more than one-fifth of the state's population obtained health insurance coverage from Medicaid (Executive Office of Health and Human Services [EOHHS] 2007). This included 15% of the state's elderly residents and 40% of its school aged children. That year, the program constituted about $800 million or approximately one-quarter of the state's budget (EOHHS 2007). Given that the state projected a structural deficit of more than $350 million over 5 years and that Medicaid spending growth far exceeded general revenue growth, Medicaid stood at the forefront of state budget discussions (EOHHS 2007). It is in this context that Republican Governor Donald Carceri submitted his administration's Global Consumer Choice Compact Medicaid Waiver application to CMS, the federal agency responsible for administering Medicaid, on August 8, 2008.

The state originally asked for the provision of a fixed, upfront federal allotment or block grant that would no longer require a state match. It instead proposed a state maintenance of effort provision where RI would continue to allocate 23% of its general revenue budget to the Medicaid program every year. CMS gave its official approval on January 16, 2009, the waiver's official start date. Rhode Island became the first state granted permission from the federal government to operate virtually all of Medicaid under the state plan and a single 1115 "research and demonstration" waiver, with the exceptions being disproportionate share hospital payments and local education agency funding. Prior to the Global Waiver, Rhode Island's Medicaid program operated under the state plan and multiple waiver authorities.

The final version of the Global Waiver approved by CMS and implemented by the state beginning July 1, 2012 did not include the block grant structure. It instead set a cap whereby the state agreed to limit federal fiscal participation to a level no higher than the federal share of total state and federal spending of $12.075 billion over a five year demonstration period in exchange for the ability to make certain program changes. This five year budget was based on historical caseload and health utilization trends, accounting for a 7.8% rate of program growth. This kept Medicaid's traditional funding structure intact, with the state having to spend a dollar first in order to receive the federal match. The Global Consumer Choice Compact Waiver has been implemented in the context of proposals to revamp Medicaid via the block grant strategy.

The Medicaid Block Grant Debate

Republican Congressman, House Budget Committee Chair and former Vice Presidential candidate Paul Ryan included provisions block granting Medicaid in the Fiscal Year (FY) 2012 and 2013 House budget proposals (Ryan 2011, 2012). Both these proposals, which also would

have repealed the Patient Protection and Affordable Care Act of 2010, passed the Republican controlled House of Representatives along a party line vote, a year after being proposed as part of a deficit reduction plan developed by Congressman Ryan with Alice Rivlin of the Brookings Institution (Rivlin and Ryan 2010). Former Massachusetts Governor and unsuccessful Republican Presidential candidate Mitt Romney drew from these proposals, with his economic plan claiming that "block grants have huge potential to generate both superior results and cost savings by establishing local control and promoting innovation" (Romney 2012). Romney even mentioned the potential of the block grant concept during the last Presidential debate, arguing that "states like Arizona, Rhode Island have taken these, these Medicaid dollars, [and] have shown they can run these programs more cost-effectively" (Millman 2012). Romney also famously promised to repeal "ObamaCare" on day one. These proposals to block grant Medicaid were made less than ten years after the George W. Bush Administration's 2003 proposal to do so (Guyer 2003; Thompson 2012). Moreover, the Bush Administration's proposal came less than ten years after the House Republican majority's 1995 Medigrant proposal, which, in turn, came 15 years after the block grant proposal put forth by the Reagan administration in 1981 (Lambrew 2005; Holahan and Liska 1995; Thompson 2012).

Although each block grant proposal would provide states a fixed allotment of federal funding in exchange for considerably greater flexibility over program eligibility, benefits, payments, and structure, the most recent proposals put forth by Congressmen and others are considerably less generous than those put forth previously. Federal allotments under the 1981 Reagan administration proposal would have equaled federal spending at FY 1981 levels plus 9%, adjusted in subsequent years for the Gross National Product's price deflator, an indicator of economic growth. Federal allotments under the 1995 House Republican proposal would have been determined by a complicated formula based on historical spending adjusted annually for state input costs, case mix, and number of poor people, subject to an overall, aggregate cap on federal Medicaid expenditures (Lambrew 2005). Under the 2003 Bush Administration proposal, spending levels in FY 2002 would have been used as the base from which federal allotments would be determined. These would have then been increased by 8.5% per year, the average Medicaid growth rate at the time. The Romney plan, by contrast, suggested that "Medicaid spending should be capped and increased each year by CPI [Consumer Price Index] +1%" (Romney 2012). Increases under the 2012 and 2013 House budget plans would have been limited to the CPI only while those under the 2010 Ryan-Rivlin plan to the GDP per capita plus +1%. An even less generous proposal put forward by the House Republican Study Committee would have fixed funding at 2012 spending levels with no subsequent adjustments for inflation or increases in health care costs (House Republican Study Committee 2012).

There are several reasons proponents cite to support delegating further responsibilities to the states by block granting the Medicaid program (Davidson 1997; Labrew 2005; Anonymous 2003; Holahan and Weil 2003; Leichter 2008; Miller 2002; Rivlin and Ryan 2010; Ryan 2011, 2012)**.** Most obviously, it would provide the federal government with fiscal certainty regarding the amount that would need to be paid out in any given year. Additionally, it theoretically offers those government officials "closest to the people" greater freedom to appropriate funds where they might have the most beneficial impact. This is both because doing takes advantage of experience state and local officials have in managing day-to-day program operations, and because state and locally run programs tend to be less rigid and bureaucratic than their nationally administered counterparts. It is also because state and locally administered programs best account for local norms, circumstances, values, and standards, say, with regard to the amount of

funding allocated and service delivery options made available. Proponents further believe that the additional flexibility provided by a block grant would enable states to reshape Medicaid to promote greater personal responsibility, thereby mirroring trends visible in the private health insurance market. For example, greater cost sharing could be imposed, and benefit packages made to more closely resemble private insurance benefits to better preclude crowd-out of the private market. Moreover, block grant enthusiasts express confidence in the capacities of state and local officials to experiment, innovate, and ultimately develop policy approaches that best meet people's needs and preferences when freed from constraints otherwise placed on them by the federal government.

There are several reasons opponents cite to oppose delegating greater state control of health policy under the block grant strategy (Davidson 1997; Anonymous 2003; Holahan and Weil 2003; Lambrew 2005; Miller 2002; Park 2011; Holahan, et al. October 2012). Those opposing block granting Medicaid fear marked reductions in federal fiscal support for the vulnerable populations Medicaid serves. It is feared that growth in state allotments would fail to keep pace with increases in health and medical costs over time. It is also feared that state allotments would fail to keep pace with growth in Medicaid enrollment, particularly during economic downturns. The result would be a gradual shifting of costs from the federal to state and local governments, providers, and programs beneficiaries over time. Opponents of block grants also fear a race-to-the bottom if national standards are loosened and a growing proportion of the financial burden falls to the states. States already exhibit considerable discretion when administering Medicaid, resulting in substantial cross-state variation in program spending, eligibility, benefits, provider payments, and service delivery system characteristics nationally (Miller 2002; Snyder, et al. 2012). This variation would increase dramatically as state political, economic, programmatic, and cultural characteristics became even more determinative of state policy making in this area. Fundamentally, opponents believe that it is the responsibility of the federal government to reduce interstate variation, or to bring it within a reasonable or acceptable range, so that the locus of one's birth or residency does not influence one's ability to receive health and medical care as a result of states' varying commitments and willingness to act.

In a January 2011 report, former EOHHS Secretary Gary Alexander claimed that RI's Global Consumer Choice Compact Waiver represented a model for entitlement reform throughout the nation (Alexander 2011). He claimed that in exchange for the aggregate cap agreed upon with the federal government, the state received "unprecedented flexibility and some relief from onerous federal rules" to "tailor its program to meet the needs of its population." He also claimed that the waiver enabled the state to achieve $100 million in savings during the first 18 months, a figured he projected to reach $146 million over two years. Despite doubt's in RI about the veracity of Alexander's conclusions (Hall 2011; Levy 2011; Pugh 2011), conservatives have held up the Global Waiver as a successful example of what might be achieved nationally if all states received block grants to run their Medicaid programs (Anonymous 2011; Roberts 2011; Pugh 2011; Lawless and Ferrier 2011; Senate Finance Committee 2011; Volsky 2011; Romney 2012; Ryan 2011, 2012).

Because RI is the first state to receive permission to operate its entire Medicaid program under a global cap it has entered the national consciousness as a key data point potentially supporting the block grant approach to Medicaid reform. Block grant advocates' hope that this basic concept will spread from RI to other states. This study draws lessons from the design and implementation of RI's Global Consumer Choice Compact Medicaid Waiver for federal block grant initiatives and other proposals that seek to retrench the program.

Methods

This study relies on two primary sources of data: archival documents and in-depth open-ended interviews with key stakeholders. The interviews were undertaken with people chosen through a combination of purposive and snowball sampling (Patton 2002). Thus, selection of subjects was initially based on our own knowledge about RI and the Medicaid program but later on information provided by our respondents regarding additional actors who should be interviewed about the design and implementation of the Global Waiver. Twenty-six semi-structured interviews were conducted with 30 individuals from March 17, 2010 through May 28, 2010. Two interviews included two subjects each (two consumer advocates; two executive branch officials); one interview included three subjects (three state officials). Interviews were about one hour long. Interview subjects included: legislative staff (2 individuals); current and former officials within the pertinent executive/administrative agencies (7 individuals); consumer advocates representing different populations (e.g., the elderly, developmentally disabled, mentally ill, physically disabled, children and families) (10 individuals); provider representatives representing different service modalities (e.g., nursing homes, home care, managed care, shared living, community providers) (8 individuals); and other knowledgeable observers (3 individuals) (i.e., consultant, other executive branch officials).

Stakeholders representing different backgrounds were recruited as interview subjects to ensure representation of varying points of view about Medicaid and the Global Waiver (Glaser and Strauss 1967). Use of a diverse sample is important because the greater the degree to which the perceptions of people about a particular phenomenon converge, the more likely that they provide a reasonably accurate portrayal of the process studied (Jick 1979). Use of a diverse sample also is important because employing multiple types of informants minimizes the threat of single-source information bias while maximizing the breadth of the information consulted (Pothas and de Wet 2000).

Through our interviews we sought to identify what factors contributed to the design of the Global Waiver. This includes the purpose of the waiver and the reactions of government officials and other interested actors. We also sought to understand factors influencing subsequent approval and oversight of the Global Waiver by the federal government. This includes negotiations between state and federal officials that resulted in changes to the state's waiver application. We further sought to understand factors facilitating and/or impeding implementation of the Global Waiver. This includes the role of the economic recession, state budget crisis, and federal stimulus package, and other factors in this regard. All interviews were recorded and transcribed. Each transcript was coded to identify recurring themes and patterns in responses (Miles and Huberman 1994). This was an emergent process to the extent that we formulated new categories and revised old ones as we read the transcripts. Once a full set of codes were developed, we went back and recoded all transcripts using the common set of themes developed. Quotes illustrative of each theme identified for each major programmatic phase—waiver development, federal approval, and program implementation—were excerpted (See Table).

[Table about Here]

In addition to analyzing interview transcripts, more than 325 archival sources published between 2007 and 2012 were reviewed. Pertinent statutes and regulations about Medicaid and the Global Waiver were identified and collected; so too were relevant government reports, press releases, letters, and other documents. Information was collected from consumer advocacy groups, provider organizations, and other non-governmental entities, in addition to articles published in the *Providence Journal* and other news sources. This information was used to cross-

validate the descriptions and perspectives of key informants (Jick 1979), corroborating accounts given by interviewees through independent verification in alternative sources. They also provided historical background on Rhode Island's Medicaid program and the Global Waiver.

Findings

Phase 1. Waiver Development

The Global Waiver derived largely from political and ideological alignment between RI's Republican Governor and the George W. Bush administration which had long advocated block granting the program. The lack of specifics provided during the waiver development process exacerbated stakeholder concerns about the block grant strategy pursued.

1.a. *The Global Waiver Was Politically and Ideologically Motivated*

In light of perceived challenges, RI would have been unlikely to propose its plan for Medicaid restructuring in the absence of federal encouragement. On January 31, 2003, the Bush administration unveiled a proposal through which states could volunteer to block grant Medicaid (Lambrew 2005; Holahan and Weil May 27, 2003; Guyer May 2003; Thompson 2012). Under this proposal, states that chose to participate would no longer have to apply for waivers to modify federal standards for Medicaid design. While participating states would still be required to provide comprehensive benefits for low-income beneficiaries whose coverage is federally mandated, they would have significantly more flexibility to change service delivery, eligibility, and benefits for optional beneficiaries without going through the labor-intensive waiver process each time. Instead of receiving matching funds based on actual needs and costs, state would have received a fixed amount of money per year from the Federal government, with responsibility for expenditures beyond this cap falling solely on the states. Under this proposal, as noted, spending levels in FY 2002 would have been used as the base from which federal allotments would be determined. These would have then been increased by 8.5% per year, the average Medicaid growth rate at the time. As an incentive for states to participate, federal contributions would have increased by an additional 2% in 2004 to fund new programs and an additional 1% between 2004 and 2010 but subsequently reduced for three years so that the total amount would have been budget neutral over ten years. States, however, would have been obligated to show maintenance of effort, requiring them to devote, at a minimum, an amount equal to their FY 2002 spending, increased each year by the medical inflation portion of the CPI.

Not able to convince Congress to give them the authority to block grant the program, however, the Bush administration sought to demonstrate the effectiveness of the general approach by recruiting states willing to place an overall cap on federal contributions. This is consistent with Thompson and Burke's (2007) observation that "CMS acted more as a teacher of the states than as a student of them. The Bush administration held strong views on how to improve Medicaid…The administration invited states to submit waivers targeted toward these ends less because it thought it could learn from the demonstrations than because it wanted states to adopt its approach. 'Try it, you'll like it' might as well have been the motto." The only states that considered the administration's proposal were states with Republican governors (e.g., Connecticut, California, Colorado, New Hampshire, and Florida) (Anonymous 2003; Gold 2004**).** Ultimately, the governors in these states either chose not to pursue this policy, or were blocked in doing so by Democratic controlled state legislatures.

Rhode Island proved to be the only volunteer, though Vermont had previously received two such 1115 waivers with separate caps for acute and long-term care. Because of its small size state officials believed that RI was in an excellent position to test Medicaid reform models which could then be transferred to other states (EOHHS 2008). Like other states, however, the political

alignment of the state's Republican governor and Bush administration proved to be the key reason why the state first considered and then opted to pursue the Global Waiver. Indeed, respondents felt that the waiver was ideologically motivated, spurred on by federal and state Republican administrations focused more on restraining spending and delegating further responsibilities to the states than on improving beneficiary access and quality.

1.b. Block Grant Structure of Proposed Waiver Heightened Stakeholder Concern

The absence of specifics provided during the waiver development process, combined with the proposed block grant structure of the Global Waiver, contributed to considerable distrust and concern on the part of outside groups (Alker 2008; Byrant 2008; Davis 2008; Katz 2008 Peoples July 30, 2008; Reed and Whitehouse 2008; Solomon 2008). It was clear was that the state could acquire additional flexibility to shape Medicaid, possibly under more limited state and federal funding authority than existed before. It was unclear what the state would use that additional flexibility for. In the midst of the worst state budget crisis since the Great Depression, providers, consumers, and their representatives assumed the Global Waiver would be used by the Governor to cut back on the state's commitment to the program and the vulnerable populations it serves, particularly since official pronouncements emphasized protecting mandatory populations and services but not optional benefits and eligibility groups to which most program funding has traditionally been devoted (Alker 2008; Beckwith 2008; Bryant 2008; Davis 2008; The Poverty Institute August 15, 2008).

Key stakeholders were especially fearful that the state might have underestimated the amount of funding needed and, as such, run out of federal block grant money during the second or third year of the five year waiver period, particularly given the state of the economy and likely increase in Medicaid rolls (Alker 2008; Katz 2008; Lillis 2008; Peoples July 21, 2008; Reichard 2008). The absence of additional federal funding would, in turn, leave state officials with no choice but to fund the program entirely with state dollars or, more likely, to severely ratchet back its commitment to the populations served. This concern stemmed largely from doubts about the baseline figures and trend rates chosen to estimate the federal and state allocations requested.

Phase 2. Federal Approval

Major changes to the state's Global Waiver application were negotiated during the course of the federal approval process. These included the imposition of a dramatically different financial arrangement than the state initially requested—a capped federal-match rather than block grant structure. It also included the provision of an escape clause, permission to draw in federal matching dollars for previously state-only expenditures, and imposition of the waiver's "Special Terms and Conditions" and three-tier system of federal oversight.

2.a. Changes to the State's Waiver Application: A Capped Federal Match

In short, the state agreed to a cap on combined federal and state spending of $12.075 billion over five years (Office of the Governor 2008). It was estimated that the state would save $358 million during this time period. Several reasons were identified for why the state's block grant request was not approved. First, there may have been doubt about whether CMS had the authority to waive the federal matching structure. Many argued that statutory changes to the Medicaid program statute would need to take place first before the agency could grant requests such as this (Alker 2008; The Poverty Institute 2008; Dingell, et al. 2008; Katz 2008). At a minimum, there would have been legal challenges delaying approval of the waiver until the onset of the Obama administration which would not have been as positively disposed toward the state's intentions. Second, CMS would not permit the state to acquire the rights to the federal portion of any savings that might accumulate during the course of the waiver. Essentially, CMS

did not want the federal government to spend more under the waiver than it would have spent without the waiver, at least as reflected in the spending targets agreed upon based on assumptions about caseload and cost increases applied to five years of baseline funding history. Indeed, CMS ultimately set yearly spending targets to better ensure that the state remained within the funding cap negotiated.

2.b. Stakeholder Concerns about the Capped Federal Match

In general, outside stakeholders felt better about the capped federal match than about the proposed block grant because the state could only receive federal funding if it spent money itself, thereby better assuring state officials' commitment to the program while limiting the extent to which it could be reorganized. But while state officials felt comfortable with the $12.075 billion total funding ceiling negotiated—CMS basically accepted what state staff believed to be fairly inflated estimates (Anonymous 2009; Alexander 2011), outside stakeholders still doubted the adequacy of the state's projections, believing that the total cap on expenditures might not be sufficient to fund the program with adverse but as yet unknown implications for program beneficiaries (Anonymous 2009; Coffey 2009; National Association of Social Workers 2009; Needham 2009; Needham and Gregg 2008, 2009; Peoples December 20, 2008; Solomon 2009). They were especially concerned about the lack of details regarding the state's intentions. State officials pointed to the waiver as a general framework within which specific decisions would be made in time. Thus, Ann Martino, Policy Administrator at the Department of Human Services, argued that "[the waiver] really is a blueprint for moving forward. I think that's one of the confusions when people say there is no detail. Essentially, what the federal government did is provide us with authority to do certain things. How we use that authority is part of the implementation process and will be directed in part by the General Assembly and also input from the community" (Needham 2009).

There was particular concern about the state accepting a cap on federal funding without knowing what the future might hold. Given perceived limitations associated with the funding cap, there was also concern that state officials would use whatever additional flexibility that had been provided to draw back on its commitment to the program in order to help reduce the state's budget deficit. This outcome had already been seen in Vermont, where funds from their Choices for Care long-term care waiver were diverted by the state legislature to close a budget gap, even while waitlists for home- and community-based services persisted. That RI's $12.075 billion funding ceiling was decided on before the economic downturn reached its nadir was especially worrisome for some because it did not fully account for higher than expected unemployment and accompanying increases in Medicaid enrollment (Solomon 2009; Anonymous 2009; Goodnough 2009). The waiver was based on an assumption of a maximum unemployment rate of 4.9%, but during the recent economic downturn RI's unemployment topped 10% (Reed, et al. 2009).

In addition, the $12.075 billion cap agreed upon was substantially less than what the state had requested. In its August 2008 waiver application, the state had asked for $12.386 billion in total program funding over five-years. This was subsequently revised up to $12.9 billion in October 2008 during the state's negotiations with CMS (Solomon 2009). The final cap agreed upon was based on historical spending, adjusted with an annual growth rate of 7.8%, which is lower than Vermont's rate of 9.0%, RI's original August 2008 projection of 9.2%, and its revised October 2008 projection of 10.2% (Solomon 2009). The 7.8% rate includes a 1.2% anticipated enrollment increase, in contrast to RI's August and October 2008 estimates of 2.3% and 3.3%, respectively. [It was assumed that per member per month annual costs would increase by 6.8%.] This discrepancy between what the state requested and what was ultimately agreed upon raised

concerns that the total funding level might not be adequate to meet applicants' needs. The uncertain implications of federal fiscal support, an increasing likelihood given the outcome of the November 2008 election and the rapidly deteriorating state of the economy, raised concern a well (Solomon 2009; Needham and Gregg 2009; National Association of Social Workers 2009). Indeed, the federal stimulus package that would soon pass would temporarily increase the state's FMAP from 52% to 64% and require the state to maintain eligibility at July 1, 2008 levels or else risk losing whatever additional federal money might be provided. The latter provision also meant that state officials would have little control over whatever enrollment increases might occur as a result of the recession.

2.c. Stakeholder Concerns about the Inclusion of an Escape Clause

State officials highlighted negotiation of a clause permitting the state to opt out of the waiver should the funding situation become untenable due to unforeseen and emergent conditions (Carcieri 2009; Anonymous 2009; Peoples February 4, 2009). Should that happen, however, outside stakeholders were concerned that the program would revert back to the state plan only. If this happened the state would lose initiatives originally authorized under the state's eleven prior waivers but folded into the Global Waiver. This includes the states highly successful RIte Care waiver enrolling children and families in managed care and various home- and community-based services programs serving the elderly, severely mentally ill, developmentally disabled, and other populations (Reed, et al. 2009).

2.d. Changes to the State's Waiver Application: Special Terms & Three-Tier Oversight

In exchange for the total cap on program expenditures negotiated, the state wished to obtain as much flexibility as it could to make changes (Alexander 2011). Ultimately, state officials negotiated the waiver's "Special Terms and Conditions" (STCs) which required state officials to be somewhat explicit about the actual changes they intended to make (Weens 2009). Essentially, the state was granted the flexibility to make the changes documented in the STCs without having to request permission for making those changes from the federal government (Weens 2009). If, however, the state wished to make changes that were not so specified, then the degree of federal oversight would depend on the three category system of federal oversight adopted. These categories, termed I, II, and III and defined by CMS when it authorized the waiver, were designed for purposes of establishing federal oversight protocols and to make federal review more commensurate with the scope of program changes proposed.

Category I changes include those that are administrative in nature which the state has authority to change under the State plan or waiver's STCs; these may not affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies, or cost sharing. Although the state must notify CMS of a proposed change, federal approval is not required for implementation. Category II changes include those that could be made as a State Plan amendment or through a 1915 waiver authority without changing the waiver's STCs. They may not affect eligibility but can extend to other program dimensions. Although CMS approval is not required prior to implementation, federal matching funds will not be provided for changes that are implemented but not approved; states must also comply with State Plan public notice requirements and inform CMS in writing prior to implementation, including pertinent justification and assurances. Category III changes include those that require modifications to the current waiver or expenditure authorities or STCs and any change not clearly identified as I or II. CMS approval is required prior to implementation; states must also comply with State Plan public notice processes and notify CMS in writing and submit a demonstration amendment to the Global Waiver. Negotiations between federal and state officials focused on picking and choosing

what types of changes went into each of the three categories identified and how long CMS had to review changes associated with each. Most felt that the state has likely faced far more scrutiny under the Obama administration than it would have had under a Republican administration.

2.e. Changes to the State's Waiver Application: Cost Not Otherwise Matchable

CMS granted RI the authority to obtain up to $22 million in federal matching funds annually for populations and services previously covered only by the state. These are known as CNOMs or Costs Not Otherwise Matchable. The purpose in granting the state this authority was determine if such a strategy was cost-effective over the long run by slowing down or preventing the trajectory towards full Medicaid eligibility, say, through the provision of adult day care services that preclude future nursing home placement. CMS agreed to permit the state to CNOM certain state-only programs, although limited to people with incomes up to 200% of the federal poverty level (FPL) at the insistence of the Federal Office of Management and Budget. State officials believed that CMS was amenable to the state's CNOM request because they persuasively argued about the potential benefits of doing so for the bottom line.

Phase 3. Waiver Implementation

Federal stimulus money helped the state support caseload increases resulting from rising unemployment levels while softening the state's emphasis on reducing spending. That the state had to maintain eligibility levels to qualify for federal stimulus support has also helped to ameliorate stakeholder concerns. So too has been recognition that the state would not lose its federal match as a result of exceeding the federal funding cap. The latter was both because of the generosity of the funding cap itself and because state spending was not high enough in the current fiscal climate to draw in enough federal matching dollars to exceed it. The provision of federal CNOM money helped to support the program as well.

3.a. Federal Stimulus and Health Reform Legislation Facilitated Implementation

The American Recovery and Reinvestment Act (ARRA) of 2009 provided states with significantly enhanced federal fiscal support which, in the case of RI, reduced the state's contributions from 47.43% to 36.11% of Medicaid program costs from October 1, 2008 through December 31, 2010, subsequently extended through June 30, 2011 though at somewhat lower levels. This, in turn, increased federal contributions by a total of $523 million during this time period (Cross-Call 2012). In short, the ARRA helped reduce advocates fears about the Global Waiver (Prah 2010). They particularly appreciated the stimulus' eligibility provisions; in order to be eligible for additional federal matching dollars states could not adopt more stringent eligibility requirements than those existing as of July 1, 2008, a provision since extended with the Affordable Care Act. Indeed, the number of Medicaid eligibles increased considerably during the course of Global Waiver implementation, from 181,288 in July 2009 to 196,985 in December 2011, due largely to growth in the state' unemployment rate (DHS 2010-2012). Ultimately, additional federal financing provided under the ARRA helped to support caseload increases resulting from the recession while, perhaps, ameliorating the state's emphasis on restraining program spending and giving it time to prepare administratively for changes planned under the Global Waiver. It has been estimated that the ARRA saved the state $148 million and $207 million, respectively, in state FY 2009 and FY 2010 (EOHHS 2011).

3.b. Cap on Federal Expenditures Has Not Been an Issue

Rhode Island was not in danger of losing its federal Medicaid match despite initial fears that it might exceed the targeted amount agreed upon with the federal government. At $1.76 billion during the waiver's first demonstration year (calendar year 2009), for example, the state had spent $838 million less than its $2.6 billion expenditure target (DHS 2010-2012). The same

is true of the waiver's second and third demonstration years (calendar years 2010 and 2011) where, in fact, the difference between actual and projected spending grew. At $1.9 billion in 2010, the state spent $1.3 billion less than its $2.4 billion expenditure target. At $1.9 billion in 2011, the state spent $1.8 billion less than its $2.3 billion target. Especially in the current fiscal climate the limiting factor has been the level of state appropriations and spending; there is just no way the state can come up with enough of its own funding to exceed the federal cap. This cushion also derived from overly generous assumptions regarding the rate of program growth. The state's expenditure target was based on a five-year average, trended forward on the basis of expected enrollment and utilization increases. One reason that actual spending levels have been so much lower than projected levels is that the trend factor used did not take into account the actual levels of spending the state would experience due to the prevailing fiscal crisis. Another reason is that the state purposefully built a cushion into its projections. Both provider representatives and consumer advocates recognized that fear about the spending cap had been somewhat over blown (Pugh 2011; Cross-Call and Solomon 2011).

3.c. **CNOM Dollars Helped Ameliorate Impact of Fiscal Crisis & Spending Cap**

The state has been successful in using its CNOM authority to obtain additional federal dollars for services and populations that do not typically qualify for the federal Medicaid match—that is, programs previously funded entirely through general revenue funds, including for people who do not meet state Medicaid eligibility criteria and services for people who are eligible for Medicaid but do not typically receive a particular type of coverage. The state's CNOM authority appears to be one of most popular aspects of the Global Waiver (Freyer 2011). This is because the ability to CNOM state programs has saved the state money, in some cases supporting expansions, in others helping to prevent service cuts. Indeed, there is general agreement that CNOMs, which have provided the state with much needed fiscal relief, have been used to maintain service levels and benefits that otherwise would have been reduced or eliminated due to prevailing budgetary difficulties.

Lessons for Block Granting Medicaid and Other Retrenchment

Rhode Island's experience with the Global Waiver provides lessons, both for the federal block grant debate and Medicaid retrenchment more generally. Findings indicate that the Global Waiver is neither a block grant nor a model for one and that block granting the program would do irreparable harm, resulting in marked reductions in state spending, beneficiary enrollment, and provider payments. Despite potentially negative effects, it is likely that proposals to block grant and retrench Medicaid will continue to be made as state and federal health reform continues to be debated in today's hyper-partisan political environment.

The Global Waiver: Not a Block Grant nor a Model for One

Simply put, RI's Global Waiver is not a model that supports extension of the block grant concept to Medicaid reform nationally. As noted previously, the Global Waiver is not a block grant but a caped federal match whereby the state is still required to expend its own resources before receiving contributions from the Federal government. Furthermore, the state did not receive significantly more discretion to administer Medicaid but instead acquired permission to make certain program changes under the waiver's Special Terms and Conditions, with additional changes being subject to the three-tier system of federal oversight adopted. Moreover, most of the savings achieved by RI during this time period derive not from the Global Waiver but from other sources, including increased spending on the part of the Federal government. Indeed, analysts at the Center for Budget and Policy Priorities conclude that one reason RI spent less under the Global Waiver was the provision of millions of dollars in federal stimulus support and

the institution of cost-savings measures that could have been implemented independently, either of a federal waiver or the global cap (Cross-Call and Solomon 2011). They also conclude that the Federal government actually spent more money under the Global Waiver than it would have otherwise spent, not only because of the federal stimulus package and CNOM authority but because the global cap was set well above what the state expected to spend. That the state has spent substantially less than it could have spent under the waiver agreement—for example, $1.76 versus $2.6 billion in year 1—reflects the overgenerous ceiling put into place, not "savings" or "surpluses" claimed by block grant advocates.

Overall, just $22,944,888 in state savings deriving from the Global Waiver provisions approved by CMS have been identified during the first three fiscal years of implementation (2009-2011), all of which could have been implemented under other authorities without a global federal cap and a far cry from the $100 million purportedly saved during the first 18 months (The Lewin Group 2011). Combined with $42,771,921 in additional federal matching dollars brought in under the waiver's CNOM authority, the state reduced its total spending by $65,716,217 as a result of the Global Waiver. Other initiatives implemented during this time also saved the state money but cannot be attributed to the state's Global Waiver agreement with the federal government and certainly do not depend on a global cap. These can be divided among savings deriving from initiatives requiring additional CMS approval—$9,396,325—and program management initiatives requiring state agency and/or legislation action—$22,892,894

Block Grant Proposals Would Sharply Reduce Spending

The generosity of the waiver agreement received by RI is in marked contrast to extant block grant proposals which would substantially reduce federal fiscal support provided to states under Medicaid. In 2011, the Congressional Budget Office (2011) estimated that federal Medicaid spending under Ryan's FY 2012 House budget proposal would fall 35% short of current projections for 2022 and 49% short of current projections for 2030 due to the block grant provisions. A year later the Congressional Budget Office (March 2012) reported that under Ryan's FY 2013 proposal, federal Medicaid, CHIP, and health subsidy spending would fall 58.3%, 61.5%, and 75% short of current projections in 2023, 2030, and 2040, respectively.

It is unlikely that states could overcome such a reduction through increased efficiencies. States already aggressively pursue cost containment under the existing Medicaid program framework, including reducing provider payments, limiting the scope of benefits, eliminating optional services, contracting with managed care plans, instituting pharmaceutical management tools, and restricting eligibility in areas exempt from the Affordable Care Act's maintenance of effort provisions (e.g., adults with incomes above 138% FPL in states certifying budget deficits) (Holahan and McMorrow 2012; Johnson, Oliff, and Williams 2011; Rosenbaum 2012; Williams, Leachman and Johnson 2011; Smith, et al. 2012). Thus, although average annual Medicaid expenditure growth is expected to reach 8.5% over the next decade, growth in per enroll spending is expected to continue at a modest 3.6%, with the remaining portion of projected growth in spending resulting from increases in enrollment (Holahan and McMorrow 2012). Unable to further reduce per enrollee costs states would be left with one of two options should program federal retrenchment occur, either funding their programs at existing levels but making up the difference through increased state spending, or, more likely, contracting their programs considerably. Moreover, no block grant proposal would permit states to opt out at any time due to overseen or untenable fiscal circumstances as is currently the case with the escape clause included in the waiver agreement between RI and the Federal government.

Looking forward the Urban Institute estimates that the House budget plan proposal would reduce federal Medicaid spending by 22% or $810 billion between 2013 and 2022 (Holahan, et al. October 2012). The impact of the House Republican Study Committee's proposal would be even more dramatic, decreasing total Medicaid spending by $1.1 trillion, or 30%, between 2013 and 2022, with federal Medicaid spending being 47% lower than it would be under current law by 2022 (Park and Broaddus 2012). Looking backward, the Center for Budget and Policy Priorities estimated that if the House budget plan had went into effect in 2001 total federal Medicaid spending would have been $555.0 billion or 31% less between 2001 and 2010, with a $80.7 billion or 37% reduction experienced in 2010 alone (Park and Broaddus 2012). Because annual growth in federal Medicaid allotments to states would only increase with population growth and inflation, it would grow at a much slower rate than otherwise expected. As a result, the gap between what the Federal government provides and what state's need to fund their programs would widen with each passing year. This dynamic is reflected in both the prospective and retrospective analyses of the Ryan proposal described here.

Doubts about the ability of block grants to account for changes in Medicaid program needs is also reflected in proposals made by the Reagan administration in 1981 and House Republicans in 1995. Both proposals included funding formulas later found to create a mismatch between proposed federal contributions and actual program costs. This is reflected in retroactive comparisons of Congressional Budget Office projections for spending under each proposal to actual program spending (Lambrew 2005). Under the Reagan administration's proposal, projected federal Medicaid spending under the cap would have been 6% lower than actual spending over five years and 26% lower than actual spending over ten. Moreover, the difference between projected and actual funding levels would have risen considerably over time, with projected spending levels under the cap being 2%, 27%, and 53% lower than actual levels in 1984, 1988, and 1991, respectively. Under the House Republican proposal, projected federal Medicaid spending under the cap would have been 3% higher than actual spending over five years and 2% lower than actual spending over seven. Again, the difference between actual and projected funding levels would have varied considerably over time, with the amount by which projected levels would have exceeded actual levels declining from 7% in 1997 to 2% in 1998, after which projected spending levels under the cap would have been lower than actual spending; for example, 3%, 8% and 16% in 2000, 2001, and 2002, respectively. Nationally, this reduction in spending would have resulted in 6 million people losing Medicaid coverage in 2022, if states addressed the entire shortfall by tightening program eligibility.

Prior experience suggests just how difficult it is to create a suitable and fair formula to determine funding levels for a Medicaid block grant. Even if the goal was to establish funding formulas that adequately met future program needs, doing so is extremely challenging as economic, demographic, and medical inflation trends can be highly variable and unpredictable. Perhaps this is best reflected in comparison of actual federal Medicaid spending to projections made by the Congressional Budget Office (Lambrew 2005). Results indicate that the accuracy of three-year projections made from 1990 through 2002 ranged from 28% above actual spending in 1996 to 31% below in 1992. Results also indicate that the accuracy of five-year projections made during this time period ranged from 44% above spending in 1998 to 37% below in 1992. Together these findings suggest that spending projections and funding formulas are very difficult to establish, likely resulting in funding shortfalls and service cuts over the long term.

Block Grant Proposals Would Adversely Impact Provider Performance

Although states have a variety of different strategies with which to restrain Medicaid spending, freezes and reductions in provider reimbursement have often proven politically more palatable than cuts in benefits and eligibility, especially during hard economic times when people need Medicaid most (Miller 2002; Smith, et al. 2012). This suggests that marked reductions in federal spending associated with block granting Medicaid would have adverse implications not only for state budgets but also Medicaid providers. The Urban Institute estimated that the House budget plan would reduce hospital and nursing home payments by $363.8 and $220.2 billion, respectively, between 2013 and 2022 (Holahan, et al. October 2012). Such major reductions in payments could compromise the fiscal viability of already financially stressed safety net providers while reducing incentives for nursing homes, physicians, and other types of providers to participate in the Medicaid program, or to serve fewer Medicaid beneficiaries if they do participate, thereby compromising access and quality.

Medicaid is the primary purchaser of nursing home in the United States, accounting for 32.8% of total nursing home spending in 2009 (CMS 2011). It also serves as the primary source of payment for more than one-third of nursing home admissions (34.8%) and pays for all or part of the care received by more than half of current residents (59.7%) (Jones, et al. 2009). Evidence from the nursing home sector suggests just how important the level of payment and type of methodology chosen is, not just for access but also for quality of care (Feng, et al. 2008, 2010; Harrington, Swan, and Carrillo 2007; Intrator and Mor 2004; Mor, et al. 2011). Due largely to differentials in reimbursement, nursing home care in the U.S. has been "driven to tiers," with the lowest quality facilities—those with the fewest nurses, most deficiencies, and lowest occupancy rates—being those serving predominately Medicaid residents (Mor, et al. 2004). The most poorly performing facilities are also more likely than their better performing counterparts to serve African Americans and Hispanics and to be located in poor counties and rural areas (Fennell, et al. 2010; Kang, Meng, and Miller 2011; Mor, et al. 2004; Smith, et al. 2007).

Low levels of reimbursement is one reason why many doctors have either elected not to participate in Medicaid, or have limited the extent of their participation to a restricted number of clients, thereby leaving many beneficiaries to seek care from hospital emergency rooms, federally qualified health centers, or other safety-net providers (Cunningham and Nichols 2005; Cunningham and O'Malley 2009; Zuckerman, et al. 2004). Physicians practicing in states with higher Medicaid-to-Medicare fee ratios are significantly more likely to accept new Medicaid patients (Decker 2012). Recognizing challenges recruiting providers due to low payment levels, the Affordable Care Act increases payments to primary care physicians under Medicaid to Medicare levels. This change, however, will only last two years—2013 and 2014—and, as such, may have minimal impact on improving Medicaid beneficiary access to primary care over the long run. Given the history of low provider payment sin this area and the lingering effects of the fiscal crisis, it is highly unlikely that states will maintain Medicare-level reimbursement rates unless the Federal government picks up the tab, an even more remote possibility should the program be block granted.

Because Medicaid is the single largest revenue source for safety-net providers, the impact of fiscal retrenchment, including block granting, on the limited revenue streams of public hospitals and providers that serve large numbers of low income patients is especially concerning. Medicaid constituted 33% of $40 billion in net revenues received by public hospitals in 2008 (Kaiser Family Foundation 2010). Although evidence is mixed about the quality of care provided to patients served in safety-net hospitals relative to other hospitals (Chatterjee, et al. 2012; McHugh, Kang, and Hasnain-Wynia 2009; Marshall, et al. 2012), there is little doubt that safety-

net hospitals provide Medicaid and uninsured patients access to higher quality care than otherwise would be the case (Sabik and Bradley 2012; Hall, Hamacher, and Johnson 2012; Hall, Hwang, and Jones 2011). Provisions contained with the Affordable Care Act markedly reducing disproportionate share hospital (DSH) payments, which provide additional Medicaid and Medicare reimbursement to providers that disproportionately serve low income individuals who are more likely to be uninsured or on Medicaid, could pose a particular challenges to the nation's safety net system (Davis July 2012; Mitchell 2012).

One reason providers did not actively oppose the Affordable Care Act was the expectation that Act's Medicaid expansion together with increased access to subsidized private coverage would help compensate for lost revenues resulting from reductions in DSH and other public payment sources (Jost and Rosenbaum 2012; Moon 2012; Oberlander 2012). This suggests that those safety net providers located in states that choose not to expand Medicaid coverage or to aggressively pursue enrollment of potential eligibles if coverage is expanded, will have fewer resources to care for their patients than they had previously given the concomitant reduction in federal subsidies made available. Resulting fiscal pressures could, in turn, limit the provision of uncompensated care, increase bad debt, and result in closures of critical safety net institutions while adversely impacting access to and quality of care. Clearly, the adverse consequences of this dynamic would extend even more broadly should substantial reductions in federal Medicaid spending be enacted as per proposals to block grant the program and/or reduce the rate of expenditure growth to, say, the CPI +1%, as the resources available for paying providers would decline and fewer states would choose to participate in the Medicaid expansion while many of those that had chosen to participate would likely withdraw (Rosenbaum 2012).

Block Grant Proposals Would Adversely Impact Beneficiary Well-Being

Marked reductions in federal spending associated with a Medicaid block grant or other retrenchment would have especially adverse implications for beneficiaries. There are several reasons. As noted, subsequent reductions in provider payments would result in considerable state fiscal pressures that would, in turn, lead to reductions in the number of participating providers, thereby compromising access and quality. Moreover, restrictions on the number and scope of benefits would be put into place along with increases in beneficiary cost-sharing. The latter is particularly problematic. Extant research indicates that increasing cost-sharing through premiums, co-pays, and deductibles cause people to disenroll and/or reduce use of needed services, especially among the low-income populations Medicaid primarily serves (Wu and Wachino July 7, 2005; Artiga and O'Malley May 2005). It also indicates that cost sharing disproportionately disadvantages the chronically ill and those who have more frequent need of health care services.

Even more fundamentally considerably more stringent restrictions on program eligibility would be adopted while investments in education and outreach aimed at enrolling otherwise eligible individuals would decline or cease. This, in turn, would impact a majority of Americans, 51% of whom report some degree of personal connection to the program, either because they, a family member or friend has received some level of health and long-term care support (Kaiser Family Foundation May 2011). The Urban institute estimates that the House Budget Plan would result in 14.3 to 20.5 million fewer persons on the Medicaid rolls by 2022, a 25% to 35% reduction, with states needing to increase spending by $164.2 to $273.0 billion, or 46% to 77%, to avoid this decrease (Holahan, et al. October 2012). Most of those losing Medicaid coverage would become uninsured.

The number of uninsured Americans increased markedly from 43.4 to 49.2 million between 2007 and 2010 with the decline in employer-based coverage stemming from rising levels of unemployment and declining family incomes during the late recession and slow recovery (Kaiser Family Foundation September 2012). However, this figure would have been far higher without Medicaid, a quintessential countercyclical program that kicks into higher gear during hard economic times when the demand for government-subsidized assistance grows. It has been estimated that every percentage point increase in the unemployment rate is associated with both a 1.1 million increase in uninsured and a 1.0 million increases in Medicaid enrollment (Dorn, et al. April 2008). Thus, from December 2007 to June 2010 the number of Medicaid enrollees increased by 7.6 million or 17.8% as the unemployment rate rose from 5.0 to 9.5% nationally (Kaiser Family Foundation February 2011).

It was expected that the expansion of Medicaid under the Affordable Care Act to those with incomes up to 138% of the FPL would result in greater uniformity in Medicaid eligibility nationally, with an additional 21.3 million Americans obtaining health insurance coverage as a result of the expansion by 2022, 41% above expected baseline enrollment levels (Holahan, et al. November 2012). In a surprise move, however, the U.S. Supreme Court made the Medicaid expansion optional for states in its June 28, 2012 ruling on the constitutionality of the Affordable Care Act (Jost and Rosebaum 2012). In view of the decision, the impact of the expansion has been revised downward; it is now only expected to result in 11 million additional enrollees (Congressional Budget Office July 2012). To qualify for subsidies to purchase private health insurance coverage through the exchanges residents would need to have incomes between 133% and 400% of the FPL. That there is little overlap between the public and private coverage groups suggests that the vast majority of low income people living in states that either elect not to expand Medicaid coverage under the Affordable Care Act or to pull back on the expansion should the program be block granted or retrenched would be ineligible for subsidies through the exchanges and, as such, would remain uninsured (Oberlander 2012). In turn, those losing coverage would face considerable obstacles to obtaining needed care with adverse implications of health and well-being.

Evidence from a randomized trial in Oregon provides strong evidence about impact of losing coverage (Baicker and Finkelstein 2011). Results indicate that those enrolled in Medicaid after being randomly selected to apply had a higher probability of prescription drug, outpatient care, and inpatient hospital use than those who remained unenrolled but on a waitlist for the program. Results also indicate that those enrolled in the program were more likely to have a usual source of care and to use preventive services. Increased use of health care services provided both health and financial benefits. Health-wise, Medicaid coverage increased the probability of reporting being happy and in better self-reported health while decreasing the likelihood of being screened for depression. Financially, Medicaid coverage reduced the likelihood of having to borrow money or to skip payments on other bills to pay for medical expenses, in addition to lowering the probability that unpaid bills would be referred to a collection agency. Although less methodologically rigorous, findings from this unique trial are broadly consistent with numerous other investigations that demonstrate access, health, and financial improvements associated with Medicaid and CHIP coverage, particularly when compared to being uninsured (Davis, et al. 2012; Institute of Medicine 2002; Kaiser Family Foundation October 2012; Ku and Ferguson 2011).

Still other studies find survival benefits associated with coverage. This is reflected in a study that compared three states—New York, Maine, and Arizona—that expanded adult

Medicaid eligibility since 2000 to neighboring states that did not expand coverage. Results indicate that expansion was associated with a significant reduction in mortality—particularly among older adults, minorities, and residents of poor counties, increased rates of Medicaid coverage and decreased rates of uninsurance, lower rates of delayed care, and improvements in self-reported health, (Sommers, Baicker, and Epstein 2012). The mortality benefit, in particular, is consistent with the conclusions of an influential Institute of Medicine's report that the uninsured not only receive too little care too late and receive poorer care when it is received, but are sicker and die earlier, including an estimated 18,314 deaths resulting from a lack of coverage in 2000 (Institute of Medicine 2002). Subsequent analyses by the Urban Institute place the number of deaths resulting from the lack of coverage between 2000 and 2006 in the 137,000 to 165,000 range (Dorn 2008).

Partisanship Drives State Responses to Medicaid Block Grant Proposals/Retrenchment

How exactly would particular states respond if the Medicaid program was block granted? The answer will depend largely on a combination of political, economic, and programmatic considerations (Congressional Budget Office July 2012; Miller 2004, 2005). Block granting the program would increase state discretion over Medicaid program design and administration beyond the already considerable levels states possess. Traditionally, states of all types—rich and poor, conservative and liberal—have responded reliably to financial incentives promulgated under Medicaid (Kaiser Family Foundation August 2012). More than half implemented the program in 1966, the year in which federal funding first became available. All but Alaska (1972) and Arizona (1982) did so within four years. Thereafter, states responded to federal incentives to expand Medicaid to both newly mandatory and optional populations (e.g., pregnant women, infants, and children). Moreover, during FY 1998, the first year in which enhanced federal fiscal support became available under the Children's Health Insurance Program, virtually all states (45) expanded coverage to low and moderate income children and families, with the remaining doing within the next two years.

Federal matching grants such as Medicaid both increases the recipient government's income, and lowers the price of the public good that is being provided (Miller 2004). Whereas states with a 50% FMAP, for example, pay for half of Medicaid program costs (e.g., New York, California), those with a 75% FMAP pay for just one-fourth (i.e., Mississippi). The result is that poor states have even greater incentives than financially well off states to increase spending beyond what otherwise would have been the case, a dynamic missing with block grants which have an income effect only and therefore tend to be much less simulative in their impact. This suggests that the gap in coverage between rich and poor states would surely widen if a block grant strategy to reforming the Medicaid program was pursued.

Today's hyper-partisan political environment further suggests that those states that might be most adversely impacted if the program were block granted or retrenched may, in fact, be most supportive if the federal government pursued this strategy. A May 2011 survey found that 35% of Americans preferred to block grant Medicaid while 60% preferred to keep the Medicaid intact (Kaiser Family Foundation May 2011). The proportion preferring the block grant, however, increased from 18% among democrats to 36% among independents and 57% among republicans, a dynamic that has remained largely intact over time (Kaiser Family Foundation 1996). This underlying opinion structure explains, in part, why conservative states dominated by republican officials have exhibited substantially stronger support for the block granting the program since such proposals began to hit their stride in conservative circles nearly 20 years ago (Lambrew 2005; Thompson and Burke 2007; Thompson 2012).

It is likely that partisanship will play a prominent role in informing state Medicaid decision making in the present political environment, even more so than fiscal or programmatic concerns. After all, it was Republican led states, including those with the highest proportion of uninsured residents, that brought the lawsuits challenging the constitutionality of the Affordable Care Act, elected not to form their own state health insurance exchanges, and delayed accepting federal stimulus money, including $87 billion in additional Medicaid funding despite rising unemployment (Miller and Blanding 2012; Muscumeci July 2012; Oberlander 2012; Statehealthfacts.org. 2012). It is also Republican led states that have declined to participate in the Medicaid expansion. That the federal government will pay 100% of the costs during the first three years and at least 90% thereafter while eliminating almost all uncompensated care costs and providing health coverage to millions more Americans suggests just how good a deal the expansion is for state governments no matter what their particular circumstances (Rosenbaum and Westmoreland 2012; Angeles 2012). Indeed, the Urban Institute projects that if all states expanded the program state costs would be just 0.3% or $8 billion higher between 2013 and 2022 relative to current law as compared to an increase of 21% or $800 billion for the federal government (Holahan, et al. November 2012). Moreover, states can expect a net decrease in costs of $10 billion as a result of an expected reduction of $18 billion in state and local uncompensated care costs.

Ten states had already chosen not to participate in the Medicaid expansion as of January 8, 2013, an additional five were leaning towards not doing so; each with a Republican governor (The Advisory Board Company 2013). This is in contrast to seventeen states and the District of Columbia that had already chosen to participate and another four that were leaning toward saying yes; all but four of which had a Democratic governor. Those Republican governors that have been quickest to decline participating led states that would have benefited more from the expansion than those who were quickest to declare their participation. This is reflected in the finding that, on average, states declining to expand would have experienced a 20.3% increase in total spending, primarily due to the provision of additional federal financial support, between 2013 and 2022, as compared to a 13.8% estimated increase for states that have already agreed to do so (Holahan, et al. November 2012). It is also reflected in the finding that, on average, states declining to expand would have experienced an estimated incremental reduction of 24.5% in the number of uninsured residents during this time period as compared to an estimated reduction of 17.4% for states that have already agreed to expand coverage under the program.

Just as the Affordable Care Act passed Congress without a single Republican vote, House Budget Committee Chairmen Paul Ryan's FY 2012 and FY 2013 budget proposals, which included provisions block granting Medicaid, passed the House of Representatives strictly along party lines before failing to make progress in the Democratically-controlled Senate. These proposals were strongly favored by the nation's Republican governors and opposed by the nation's Democratic governors (Republican Governors Public Policy Committee 2011; Stein 2011). Whereas Democratic governors were open to negotiating beneficiaries' entitlement to services but not states' entitlement to federal fiscal support, Republican governors were open to negotiating radical departures in both areas. As with the Medicaid expansion, Republican-led states in favor of blocking granting the program would have been more adversely impacted than the Democratic-led states that opposed doing so. This is reflected in the finding that new state spending required to avoid enrollment cuts resulting from the House Republican block grant proposal varied across states with Republican and Democratic governorships, with the former being affected more, on average, than the latter. Thus, it was estimated that in 2022 Republican

led states would have to increase spending by 53.7% to 89.6%, on average, as compared to 49.0% to 81.6% in states led by Democrats to prevent enrollment cuts that would result if the program was blocking granted (Holahan, et al. October 2012).

Of course, neither block granting Medicaid is going to happen anytime soon in light of President Obama's electoral triumph. Furthermore, the Budget Control Act of 2011, enacted August 2, 2011 to end the debt ceiling crisis, excludes Medicaid from automatic budget sequestration—that is, $1.2 trillion in across the board spending cuts from 2013 to 2012—if Congress and the President do not agree on deficit reduction equal to this amount. The Act, however, does not prevent Congress and the President from including Medicaid in a deal should negotiations to either prevent or ameliorate the effects of sequestration prove successful. At 8%, Medicaid is the third largest domestic program in the federal budget, behind Medicare (8%) and Social Security (20%) (Kaiser Family Foundation May 2012). Moreover, both Democrats and Republicans agree that, as a major contributor to the long term federal budget deficit, growth in federal health care spending needs to be restrained, though Republicans feel more strongly in this regard (Kaiser Family Foundation May 2011). Where they disagree is how best to achieve this objective with, according to Rosenbaum (2012), "Democrats emphasize transformation of the health care system through payment reform and organizational restructuring and Republicans [favor] tougher limits on federal spending that might galvanize deep downstream changes on the part of health care providers and consumers." It likely, therefore, that block granting Medicaid reform will continue to be proposed by Republican officials, both in future budget proposals and presidential party platforms.

Limitations

We note several potential study limitations. First, we studied Medicaid reform in just one state. Consequently, our findings may not apply to other states which face substantially different circumstances. In general, however, we believe our findings are transferable. The general contours of other states' policy communities within which long-term care policy is developed and implemented is similar to that which exists in RI (Miller and Banaszak-Holl 2005; Miller, et al. 2012). Second, there may have been bias inherent in the particular interview subjects selected. Because there was no sampling frame, and we relied on a combination of purposive and snowball sampling, potentially knowledgeable individuals may have been excluded. While we are confident that we spoke with most, if not all of the relevant stakeholders, our impressions may have been dependent, in part, on the specific individuals interviewed. Finally, the study was designed to acquire detailed information on the particular topic addressed, the design and implementation of Medicaid reform through RI's Global Consumer Choice Compact Medicaid Waiver. Although providing a rich source of data, doing so sacrificed breadth for depth. Future research could build on the results reported by exploring additional retrenchment strategies.

Conclusion

Medicaid has remained remarkably durable over time, overcoming concerted efforts on the part of Republican presidents and Congressional majorities to block grant the program (Thompson 2012). Although it now serves as the backbone of the nation's health reform efforts, continued vigilance will be necessary to promote expansion to the low income uninsured in recalcitrant states. It will also be necessary to ensure that sufficient resources are deployed to undertake the requisite education and outreach required to identify and to recruit potentially eligible participants. Should the current level of partisan disharmony continue over the long term program advocates will need to be especially vigilant should the Republican Party's electoral success at the state level be matched federally. Rhode Island's Global Waiver, which

conservative commentators and politicians have pointed to in support of radical reform, is not a true block grant, nor nearly as successful as they would claim. It is also substantially more generous than contemporary block grant proposals, both in the level of federal funding allocated and in the ability of the state to terminate participation virtually at any time. If the Medicaid program is to meet the needs of vulnerable Americans—low income children and families, the mentally ill, developmentally disabled, physically disabled, a growing population of elders in need of long term services and supports, its basic entitlement—both for states and beneficiaries—needs to remain intact. Program performance must continue to improve as well, perhaps informed by lessons drawn from the Global Waiver and other state reform efforts, both for state health reform generally and for strategies for reducing federal and state government commitment to the program.

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Table. Major Themes Arising During Three Major Phases with Illustrative Quotes

Phase 1: Waiver Development

1.a. The Global Waiver Was Politically and Ideologically Motivated

"One of the things we really wanted…was…to test the financial model. You pick up a newspaper in this country once a week and you find out some state is talking about [how] it can't sustain Medicaid. We actually wanted to say, 'Well, try us. Rhode Island is a small state; we've got some good budget projections. Give us a bag of money; give us the rules you want us to run by, and let us see what we can do.'" (State Official)

"This governor being the Republican that he is wanted to do something that was more along the lines of good Republican politics." (Provider Representative)

"There were conversations with CMS in the waning days of the Bush administration…There appeared to be a fair amount of interest…both on the part of the Bush administration, as well as the local administration in attaining a waiver that had a cap on expenditures. That turned out…to be a driving force in getting that approved." (Provider Representative)

1.b. Block Grant Structure of Proposed Waiver Heightened Stakeholder Concern

"There was lots of concerns that the state was getting some blanket waiver of federal laws without them really having to be specific about what they would do. They were given flexibility to carve out different populations and offer them different benefit packages but we didn't know who those populations were, or what the benefit packages were, that kind of thing." (Consumer Advocate)

"The idea was the state was saying to the feds, 'you give us X amount of federal dollars over the course of five years, and which we could access at any time we want,' and we will agree to a maintenance of effort amount, where we'll put in a state amount [equal to] I think 23 percent of the budget…That really locked Rhode Island into a capped amount of money, which potentially they could have used more up front, leaving us with nothing towards the end of the five years." (Consumer Advocate)

Phase 2: Federal Approval

2.a. Changes to the State's Waiver Application: A Capped Federal Match

"The rationale [for not allowing the block grant] was that it…would have taken [federal] legislation to roll back the law…And we [would] have fundamentally changed the nature of what's an entitlement program…CMS said, 'That's not our issue to decide.'" (State Official)

"We went into that block grant discussion saying, 'We save money, we want to keep this federal money. In other words, put it back in, and they're saying, 'What is this? You're going to save money and keep the federal share? No, that's our money." (State Official)

2.b. Stakeholder Concerns about the Capped Federal Match

"The most important thing is the state still controls the spending. This is still a matched program. So in order…to get a federal dollar, the state has to spend a dollar first. So, really the Medicaid program is largely as it was before the Global Waiver was enacted. The question remains how much is the state willing to spend for Medicaid funded services [and] how can the state achieve savings…without harming beneficiaries or making unreasonable demands on providers." (Consumer Advocate)*

*"*There is not enough information…There's not enough detail. They have not involved the community from the get-go. If they had, some of the questions we are asking, we might not have to." (Consumer Advocate)*

"The state was putting itself at risk because you just don't know what circumstances are going to be over the course of the five years" (Consumer Advocate)

"[Worried] they were going to woefully underestimate what we needed to fund this system." (Provider Representative)

2.c. Stakeholder Concerns about the Inclusion of an Escape Clause

"One of the things that was a concern for people was that if we got into this and accepted it and went forward and then a year into it, or 18 months in it, or two years into it, people were like, 'Man, this is not a great idea for us,' if we walk away, we go back to bringing the Medicaid program under a state plan, which is not what anybody here would want. You don't get to walk back to the RIte Care waiver." (Provider Representative)

2.d. Changes to the State's Waiver Application: Special Terms & Three-Tier Oversight

"The state can go forward and do, like, Category I changes pretty easily with CMS' approval…Category II needs a little bit more of a public engagement process and is a little bit harder to do…And then [Category] III changes kind of like would really be hard to do." (State Official)

"[The goal of the three-tier system was] to ensure that the level of review by CMS was commensurate with the scope of that change. Prior to the Global Waiver any change regardless of how involved the change required the same amount of time and process from CMS." (State Official)*

"We didn't get as much as we wanted to, we got more than we thought we were going to end up getting, ultimately because they moved." (State Official)

"It's kind of an interesting twist of fate that the Governor's Office has pursued this waiver thinking that the federal government would give them all sorts of carte blanche to do things, where now I think the administration will be looking very closely at what the state is saying it wants to do." (Consumer Advocate)

2.e. Changes to the State's Waiver Application: Cost Not Otherwise Matchable (CNOM)

"One of the things that the central office said to us is that of the state's that came in asking for CNOMs, we were the only ones who had come in with a very thought out, legitimate argument that could show that if we CNOM'd this program, and preserved it, and expanded it, it would ultimately, over time, reduce utilization in that case, or utilization of more higher cost services." (State Official)

Phase 3: Program Implementation

3.a. Federal Stimulus and Health Reform Legislation Facilitated Implementation

"Well, the main thing that the ARRA funding has done is to protect the state from rolling back eligibility for parents, and implementing the premiums in the RIte Care program, because I'm 100 percent certain that if the ARRA hadn't been in effect the state this year would have [done so] since they've done it in less severe fiscal times" (Consumer Advocate)

"All I can say is thank goodness for the federal stimulus package because if we didn't have these federal requirements, what's called the MOE, the Maintenance of Effort requirements, I think RIte Care would be sliced and diced in a million ways to Sunday by now, and luckily health care reform also put in MOEs beyond what the stimulus MOEs are." (Consumer Advocate)

"In general, the enhanced FMAP delayed or prevented the need to make some really, really tough decisions. It allowed us to go forward and do some things with implementation, because there was an influx of money coming in where we may have [otherwise have] been in a position where we were reacting to the deficit. A lot of best made plans get tumbled when we get, 'come up with $90 million,' you know?" (State Official)

"I don't think the waiver would have worked without the federal Medicaid enhancement and stimulus…because in order to do the rebalancing that needed to happen, that's like 18 months to two years worth of just internal work about redesigning programs, retraining-recruiting staff." (State Official)

3.b. Cap on Federal Expenditures Has Not Been an Issue

"You have to remember under the cap our Medicaid expenditures are driven by state spending and we just knew the state didn't have the money…The way general revenue was moving, even if things had improved substantially, we knew we weren't going to hit the cap, and we knew we had a fiscal and an administrative cushion because of the incoming CNOM." (State Official)

"Rhode Island is well within its budget protection. We built in a caseload growth factor in the vicinity of 6.5%...We thought we'd be within 4 points on a real basis, but we wanted to put on some cushioning there, because of the unemployment…[So we] thought we had enough money and it's shown itself out now…The number [in the revised waiver application was $12.9 billion] over a five year period—we're trending right now to spend $10 billion…We didn't want to sign a deal if we thought we were going to lose money." (State Official)

"The cap is really not a cap…the cap is like star wars…I mean they couldn't spend $12 billion if they tried in five years" (Provider Representative)

"In hindsight, some of the good news is it looks like the cap that the state was able to negotiate with CMS will be sufficiently high." (Provider Representative)

"The federal cap is so high that it's almost a red herring. It provided an opportunity for everybody to stand up and say there's a cap on the federal dollars, but the likelihood of getting there was slim and none. There are not enough state dollars to ever reach that cap." (Provider Representative)

3.c. CNOM Dollars Helped Ameliorate Impact of Fiscal Crisis and Federal Spending Cap

"The greatest thing that came out of it for the state was the CNOM areas where they were able to grab Medicaid dollars that they hadn't been able to get before." (Provider Representative)

"A good part of the waiver in these economic times is that those state funded programs might have been cut were it not for the ability to get the federal matching dollars…[A program] that had been proposed to be cut, for example, last year [because it was state funded], now it wasn't on the chopping block….because…now its federal and state funded." (Consumer Advocate)

"The Global Waiver allowed us…[to fund] the [co-pay] program at a slightly higher level [and accrue] savings [in] general revenue funds, because we had the federal match, so we were extremely happy that it was accepted and approved by CMS…to qualify as a CNOM." (State Official)

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*Quote derives from legislative hearing