

In August, 2001, the Centers for Medicare and Medicaid Services (CMS) announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. HIFA encourages states to seek waivers of various provisions of the Medicaid Act and the State Children's Health Insurance Program in order to expand basic health insurance coverage to groups not currently eligible to receive benefits under those programs. In return, CMS has promised the states fast-track consideration of their waiver requests, and the "flexibility" to limit the benefits and rights of some current recipients in order to meet CMS

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requirement that any expanded coverage not cost the federal government any more money than it is now paying to a state. With HIFA, CMS has once again focused attention on its powers under

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1115 of the Social Security Act (42 U.S.C.

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1315) to waive various provisions of the Medicaid Act in furtherance of "demonstration projects." This paper examines some of the substantive and procedural limitations on those powers.

The language of ' 1115 provides the starting point for any analysis of the scope of CMS= waiver authority. It states, in relevant part:

(a) Waiver of State plan requirements; costs regarded as State plan expenditures; availability of appropriations

In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary [of HHS], is likely to assist in promoting the objectives of subchapter . . . XIX of this chapter [*i.e.*, Medicaid], . . . in a State or States B

(1) the Secretary may waive compliance with any of the requirements of section . . . 1396a of this title, . . . to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section . . . 1396b of this title, . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan

Advocacy challenging past waivers in the Medicaid program has frequently focused on the process by which a particular waiver was considered and granted, or on the fact that the waiver did not assist in promoting the objectives of the Medicaid Act. This approach, which will be discussed in a future paper, has yielded mixed results, but in all cases has had to overcome the considerable hurdle posed by the broad discretion that

' 1115 affords the Secretary. However, the statute contains at least one constraint on the Secretary

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s power that is not at all discretionary and may provide advocates with a powerful tool for negotiating, and if necessary challenging, the terms of any proposed waiver program.

Section 1115(a)(1) only authorizes the Secretary to waive provisions found in 42 U.S.C. ' 1396a (SSA 1902), which describes what must and may be included in a state

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s Medicaid plan. Section 1115(a)(1) is a significant limitation on the power of the Secretary. While

' 1396a contains many provisions central to Medicaid, many other important aspects of the program are found elsewhere in the Act. Among these are protections for observance of religious beliefs (

' 1396f), the HMO consumer protection requirements (

' 1396b(m), and provisions regarding Indian health service facilities (

' 1396j)). Provisions not found in

' 1396a simply cannot be waived. Thus, the first step in analyzing any waiver request should be a precise examination of exactly what the state is proposing to do and which provisions it proposes to waive.

This approach is complicated, however, by the fact that many aspects of the Medicaid program are mentioned both within '1396a and elsewhere in the Act. Whether these provisions are subject to waiver because they are referenced in ' 1396a will normally depend on the exact language of the section of the Act located outside

' 1396a.

An examination of these outside sections reveals that they fall into several general categories. Some state unequivocally that they apply. Notwithstanding any other provision of this chapter.

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See e.g.,

42 U.S.C.

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1396u-1(g) (SSA

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1931). Section 1115 is in the same chapter as

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1396u-1. Therefore, the requirements of

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1396u-1 cannot be waived pursuant to

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1115. Other provisions outside

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1396a independently require that they be included in a state

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s Medicaid plan. Yet other provisions do not explicitly require that they be included in the state plan, but they are nonetheless written in mandatory language. These, too, probably cannot be waived.

Finally, some outside sections merely contain definitions or clarifications of terms addressed in

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1396a. Most of these provisions probably can be waived.

The following two charts set forth those provisions of the Act that are referenced both in ' 1396a and elsewhere, and that NHeLP has determined cannot be waived. Chart I lists those provisions that either state they are not subject to waiver or contain an independent requirement that they be included in the state plan. Chart II lists provisions that cannot be waived either because they are written in mandatory terms or they involve a core provision of the Act. See *PhaRMA v. Thompson*

, n. 2,

supra.

Each chart provides a cross reference between the relevant subsection of

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1396a and the related provision found outside

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1396a, and summarizes the substance of each.

A final issue that is likely to arise in the context of a challenged waiver provision emanates from Section 1115(a)(2)(A), which allows reimbursement to the states for the Acosts of such project which would not otherwise be included as expenditures under section . . . 1396b of this title

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(
i.e.,
the costs of an approved demonstration project).
In
PhaRMA v. Thompson, supra,
the Secretary attempted to fashion from this language a waiver authority that was somehow broader than that provided by Section 1115(a)(1).
The D.C. Circuit rejected this proposition and ruled that the Secretary was without authority to approve a state waiver that forced drug manufacturers to pay rebates beyond those authorized by

1396r-8.
PhaRMA v. Thompson,
251 F.3d at 222.

This is almost certainly the right result, and the court reached it without addressing what is perhaps the strongest argument against the position proffered by the Secretary.

With its reference to

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such project

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, subsection (2)(A) clearly reflects the intent to allow federal reimbursement for state expenditures that result from an approved waiver.

It is circular, and renders subsection (1) meaningless, to argue that this reimbursement authority allows the Secretary to approve any expense he chooses, even those that a state could incur only by ignoring a provision of the Medicaid Act that is not otherwise subject to waiver.

Nonetheless, advocates should assume that they will continue to hear this argument when they seek to confine the Secretary

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s waiver authority within its proper limits.

Home and community based care waivers pursuant to 1396n raise separate issues. Section 1396n(c)(3) (regarding waivers for the developmentally disabled and mentally retarded), 1396n(d)(3) (regarding the elderly) and 1396n(e)(3) (regarding children infected with AIDS) specify the provisions of 1396a which can be waived as part of these programs. These are limited to statewideness, comparability, and community income and resource rules. Each provision should be separately consulted because there are slight variations among them in terms of the 1396a provisions that may be waived. Importantly, this should mean that provisions not listed cannot be waived. These include such important provisions as: (a)(8) (requiring reasonable promptness and provision of services to all who are eligible); (a)(30) (requiring payments that ensure equal access); and (a)(43) (requiring EPSDT).

See e.g., C.K. v. N.J. Dept. of Health and Human Services, 92 F.3d 971 (3d Cir. 1996); *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994); *Crane v. Mathews*, 417 F. Supp. 532 (N.D. Ga. 1976; and, *California Welfare Rights Org. v. Richardson*, 348 F. Supp. 491 (N.D. Cal. 1972).

Pharmaceutical Research and Manufacturers of America v. Thompson, 251 F.3d 219, 222 (DC Cir. 2001)(Although the Act authorizes the Secretary to waive certain Medicaid requirements for such demonstration projects, it does not authorize him to waive any requirements of section 1396r-8's rebate provision or the requirement that Medicaid beneficiaries contribute no more than a "nominal" amount to the cost of medical benefits they receive. See id. , 1315(a)(1). @).

Several courts have decided that the reasonable promptness prong of ' 1396a(a)(8) cannot be waived in the context of home and community based waivers.

See e.g., *Lewis v. New Mexico Dept. of Health*,
94 F. Supp. 2d 1217, 1234 (D.N.M. 2000) and
McMillan v. McCrimon,
807 F. Supp. 475, 482 (C.D. Ill. 1992).