

California is currently considering a broad restructuring of its Medi-Cal program, with an eye toward achieving the largely contradictory, if not altogether illusory, goals of providing better services and spending less money. It intends to seek a waiver under § 1115 of the Social Security Act (42 U.S.C. § 1315) from the Secretary of the U.S. Department of Health and Human Services (HHS) in order to avoid complying with various provisions of the Medicaid Act that would otherwise prohibit parts of the proposal. Such a waiver would subject all or large parts of Medi-Cal to a budget cap. Such a ceiling on federal reimbursement for state expenses would result either from the budget neutrality requirements that accompany any § 1115 waiver, or because California may affirmatively request that the federal government "block grant" its program, thereby leaving the state and/or its low-income citizenry at risk for all future unanticipated expenses associated with the program and the services it provides.

A waiver for some of what California proposes to do is unnecessary, because the same ends can be accomplished through state plan amendments that do not threaten to put the state at risk for unexpected cost increases in Medi-Cal. However, other features of the overhaul that California is considering would indeed require a waiver, and among those are many suggestions that simply are not legal, with or without a waiver. While the waiver proposal is still a work in progress, making it difficult to predict the legality of some provisions at this time, what is already clear is that California is proposing to embark upon a course of conduct that would violate the Medicaid Act and most likely the Americans with Disabilities Act as well.

Cost Sharing and the Medicaid Act

A centerpiece of California's waiver proposal is increased cost sharing and premiums, especially for those people who would receive benefits under Tier 2. However, anything beyond "nominal" cost sharing is prohibited by the Medicaid Act. 42 U.S.C. § 1396o(a)(3) and (b)(3). In each of the three categories of cost sharing that California is contemplating - copayments, coinsurance and premiums - it has proposed some payments that would, if implemented, violate the nominality limits established by the Act and its implementing regulations.

The permissible limits on each type of cost sharing are set forth in 42 CFR §§ 447.50 through 447.58. Perhaps the greatest cost sharing problems in California's waiver outline exist with regard to the premiums that the state has proposed to charge. Premiums are an amount that a recipient must pay in order to participate at all in Medicaid. Pursuant to both the Medicaid Act and its regulations, premiums (or any similar charges) may not be imposed upon recipients who are "categorically needy." 42 U.S.C. § 1396o(a)(1) and 42 CFR § 447.51(a). Categorically

needy recipients are defined as those who do, or are deemed to, receive Medicaid pursuant to any of the categories listed in 42 U.S.C. §§ 1396a(a)(10)(A)(i) or (ii), 1396a(e), 1396a(f) or 1396s. See 42 CFR § 435.4. The groups in Tier 2 to which California has proposed to apply premiums are among those listed in the above sections of the Medicaid Act, and therefore charging them any premium would be illegal. In addition, even if premiums were authorized for these groups, the amount proposed by California would nonetheless be impermissible. Premium maximums are listed at 42 CFR § 447.52(b), and are set based on a family's size and gross monthly income. The maximum listed premium, for a one or two person family with gross monthly income in excess of \$1000, is \$19 per month. All other allowable premiums are less than that amount. But California has proposed charging some people up to \$20 per month as a condition of continuing eligibility. That amount would be illegal with regard to anyone, and the legality of lesser premiums would depend on the size and income of the families against whom they were assessed.

For copayments, which are fixed payments per service for which the recipient is responsible, § 447.54(a)(3) establishes a maximum of \$3 per outpatient service. The Medicaid Act allows a state, with a waiver, to charge twice that amount (i.e., \$6) for non-emergency services received at an emergency room. California, however, has proposed under Tier 2 to charge \$10 for non-emergency use of the emergency room, which it may not do under the law.

With regard to coinsurance, which requires a recipient to pay a percentage of the cost the state pays for each service, 5 % of the state's cost is the maximum that may be charged to a recipient. 42 CFR § 447.54(a)(2). As California has proposed to charge Tier 2 recipients fully four times this permissible limit for many services, implementation of this aspect of the waiver would also be illegal.

Finally, the state has proposed to allow providers to deny non-emergency services to any recipient who is unable to meet his or her copay or coinsurance for that service. This aspect of the proposal would violate both 42 U.S.C. § 1396o(e) and 42 CFR § 447.53(e).

In issuing its waiver outline, California has apparently assumed that the statutory and regulatory requirements regarding cost sharing can be waived by the Secretary of the U.S. Department of Health and Human Services (HHS). Both the language of the § 1115 waiver provision (42 U.S.C. § 1315) and an increasing number of cases establish that this is not so.

The language of § 1115 provides the starting point for any analysis of the scope of the HHS

waiver authority. It states, in relevant part:

(a) 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 □
(1) the Secretary may waive compliance with any of the requirements of section . . . 1902 [42 U.S.C. § 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 . . . 1903 [42 U.S.C. § 1396b] of this title, . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan

As can be seen, § 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's Medicaid plan. Section 1396o, which is the basis for all of the limitations on cost sharing discussed above, is obviously not part of § 1396a. Thus, absent some other basis for waiving that section, the state must comply with its requirements.

In past cases, HHS has proffered two arguments for why it can waive the provisions of § 1396o, but courts have now rejected both of them. One argument offered by the Secretary is that he can waive the provisions of § 1396o because that section is cross-referenced in § 1396a(a)(14), which is subject to waiver under the terms of § 1115(a)(1). However, this argument ignores the fact that § 1396o(a) itself independently requires that the provisions set forth therein be included in a state's Medicaid plan, thereby providing an independent basis for that requirement that cannot be waived.

In addition, § 1396o was enacted in 1982, following a decision from the district court in Georgia in *Crane v. Mathews*, 417 F. Supp. 532 (N.D. Ga. 1976), which had concluded, correctly, that the substantive limitations on cost sharing, then found only in § 1396a(a)(14), could indeed be waived. Thus, had Congress intended to have the cost sharing provisions remain subject to waiver under § 1115(a)(1), it would have just left those provisions where they were. However, it instead moved those protections outside of § 1396a, thus insulating them from waiver by the Secretary.

Finally, the case of *PhaRMA v. Thompson*, 251 F.3d 219 (D.C. Cir. 2001), establishes that § 1396o is not subject to waiver by the Secretary. In dictum, the court says precisely that.

PhaRMA

, at 222 . However, the holding of the case also establishes this principle. In

PhaRMA

, the plaintiff alleged that the Secretary had exceeded his authority by waiving not only § 1396o, but also § 1396r-8, which among other things regulates what charges can be imposed on drug companies participating in the Medicaid program. Like § 1396o, § 1396r-8 is cross-referenced in § 1396a, at 42 U.S.C. § 1396a(a)(54). Unlike § 1396o, however, § 1396r-8 does not include an independent requirement that its provisions be included in a state's Medicaid plan.

Nonetheless, the D.C. Circuit held that the Secretary did not have the authority to waive § 1396r-8. *Id.* Hence, a fortiori, the Secretary lacks authority to waive § 1396o, for, like § 1396r-8, it resides outside of, but is cross-referenced in, § 1396a, but in addition contains an independent requirement that its provisions be included in a state's Medicaid plan.

The second argument put forth by the Secretary for why he can waive (or at least ignore) the provisions of § 1396o is that he possesses completely independent authority under § 1115(a)(2)(A) to consider as Medicaid reimbursable costs expenses by a state that would not otherwise be reimbursable under the program. Thus, the argument goes, expenses incurred by a state while operating a Medicaid program that ignores the requirements of § 1396o can be reimbursed under this perceived authority, even assuming the Secretary lacks the ability to waive § 1396o outright. This argument is equally unavailing for the state.

First, the Secretary has previously offered this argument only with regard to people covered by a waiver who could not be covered by Medicaid at all without the waiver in question, i.e., so-called expansion populations. These people, according to the Secretary, are not receiving Medicaid "under the state plan" at all, and therefore are entitled to none of the protections of the Medicaid Act, except as the Secretary directs. Whatever the legal shortcomings of this argument, a factual problem is that the California waiver outline does not purport to create any expansion populations. Rather, everyone receiving benefits is within a group able to be covered under the Medicaid Act. Thus, a major underpinning of the Secretary's argument is absent in the case of California.

The larger problem for the Secretary and California is that every court that has considered this argument of independent authority under § 1115(a)(2)(A) has rejected it, either implicitly or explicitly. The Secretary made this argument in *PhaRMA v. Thompson* where there were expansion groups involved, and the D.C. Circuit nonetheless found that he could not waive the analogous provisions of 42 U.S.C. § 1396r-8. *PhaRMA v. Thompson*, *supra* at 222. The decision in *Spry v. U.S.*

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, CV-03-121-ST (D. Or. 2004), also rejected this basis for waiving the provisions of § 1396o.

Spry

, in which the cost sharing provisions of the Oregon § 1115 waiver were challenged, is instructive, as California has openly stated that its outline is based in part on what Oregon did with its waiver. Most recently, the court in *N*

ewton-Nations, et al. v. Rogers, et al.

, Civ. No. 03-2506-PHX-EHC (D. Ariz.), in preliminarily enjoining continued application of Arizona's cost sharing waiver to a plaintiff class that does include expansion populations, also refused to recognize the authority that the Secretary claims to have under §1115(a)(2)(A). 2004 US Dist. LEXIS 7981 (3/17/04). In addition to prohibiting greater than nominal copays, both the

Spry

and

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cases banned the state defendant from allowing providers to deny service to Medicaid recipients unable to meet their cost sharing obligations, as California has proposed in its waiver outline.

Cost Sharing and the Americans with Disabilities Act

In addition to problems with the amounts of the cost sharing proposed by California in its waiver outline, it appears likely that the state will run into legal problems with the Americans with Disabilities Act (ADA) as a result of the manner in which that cost sharing is to be applied. This analysis assumes, as California stated at one of the waiver stakeholder meetings, that the 20% coinsurance to be charged to Tier 2 and Tier 3 recipients for certain services will not apply to long term nursing home care.

Many of the services to which the proposed 20% coinsurance would apply are among those that people with disabilities require to remain in their communities. Among these are personal care services, home health services and medical supplies. It is virtually certain that some people, and probably many people, will not be able to afford the 20% coinsurance on an ongoing basis, and therefore will have to forego those services. Without the services, many will be unable to maintain themselves in the community and will have to resort to some form of institutional care, usually in a nursing home or other long term care environment. The services that they then need in the nursing home, which would be exactly those that they could no longer afford to pay for in the community, would not be subject to the 20% coinsurance requirement. In short, California is proposing to create a system in which many of those with disabilities will be unable to receive the services they need to remain in the community unless and until they enter some sort of institution.

Fortunately, such a system is almost certainly as illegal as it is perverse and unconscionable. The Americans With Disabilities Act, 42 U.S.C. §12101 et seq., is a designed "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. §12101(b)(1). Congress identified isolation, segregation and unnecessary institutionalization of individuals with disabilities as forms of discrimination that must be eliminated. 42 U.S.C. §§12101(a)(2), (3) and (5). The ADA specifically recognizes that discrimination persists in the provision of "health services," 42 U.S.C. §12101(a)(3), and establishes a national goal "to assure... independent living... for such individuals." 42 U.S.C. §12101(a)(8).

Congress delegated to the Attorney General responsibility for issuing regulations implementing the broad anti-discrimination mandate included in the Act at 42 U.S.C. §12132. Those regulations, as relevant here, are found at 28 CFR §35.101 et seq. Section 35.130 provides in part that:

- (b)(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
 - (i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; [or]
 - (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entities program with respect to individuals with disabilities; . . .
- (d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Bearing in mind that Congress declared, and the Supreme Court in *Olmstead v. L. C.*, 527 U.S. 581, 597 (1999) affirmed, that unnecessary segregation and institutionalization of people with disabilities are forms of discrimination prohibited by the ADA, the scheme proposed by California in its waiver outline clearly runs afoul of this regulation. It will inexorably have the effect of forcing many people with disabilities who now function perfectly well in the community into nursing homes and other institutions. Once they get there, of course, the services for which the state was charging them 20% coinsurance while they were in the community will be provided without that charge. Thus, to get the services they need, many people with disabilities will be forced into nursing homes. This discrimination, i.e., unnecessary segregation and institutionalization in order to receive services, whether or not an intended result of the waiver proposal, is exactly what is prohibited by § 35.130(b)(3) and (d). While this system of administration, which will perforce drive disabled people into institutions in order to get needed services, would seem inconsistent even with California's stated goals of shaving costs and "promoting personal ownership and responsibility", it certainly is not one designed to provide services to those with disabilities in "the most integrated setting appropriate to the needs of" those individuals, as required by § 35.130(d).

That the ADA may impose limits on the manner in which a state operates its Medicaid program with regard to people with disabilities, even for optional benefits, has already been recognized by the courts. In *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1182 (10th Cir. 2003), for example, the court found that plaintiffs' claim that a five-prescription-per-month limit in Oklahoma's Medicaid program would force them into nursing homes would, if proven, constitute a violation of 28 CFR § 35.130(d), unless the state could demonstrate that not imposing such a limit would constitute a fundamental alteration of its Medicaid program. The court was skeptical of the state's ability to show the latter, as it had previously operated the program without that limit. So too would California have difficulty demonstrating that not charging 20% coinsurance for necessary community based services would constitute a fundamental alteration of its Medicaid program, given that it has to date run that program without such coinsurance, and in fact felt it needed a waiver of the Medicaid rules (however illegal) even to implement it. Consequently, as currently structured, it is very likely that California's proposal would violate the ADA and its implementing regulations.

Mandatory Managed Care for the Elderly or Disabled on Medicare

In its waiver outline, California has made clear its desire to expand the use of managed care. What is less clear is where and to which eligibility groups such an expansion would apply, but requiring the elderly and disabled to use managed care appears to be under consideration. However, many elderly and disabled Medicaid recipients also receive Medicare, and as to them any requirement to use managed care would violate 42 U.S.C. § 1396u-2(a)(2)(B), which prohibits exactly that.

California may believe that it is not subject to the provisions of § 1396u-2 because it operates its managed care programs under the waiver authority of § 1915(b) of the Social Security Act [42 U.S.C. § 1396n(b)], rather than under the authority granted in § 1396u-2. Such a belief is incorrect. Section § 1396u-2. was added to the Medicaid Act in August of 1997 by the Balanced Budget Act of 1997 (BBA). Section 4710(c) of the BBA, as interpreted by CMS, granted states operating a managed care system under § 1915(b) a time limited exemption from complying with the requirements of § 1396u-2. See 67 Fed. Reg. 40993 - 40994 (6/14/02). According to CMS, that exemption began no later than August 5, 1997 and lasted no longer than two years from that date. Thus, after August 5, 1999, all states operating their managed care systems under a 1915(b) waiver were nonetheless required to comply with all of the provisions of § 1396u-2. *Id.* As such, California would not be able to require elderly or disabled Medicare recipients to enroll in managed care.

It is true that CMS believes that it retains the authority under § 1115 to waive provisions in § 1396u-2, at least for states operating their managed care systems under § 1915(b), should it choose to do so. *Id.* at 40994. However, since § 1396u-2 is not one of those sections that the Secretary is authorized to waive under the authority of § 1115(a)(1), that perceived waiver authority would have to reside in § 1115(a)(2)(A). But, as discussed above with regard to waiver of the cost sharing protections found in § 1396o, every court to consider the issue thus far has concluded that the Secretary in fact possesses no independent waiver authority under that subsection of § 1115. Consequently, any effort by California to force the elderly and disabled into managed care would, unless there were an exception for all those on Medicare, be illegal.

Conclusion

To the extent that California envisions saving money or imposing some misguided sense of personal responsibility on its poorest citizens by subjecting them cost sharing requirements that are more than nominal, it will find that its proposed conduct is not only ill-conceived, but also illegal under provisions of the Medicaid Act that cannot be waived. The same is true for any proposals that would force those on Medicare to participate in managed care. Finally, the manner in which the state is now proposing to apply the cost sharing requirements to certain people with disabilities almost certainly would violate the Americans with Disabilities Act, for it would inexorably result in many people unnecessarily entering institutions, where they would receive without charge the very services they needed, but could no longer afford, to support an integrated life in their local communities.