RHODE ISLAND'S GLOBAL COMPACT WAIVER

Statement of

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Chairmen Costantino, Alves and Members of the Committee

Thank you for the opportunity to present testimony on the proposed Rhode Island Consumer Choice Global Compact Waiver. My name is Joan Alker, and I am a Research Associate Professor at Georgetown University's Health Policy Institute and the Deputy Executive Director of the Georgetown Center for Children and Families. A substantial component of my research at Georgetown has focused on analyzing Section 1115 Medicaid waiver proposals.

As you know, Medicaid is an essential part of the healthcare system here in Rhode Island and in the nation as a whole. According to Census bureau data, 19% of Rhode Island's population receives their health coverage through Medicaid. Medicaid is also an incredibly important source of funding for a diverse group of services ranging from births (more than one-third of births in Rhode Island are financed by Medicaid), to long term care (one-third of Rhode Island's Medicaid spending is for long term care services). As the number of uninsured Americans continues to rise, Medicaid's importance as an essential underpinning of our health care system has only grown.

As currently structured, Medicaid is a federal-state partnership – a guaranteed source of federal financing with a matching structure. For every dollar that Rhode Island spends on permissible services for eligible beneficiaries, the federal government provides approximately 52 cents on the dollar. This flexibility in Medicaid's financing has allowed the program to respond to unanticipated events (like the HIV-AIDS epidemic which was unheard of when Medicaid began, today Medicaid is the primary payer for HIV-AIDS services) and anticipated events (for example, in times of recession, Medicaid's enrollment increases; funding is open-ended and can respond to the enrollment growth).

In contrast the State Children's Health Insurance Program (SCHIP) is a block grant with a fixed allotment of federal funds, albeit one with a more generous matching structure up to the cap. Allocating SCHIP dollars to the right place at the right time has been riddled with problems because the funding does not follow the children.

The Medicaid program operates as a federal-state partnership. There are certain populations and services that states must cover but the majority of Medicaid spending – 60% nationwide – is for "optional services" and "optional beneficiaries" that states choose to cover. The term "optional" is somewhat of a misnomer – services provided must always be medically necessary and thus are not optional from the beneficiaries' perspective. For example prescription drugs are deemed an "optional service" even though no one would describe them as optional to modern health care. In the area of long term care, an estimated 85% of U.S. Medicaid spending is "optional".

What does the Global Compact waiver do?

The Rhode Island Global Consumer Choice Compact waiver proposal released on July 28th, 2008 represents a radical and risky departure from the way Medicaid currently operates. Many of the ideas are similar to those advocated for the Medicaid program by

the Bush Administration in its early years (see for example the Bush Administration's FY04 budget proposal) but not enacted by a Republican Congress.

All Section 1115 Medicaid waivers change the way in which federal funding comes to a state by establishing a cap as part of the waiver's "budget neutrality agreement". The budget neutrality agreement is the federal government's way of ensuring that it will not spend more under the waiver than it would have in the absence of the waiver. But typically Section 1115 waivers operate under a per capita or per person cap which allows federal funding to grow with enrollment increases. The financing structure outlined in the Global waiver proposal, however, would put Rhode Island in the position of being the only state in the country that moves its entire Medicaid program[1] to a fixed capped allotment of state and federal dollars – known as a block grant.[2] The waiver proposal itself acknowledges this stating that: "the terms of the Global Compact proposed here are unique to Rhode Island and without precedent across the states" (waiver proposal p. 7).

Under the Global Compact, financing on both the state and federal sides would no longer be tied to actual health care needs. On the federal side a fixed amount would be set as part of the budget neutrality agreement, and on the state side a fixed percentage of the state's "general revenue budget" would be dedicated to Medicaid. Funding would no longer be responsive to changes in enrollment, utilization of services, new technologies, epidemics etc. In a world where it is extraordinarily difficult to predict health care costs, this is a high stakes gamble --- both for the future of the state's budget as well as the health of the hundreds of thousands of Rhode Islanders who depend on the program for their health and long term care services.

Since health care needs cannot be capped, capping the federal financing – even should the deal be a good one – necessitates a quid pro quo. The quid pro quo here is the flexibility or the state to limit services in new ways. As the state describes "the decisive factor for the State is the second dimension of the Global Compact – the administrative freedom to manage Medicaid costs within the federal fixed allotment" (p. 7). Federal rules typically allow states to add benefits and populations without seeking a waiver; "flexibility" sought through this waiver is primarily to limit services or cut people from the program in new and different ways.[3]

What flexibility is afforded within the waiver proposal that the state does not already have under current law or other waivers?

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[1] With the exception of Disproportionate Share Hospital payments, administrative expenses, and payments to local educational agencies, See p. 5 of Waiver proposal. All page references are to the July 28, 2008 version of the proposal.

[2] The state of Vermont comes the closest to the proposal but it differs in two key ways – acute care and long term care operate under two separate waivers and the matching system was retained albeit up to a fixed cap.

[3] An exception to this general principle is the "Healthy Choice Accounts" which appear likely to require a waiver to be able to offer a reward to beneficiaries.

Many of the substantive proposals outlined in the waiver document do not require waiver authority or could be accommodated under other more limited waivers. Chapter 9 provides some disturbing answers about the flexibility sought although many questions remain. In general, the state is requesting unfettered flexibility to eliminate optional services and/or optional beneficiaries. As mentioned above, optional spending typically constitutes the majority of spending in any Medicaid program, and this is likely the case in Rhode Island which covers a broad range of optional groups. The proposal repeatedly notes that the state is committing *only* to maintain mandatory services and mandatory populations (p. 81, 82).

The state seeks the authority to establish waiting lists for or cut off optional beneficiaries (pps. 81, 83) from the program. The state could, under current law, remove entire optional categories from the program, the waiver as requested gives the state new power to choose within these groups. For example the state could eliminate coverage for certain parts of the state or treat persons within optional categories differently based on diagnosis. Also under the waiver the state could establish waiting lists which is not permitted under current law.

Optional populations in Rhode Island include:

1. Children age 6 and up from the poverty line to 250% FPL; younger children from 133 FPL-250% FPL;
2. Parents from around 40% of the poverty line up to 175%;
3. Pregnant women from 133% of FPL up to 250%;
4. "Katie Beckett" kids – children with severe disabilities;
5. Low income seniors and people with disabilities over 74% FPL;
6. Seniors/people with disabilities eligible for home and community based waiver program;
7. Women eligible for the breast and cervical cancer program.

To increase cost-sharing above 5% of family income and impose new costs on unspecified mandatory groups (pps. 81-83). The proposal says, "The State does reserve its authority to impose new or revise existing cost-sharing requirements to mandatory populations." (p. 81). Those most likely to be affected adversely by new copayments are persons with chronic diseases or disabilities who use a lot of services.

What is likely to happen to the waiver proposal when it is reviewed by the federal government? This is a very difficult question to answer because the waiver review process is a secretive one with negotiations going on behind closed doors and little opportunity for public input. At the federal level, both the Centers for Medicare and Medicaid Services (CMS) and the Office of Management and Budget (OMB) at the White House participate in the review process. OMB is most engaged in reviewing the fiscal terms of agreement. There are a number of features in the proposed request with respect to the budget neutrality agreement that have never been approved heretofore which suggest that it is unlikely that the proposal would be approved as is. These include:

1. *A waiver of the matching structure and move to a state maintenance of effort based on a fixed percentage of the state's budget.* Many question whether the

federal government has the legal authority to waive these provisions. A move to state MOE financing as described in the proposal would not be budget neutral to the federal government;

2. *No state has been granted the emergency protections that RI is seeking in case of epidemic, catastrophe, prolonged economic downturn and other situations*; (p. 45).
3. *Waiver terms for new budget neutrality agreements are typically five years not three* as the state appears to be requesting (except in case of renewals like the recently approved RIteCare waiver which is for three years). (p. 45).

The combination of these factors make it probable that the final product will undergo significant changes – indeed the state has acknowledged that this is just a starting point.

Another issue to consider which may affect the timing of the approval is the growing concern on the part of Congressional Committees which oversee Medicaid about the waiver process. The secrecy and shortcomings of the process have been outlined in recent reports from the U.S. Government Accountability Office.[4] Chairs of the authorizing committees in both the House and the Senate have expressed concern about the waiver process and are likely to be extremely interested in Rhode Island's proposal since its approval would represent a move to a block grant that looks very similar to a proposal that the Bush Administration has been peddling for some time and which has not been rejected by Congress. Indeed, initial discussions about the Rhode Island waiver prompted a letter on June 19, 2008 to HHS Secretary Leavitt about the importance of improving the Section 1115 waiver process and opportunity for public review from Sen. Max Baucus, Chairman of the Finance Committee, Sen. Jay Rockefeller, Chairman of the Health Subcommittee of the Finance Committee, and Rhode Island's Senators Reed and Whitehouse.

In conclusion, I congratulate the Committees on their efforts to remain deeply engaged in the waiver process as it moves forward as there is much at stake here. Given the state's budgetary challenges, I would urge the legislature to push the state to move forward on the policy changes that can be accomplished without the waiver in order to achieve the necessary budget savings. The waiver proposal, as currently structured, is far too risky a path to take.

[4]GAO issued two reports in the past year on Medicaid Demonstration Waivers (Report #GAO-07-694R, July 2007) on the lack of public input and (Report# GAO-08-87, January 2008) on cost and oversight concerns.