

Fact Sheet

Federal Authority to Approve Medicaid Demonstration Projects

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Over the years, states have used the Social Security Act's "section 1115" waiver provision to experiment with Medicaid program design. The Bush administration has introduced a new 1115 waiver, the Health Insurance Flexibility and Accountability (HIFA) waiver.² The stated purpose of the HIFA initiative is to expand Medicaid coverage to additional population groups while capping federal spending and expanding private insurance concepts as part of the Medicaid program.³

In practice, however, the Administration is approving waivers that simply cut eligibility and services and/or impose heightened cost sharing on previously covered population groups. For example, Tennessee is using a newly-approved waiver to cut eligibility and services while Arizona and Oregon have revised their cost sharing rules so that beneficiary payments exceed the amounts authorized by the Medicaid Act, *see* 42 U.S.C. § 1396o.⁴

The Secretary of the United States Department of Health and Human Services is using an unparalleled claim of authority to approve HIFA waivers. This Fact Sheet discusses section 1115 waivers. An overview to section 1115 will be given. Then, the Fact Sheet will explain the basis for

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² *See* CMS, *Guidelines for States Interested in Applying for HIFA Demonstrations* (last modified Sept.16, 2004), at <http://www.cms.hhs.gov/hifa/hifagde.asp>.

³ For background on HIFA, *see* National Health Law Program, *What is HIFA and Why Should We Be Concerned?* (Feb. 19, 2002), at <http://www.healthlaw.org/library>.

⁴ For discussion of the Medicaid cost sharing provisions, *see, e.g.*, National Health Law Program, *NAPAS Q&A: Medicaid Cost Sharing* (Feb. 23, 2004) (on filed with National Association of Protection & Advocacy Systems and the National Health Law Program).

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the claimed HIFA authority and discuss the litigation challenging it. A recent decision from the Ninth Circuit Court of Appeals, *Portland Adventist v. Thompson*, 399 F.3d 1091 (9th Cir. 2005), will be highlighted.

Background to Section 1115

Absent a waiver, state Medicaid programs must meet the minimum requirements of the federal Medicaid law. These requirements are contained in the Medicaid Act, particularly section 1396a, which lists numerous standards for state Medicaid plans. Among the provisions are mandates for a single state agency to administer the program,⁵ comparability of benefits among recipients,⁶ statewide operation,⁷ due process when a claim is denied,⁸ reasonable promptness in the delivery of assistance,⁹ early and periodic screening and treatment benefits for children and youth,¹⁰ and adequate payment rates.¹¹

Two separate statutory provisions authorize the Secretary of Health and Human Services (the Secretary or Secretary of HHS) to waive the otherwise mandatory provisions of the Medicaid Act and allow states to engage in activities that would otherwise violate the state Medicaid plan requirements and, therefore, fail to qualify for federal funding: Sections 1915 and 1115 of the Social Security Act.

Section 1915 waivers are available for two specific purposes. First, these waivers are used to limit certain recipients' free choice of provider, typically by requiring enrollment in a risk-based managed care plan.¹² Section 1915 also authorizes states to provide home and community-based services to the elderly, people with mental retardation/developmental disability; and young children with HIV/AIDS or drug dependency at birth.¹³ The statute and implementing regulations describe the assurances the state must make to obtain a section 1915 waiver. Among other things, the state must show that freedom of choice restrictions are consistent with access, quality and the efficient and cost-effective provision of care and services and that restrictions do not discriminate among classes of providers on grounds other than efficiency and effectiveness.¹⁴ In addition, participating providers must meet quality and utilization standards.¹⁵ All states operate at least one section 1915 waiver.

⁵ See 42 U.S.C. § 1396a(a)(5) (West Supp. 2005).

⁶ *Id.* at § 1396a(a)(10).

⁷ *Id.* at § 1396a(a)(1).

⁸ *Id.* at § 1396a(a)(3).

⁹ *Id.* at § 1396a(a)(8).

¹⁰ *Id.* at §§ 1396a(a)(10), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

¹¹ *Id.* at § 1396a(a)(30)(A).

¹² Section 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b)).

¹³ Section 1915(c)-(e) of the Social Security Act (42 U.S.C. § 1396n(c)-(e)).

¹⁴ See 42 U.S.C. § 1396n.

¹⁵ *Id.*

By contrast, section 1115 of the Social Security Act authorizes experimental or demonstration projects. The experimental waiver authority was added to the Social Security Act in 1962¹⁶ and extended to include Medicaid when that program was enacted in 1965.¹⁷ The waiver statute, section 1115 (or 42 U.S.C. § 1315), allows the Secretary to approve experimental, pilot, or demonstration projects from the states which, in the opinion of the Secretary, are likely to promote the objectives of the Medicaid Act. The Secretary can waive compliance with any requirements of section 1396a of the Medicaid Act and treat expenditures for such projects as expenditures under the State Medicaid plan.

The Social Security Act requires a section 1115 waiver to be limited to an experimental, pilot, or demonstration project of limited scope and duration. At the time of its enactment, Congress described section 1115 as a way to “test out new ideas and ways of dealing with the problems of public welfare recipients.”¹⁸ It stated that demonstration projects “usually cannot be statewide in operation” and “are expected to be selectively approved by the Department.”¹⁹ In the past, these waivers have included a formal research methodology involving, for example, control/study group assessments. Moreover, the projects were implemented on less than a statewide basis, of limited duration (usually three to five years), and were not renewable.²⁰ Most often, the Medicaid 1115 experimentation has assessed various aspects of mandatory beneficiary cost sharing and mandatory enrollment in risk-based managed care.

Enforcing the Waiver Statute against the Secretary

The Secretary of HHS may approve a waiver that violates the requirements of section 1115. Adversely affected individuals can challenge that approval under the Administrative Procedure Act.²¹ The APA sets forth the standards for review and addresses situations where the Secretary has acted in an arbitrary or capricious manner or taken an action not authorized by law.²²

While section 1115 gives the Secretary of HHS broad authority to review states’ proposals, the authority is not unlimited or unreviewable. Indeed, all of the courts which have heard challenges to section 1115 waivers have refused to commit the review entirely to agency discretion.²³

¹⁶ Pub. L. No. 87-543, § 122 (adding 42 U.S.C. § 1315).

¹⁷ Social Security Amendments of 1965, Pub. L. No. 80-97 (amending 42 U.S. C. § 1315(a)(1)).

¹⁸ S. R. No. 1589, 87th Cong., 2d Sess. 19-20 (1962). *See also* H.R. No. 1414, 87 Cong., 2d Sess. (1962).

¹⁹ *Id.*

²⁰ Memorandum from David Ellwood, Bruce Vladeck, and Laurence Love, HHS, to HHS Secretary, at 2 (June 22, 1993) (on file with the author).

²¹ *See* 5 U.S.C. § 701 *et seq.*

²² *See* 5 U.S.C. § 706. *See also, e.g., Motor Vehicles Ass’n v. State Farm*, 463 U.S. 29, 44 (1983) (for purposes of APA review, a decision considered arbitrary and capricious if “the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect [or] offered an explanation for its decision that runs counter to the evidence before the agency”).

²³ The Secretary’s section 1115 authority is being challenged in three ongoing cases: *Portland Adventist*, 399 F.3d 1091 (9th Cir. 2005); *Spry v. Thompson*, 2003 WL 23411996 (D. Ore. Dec. 8,

The Secretary's Claimed HIFA Authority

When the HIFA initiative was announced in 2001, it was not clear that the Secretary of HHS perceived himself to have such an unparalleled authority to issue section 1115 waivers. However, when the Secretary's actions were challenged by beneficiaries being harmed by these waivers, the argument became clear.²⁴ Specifically, the Secretary of HHS claims that the section 1115 statute gives him three separate and independent authorities:

- “waiver” authority, to waive certain Medicaid requirements of section 1396a of the Medicaid Act;
- “expenditure” authority (sometimes called expansion authority), to approve projects that the Secretary finds are likely to promote the objectives of the Medicaid Act and use Medicaid funds to cover the costs of these projects; and
- “combination” authority, to approve projects under both the waiver and expenditure authorities.

Early on, the Secretary said the expenditure authority was tied to projects that extended Medicaid to single adults and childless couples. The Secretary said these “expansion” populations could be covered only through the demonstration expenditure authority and not a state Medicaid plan, which the Secretary said only covers “traditional” Medicaid groups such as low income children and pregnant women. Because they were receiving Medicaid due to the state's decision to obtain a demonstration waiver, the Medicaid state plan protections were inapplicable to these expansion

2003), *adopted by*, 2004 WL 1050867 (D. Ore. Apr. 6, 2004) (on appeal); and *Newton-Nations v. Rogers*, 316 F. Supp. 2d 883 (D. Ariz. 2004) (preliminary injunction). For previous section 1115 cases, see *Pharm. Research & Manufacturers of Amer. v. Thompson*, 251 F.3d 219 (D.C. Cir. 2001) (holding Secretary could not waive Medicaid drug rebate program provisions, 42 U.S.C. § 1396r-8); *C.K. v. New Jersey Dep't of Health & Human Services*, 92 F.3d 171 (3d Cir. 1996) (holding Secretary did not act arbitrarily and capriciously in approving waiver); *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994), *rev'g*, 853 F. Supp. 1195 (E.D. Cal. 1993) (finding Secretary failed to undertake adequate review of section 1115 waiver request); *Rosen v. Tenn. Comm'r of Finance & Admin.*, 280 F. Supp. 2d 743 (MD. Tenn. 2002) (later case history omitted); *California Welfare Rights Organization v. Richardson*, 348 F. Supp. 491 (N.D. Cal. 1972); *Aguayo v. Richardson*, 352 F. Supp. 462 (S.D.N.Y. 1972), *aff'd in part, mod. in part*, 473 F. 2d 1090 (2d Cir. 1973); *Crane v. Matthews*, 417 F. Supp. 532 (N.D. Ga. 1976). See generally *Hamby v. Neal*, 368 F.3d 549 (6th Cir. 2004) (requiring section 1115 Medicaid waiver program to provide adhere to due process requirements). See also *Phoenix Baptist Hosp. & Med. Center v. United States*, 728 F. Supp. 1423 (D. Ariz. 1989) (dismissed suit against U.S. under Federal Tort Claims Act for failure to monitor performance of contractors who went bankrupt, following grant of a section 1115 waiver), *aff'd*, 937 F.2d 452 (9th Cir. 1991) (expressly did not consider applicability of section 1115 issues); *Georgia Hosp. Ass'n v. Dep't of Medical Assistance*, 528 F. Supp. 1348 (N.D. Ga. 1982) (challenge to waiver of provisions concerning hospital reimbursement rates).

²⁴ The following discussion is based on the briefs filed by the Secretary of Health and Human Services in the ongoing litigation cited above: *Portland Adventist*, *Spry*, and *Newton-Nations*.

populations.²⁵ In sum, according to the Secretary, when he is acting pursuant to the purported expenditure authority, the provisions of the Medicaid Act do not apply and do not need to be waived. They can be ignored.

However, as litigation has evolved, the expenditure authority has been quietly extended. For example, when Medicaid beneficiaries in Arizona pointed out that the Secretary had used the expenditure authority to apply heightened copayments to “traditional” medically needy populations, the federal agency said the expenditure authority was used because the *state* did not seek to cover the individuals through the medically need option. With this statement of the position, then, there appear to be no limitations on when the Secretary and a state may decide to use the purported expenditure authority.

The problem with the Secretary’s argument is that it is at odds with the wording of section 1115, which provides:

(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, is likely to assist in promoting the objectives of subchapter . . . XIX [42 U.S.C. § 1396 et seq.] . . . in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section . . . 1396a, . . . 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 . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, . . . (emphasis added).

²⁵ This argument ignores the fact that states’ participation in the Medicaid program, at all, is entirely voluntary. Moreover, it is simply untrue that expansion populations cannot be served at all in the absence of the unfettered authority the Secretary claims under section 1115(a)(2). The Medicaid Act divides potential recipients into those who are considered categorically eligible and those deemed medically needy. *See* 42 U.S.C. § 1396a(a)(10). The categorically eligible are in turn divided into mandatory groups that a state must cover, as set forth in section 1396a(a)(10)(A)(i), and those that it may cover if it chooses to do so. The latter groups, known as the optional categorically eligible, are listed in section 1396a(a)(10)(A)(ii). This section of the Act, although it does not actually say so, is generally considered to provide an exclusive rather than an exemplary list of the groups that a state may choose to cover, and it does not include people like most of the plaintiffs. Section 1396a(a)(10)(A)(ii) is one of the statutory provisions listed in section 1115(a)(1) that is subject to waiver. Thus, should a state choose to cover childless and single adults and should the Secretary conclude that such coverage furthers the objectives of the Medicaid Act, the statutory mechanism for accomplishing that result is to allow the state to expand the list of optional categories currently found in section 1396a(a)(10)(A)(ii) by waiving the exclusivity of that list. Unlike the unregulated and unreviewable world imagined by the Secretary, this approach not only offers coverage for the desired expansion populations (who are nothing more than members of additional optional categorically needy groups), but also gives meaning to and complies with all of the provisions of section 1115. It also maintains the integrity of the Medicaid Act.

When read in its entirety, as it must be, section 1115(a) reveals that Congress adopted a cohesive approach to demonstration projects that is premised on the waiver of only those provisions of the Medicaid Act listed in section 1115(a)(1). Then, under section 1115(a)(2)(A), the costs of any demonstration project properly implemented pursuant to section 1115(a)(1) are regarded as Medicaid reimbursable expenditures of the state Medicaid plan. Only this reading gives meaning to every part of section 1115(a), and only this reading avoids the implausible conclusion that Congress carefully circumscribed the Secretary's authority in section 1115(a)(1) only to give him unbridled authority in section 1115(a)(2).

This plain reading of the demonstration waiver statute also fits with structure of the Medicaid statute. The Medicaid statute requires the state to have a state plan for medical assistance which has been approved by the Secretary.²⁶ Section 1396a of the Medicaid Act, the requirements of which are waivable under section 1115(a)(1), delineates the programmatic components of the state plan, including those that define the populations, services, and protections of the state's Medicaid program. Section 1396b(a) of the Medicaid Act, which is referenced in section 1115(a)(2), begins by providing that "from the sums appropriated therefore, the Secretary . . . shall *pay* to each State which has a *plan* approved" (emphasis added), and thus is the payment mechanism for an approved plan under section 1396a. Accordingly, the demonstration waiver language of section 1115(a)(2)(A), allowing the "costs of such project which would not otherwise be included as expenditures under section . . . 1396a [to] be regarded as expenditures under the State plan" is ensuring that there is provision to allow necessary payments under the Medicaid Act to support the project created by a waiver of section 1396a requirements under section 1115(a)(1). Without a waiver under clause (1), there is no need for a special payment provision under clause (2).

A recent publication from Congress, the U.S. House of Representatives Committee on Ways and Means *Green Book*, supports this reading:

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, a number of other provisions in Medicaid law and regulations specify limitations or restrictions on how a State may operate a waiver program. For example, . . . another provision specifies restrictions on cost-sharing imposed under demonstration waivers. . . *Approved Section 1115 waivers are deemed to be part of a Medicaid State plan and are financed through Federal and State matching funds at the regular FMAP [Federal Medical Assistance Percentage] rate.* (emphasis added).²⁷

By contrast, the Secretary's argument for an independent expansion authority pulls section 1115(a)(2)(A) out of the demonstration waiver statute and isolates it from the remaining text and structure. It requires section 1115(a)(2)(A) to be read as an independent grant of authority. However, that provision is not drafted in the language of a delegation of power. The only section that contains a delegation of authority is section 1115(a)(1). After (a)(1) empowers the Secretary to waive statutory

²⁶ See 42 U.S.C. § 1396.

²⁷ Comm. on Ways & Means, U.S. House of Representatives, 108th Cong. 2nd Sess., 2004 *Green Book*, at 15-Medicaid-42 (Mar. 2004), at <http://www.waysandmeans.house.gov/media/pdf/greenbook2003/MEDICAID.pdf>. The 2004 *Green Book* provides background material on the programs within the jurisdiction of the Committee on Ways and Means, including Medicaid.

requirements in section 1396a, section (a)(2) merely states that the costs of “such projects” should qualify for federal funding through the state Medicaid plan.²⁸

Second, this interpretation requires the reader to change the words of the statute by reading clauses (1) and (2) of section 1115(a) as though they were connected by the disjunctive word “or,” rather than the word “and.” However, the words “and” and “or” ordinarily are not interchangeable.²⁹

In addition, this reading ignores a rule of statutory construction called “the doctrine of last antecedent.” This doctrine states that qualifying words must be applied to the phrases immediately preceding them and are not to extend to and include other words or phrases that are more remote.³⁰ The qualifying phrase here is “such project.” As used in section 1115(a)(1), “such project” refers to the immediately preceding clause, which is the introductory language of the statute, section 1115(a) (“In the case of any experimental, pilot, or demonstration project, . . .”). As used in the next clause, section 1115(a)(2)(A), the phrase “such project” refers back to the immediately preceding clause, section 1115(a)(1). Thus, section 1115(a)(2)(A) is providing that the costs of projects that waive provisions of section 1396a are regarded as costs under the state Medicaid plan for the limited demonstration periods prescribed by the Secretary. By contrast, the Secretary’s reading of the statute requires “such project,” when used in section 1115(a)(2)(A), to leapfrog over section 1115(a)(1), the phrase that immediately precedes it, in order to refer back to section 1115(a).

A final problem with the Secretary’s reading is that it necessitates the conclusion that, simply through the use of the phrase “costs of such project which would not otherwise be included as expenditures” in section 1115(a)(2)(A), Congress envisioned, or at least intended to authorize, an entire unregulated parallel Medicaid program. But the Supreme Court has consistently rejected such attempts to find broad authority couched in cryptic phrases. As the Court stated recently:

Congress, we have held, does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not, one might say, hide elephants in mouseholes.³¹

The Portland Adventist decision

This first United States Circuit Court of Appeals to analyze the Secretary’s argument has soundly rejected it. In *Portland Adventist Med. Ctr. v. Thompson*,³² hospitals filed a lawsuit against

²⁸ In addition, there is no authorizing language in Title XI, the subchapter of the Social Security Act where the demonstration waiver provision appears, that authorizes spending money for a demonstration project. Instead, the demonstration waiver authority is dependent on appropriations from the various titles to which the waiver applies.

²⁹ Norman J. Singer, *Sutherland Stat. & Stat. Const.* § 24.14 (6th ed. Supp. 2004).

³⁰ *Id.* at § 47.33 (“Referential and qualifying words and phrases, where no contrary intention appears, refer solely to the last antecedent. The last antecedent is the last word, phrase, or clause that can be made an antecedent without impairing the meaning of the statute.”).

³¹ *Whitman v. Am. Trucking Ass’ns*, 531 U.S. 457, 468 (2001); *id.* at 485 (federal agency “may not construe the statute in a way that completely nullifies textually applicable provisions meant to limit its discretion”).

the Secretary alleging that the Secretary had wrongfully denied them disproportionate share hospital (DSH) reimbursements for services being provided to the full range of low income populations they were serving.

Under the Medicare program, the federal government reimburses hospitals for medical services.³³ Reimbursements occurs under a prospective payment system, which pays a predetermined amount that an “efficiently run hospital should incur for inpatient services.”³⁴ Recognizing that providing services to low income patients may cost hospitals more than is provided through the prospective payment scheme, Congress directed the Secretary to make additional payments to hospitals that serve a “significantly disproportionate number of low-income patients.”³⁵ Part of that calculation requires Medicare’s fiscal intermediaries to determine the proportion of low income patient days the hospital serves, a proportion known as the Medicaid fraction.

Prior to January 2000, the federal policy was uneven, and some fiscal intermediaries excluded inpatient days attributable to section 1115 expansion populations from the Medicaid fraction of the DSH calculation. After the policy was changed to include these days,³⁶ the hospitals, whose pre-2000 DSH calculations excluded expansion populations, filed suit.

The Secretary asked the Court to dismiss the case, arguing that the DSH provision was ambiguous, thus entitling his interpretation to deference. He said the Medicare statute refers only to patients who were “eligible for medical assistance under a State [Medicaid] plan.”³⁷ He argued that section 1115 patients, who receive assistance only because he has waived the states’ compliance with the Medicaid Act’s general requirements, may regarded as “not eligible” under a state Medicaid plan.³⁸ The Court rejected this argument: “Plaintiffs, in turn argue, and the district court held, that the statutory scheme is unambiguous and supports only the conclusion that expansion populations eligible under section 1115 receive medical assistance ‘under a State plan.’ We agree.”³⁹ The Court continued:

In the demonstration project statute, Congress expressly tied § 1115 waivers to approved state Medicaid plans by providing that the costs of such demonstration projects “shall . . . be regarded as expenditures under the State plan.” 42 U.S.C.

³² 399 F.3d 1091 (9th Cir. 2005).

³³ *See* 42 U.S.C. §§ 1395-1395ggg.

³⁴ *Id.* at § 1395ww(d).

³⁵ *Id.*

³⁶ *See* 65 Fed. Reg. 3136 (Jan. 20, 2000).

³⁷ 399 F.3d at 1095 (quoting 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)).

³⁸ *Id.* at 1096.

³⁹ *Id.*

§ 1315(a)(2)(A) [1115(a)(2)(A)]. Thus the statute defined low-income individuals receiving medical assistance under a § 1115 plan as receiving medical assistance under a Title XIX [Medicaid] plan.⁴⁰

The Secretary also argued that section 1115 itself provides authority for excluding expansion populations from the DSH calculation. Here, the Secretary argued that the expansion populations' eligibility for medical care coverage derives not from Title XIX of the Social Security Act [the Medicaid Act] but from the demonstration statute, which is part of Title XI. In other words, according to the Secretary of HHS, the Social Security Act contemplates two types of medical assistance: one under Title XIX state plans and another under Title XI demonstrations. And, the Secretary said, the language of section 1115 confers him with the discretion to decide how to characterize demonstration project expenditures.⁴¹ The Court also rejected this construct:

It is true that § 1115 also provides for demonstration projects designed to serve populations other than low-income medical patients, such as children and the unemployed [citations omitted]. But § 1115 also clearly requires that such projects be tied to and fully consistent with those portions of the Act creating programs for those specific populations. The provision's breadth and flexibility in this regard cannot be read as conferring discretion on the Secretary to interpret § 1115 as establishing a new, freestanding assistance scheme.⁴²

Thus, according to the *Portland Adventist* Court:

The plain language of the statute requires us to conclude that § 1115 does not confer on the Secretary discretion to characterize expenditures as Title XIX (Medicaid) expenditures for some purposes and not for others. On the contrary, while the provision gives the Secretary discretion in *approving* projects, the provision *requires* the Secretary to regard expenditures under § 1115 projects designed to assist low-income patients as Title XIX expenditures for the duration of such projects, and therefore to regard § 1115 expansion populations as receiving Medicaid assistance under a state plan approved under Title XIX.⁴³

Unfortunately, in the weeks following *Portland Adventist*, it has already become clear that the debate has not ended. Currently, in the *Spry* beneficiary cost sharing case—which is now before the Ninth Circuit Court of Appeals—the Secretary is attempting to circumscribe *Portland Adventist* by arguing that it concerns a *Medicare* statute and does not affect his ability to ignore the Medicaid Act when he is exercising his expenditure authority under section 1115(a)(2)(A). This argument should not minimize the importance of *Portland Adventist*, however, because the Court was analyzing an underlying statute that is worded similarly to the Medicaid Act provisions that are being ignored by the Secretary in *Spry*.⁴⁴ Moreover, *Portland Adventist* squarely rejects the Secretary's discretion to

⁴⁰ *Id.*

⁴¹ *Id.* at 1097.

⁴² *Id.* at 1098; *see Id.* at 1097 (“Section 1115 does not establish a new, independent funding source.”).

⁴³ *Id.* at 1099 (emphasis in original).

⁴⁴ Compare 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (concerning patients who are “eligible for medical assistance under a State plan approved under [title] XIX”) with 42 U.S.C. § 1396o (concerning “individuals . . . who are eligible under the [State] plan”).

exert a separate expenditure authority under section 1115(a)(2)(A) and instead ties that provision to the remaining provisions of section 1115(a). In particular, *Portland Adventist* notes that section 1115 authorizes the Secretary to waive compliance with the requirements of certain Social Security Act provisions, specifying section 1396a of the Medicaid Act, and finds the costs of the project are then Medicaid state plan expenditures.⁴⁵ Indeed, *Portland Adventist* finds that section 1115 “requires the Secretary to regard § 1115 expansion populations as receiving medical assistance under a state plan approved under Title XIX.”⁴⁶

In sum, *Portland Adventist* holds that all expenditures in a section 1115 project are necessarily Medicaid expenditures under a state plan and that all populations covered by a section 1115 project are necessarily Medicaid populations under a state plan. As a result, section 1115 Medicaid demonstration projects must be tied to and fully consistent with the state plan provisions of the Medicaid Act that have not been waived or that cannot be waived.

Conclusion

Two federal district courts in Arizona and Oregon have also rejected the expenditure authority as the basis for imposing cost sharing beyond that authorized by the Medicaid Act. As did the *Portland Adventist* court, these courts find that populations are state plan populations whether they are labeled traditional or expansion. As a result, Medicaid Act provisions which have not been waived or that cannot be waived continue to apply. A preliminary injunction has been issued in the Arizona case, *Newton-Nations*, and the case has been stayed while the courts awaits the decision in *Spry*, the Oregon case, which is now on appeal to the Ninth Circuit Court of Appeals. Unlike *Portland Adventist*, both of these cases have been filed by Medicaid beneficiaries and both challenge heightened cost sharing. The Medicaid beneficiaries in these cases argue that the Medicaid Act cost sharing provisions are located in § 1396o of the Act, which is outside of § 1396a, and thus should not be waivable by the Secretary at all.

Advocates should monitor these cases carefully. If the higher courts find that the Secretary has the broad authority that he claims, then he will be able to use federal Medicaid dollars to approve projects that are untethered from the Medicaid Act. Coupled with the Bush administration’s desire to cap federal spending as an element of the HIFA initiative, the effect of these waivers could be to block grant the Medicaid program on a state-by-state basis. The National Health Law Program is co-counsel in both of these cases and will provide updates.

Activities in Congress could affect the arguments surrounding the Secretary’s authority under section 1115 of the Social Security Act. Advocates should also monitor activities in Congress. Some members of Congress are seeking to block grant Medicaid or, as an alternative, to give the Secretary and states more flexibility in approving and implementing waivers.

⁴⁵ 399 F.3d at 1097-98, n. 6.

⁴⁶ *Id.* at 1099 (emphasis added).