Section 1115 (and HIFA) Waivers

Section 1115 waivers have been a “legal” Achilles heel for advocates who are seeking to preserve Medicaid health care benefits and eligibility for the poor (in the case of FQHCs, for their patients). Found in section 1115 of the Social Security Act (42 USC 1315), this provision allows a state to seek a waiver of certain requirements of the Social Security Act so that it may implement a demonstration program that it could not otherwise implement due to these SSA requirements. Thus, in the past, states have sought and received waivers under section 1115 allowing them to waive, among other things, patient freedom of choice, limited length of patient lock-in to managed care providers, 90 day retroactive Medicaid eligibility, service comparability, limitations on groups of Medicaid eligibles, FQHC services as a mandatory Medicaid services, and PPS reimbursement for FQHCs for services to new groups of eligibles created under the waiver.

Particularly important for PCAs and health centers is CMS’ fostering of so-called “HIFA” waivers. This is a Section 1115 waiver, which CMS has established through a boiler-plate application form and encouraged states to apply for. It focuses on the provision of limited Medicaid services to groups of poor people—such as single adults or couples-- that do not fit into current Medicaid eligibility groups and would not be eligible for Medicaid but for a waiver. However, section 1115 waivers must be budget neutral and states usually make up for the extra expense of this population expansion by cutting back on other services, adding cost-sharing, and, in at least one instance (Utah), **limiting an FQHC to fee-for-service reimbursement (rather than PPS) for services it furnishes to these new eligibles**.

CMS has not promulgated regulations relating to review and granting of a Section 1115 waiver, nor does there appear to be detailed written federal policy on how these waivers are evaluated, approved or rejected by CMS. Consequently, it is difficult for FQHCs and others to evaluate the pluses or minuses of a particular Section 1115 proposal and to impact on those which they believe will be harmful to health centers and their patients. Nonetheless, there are some legal handles for PCAs and health centers to consider with regard to proposed waivers.

--The Social Security statute requires that in approving a section 1115 Medicaid demonstration waiver program, the Secretary must have determined that it is “ likely to assist in promoting the objectives” of the Medicaid statute. Thus, for example, a state waiver proposal that would clearly undermine FQHC stability as to patients and/or reimbursement might be contrary to promoting the objectives of the Medicaid statute in light of Congress’s recent reaffirmation of the importance of health center financial stability through its establishment of PPS reimbursement effective January, 2001.

--CMS has made it clear that in crafting and proposing Section 1115 demonstration waivers, states must allow and provide for a process of public input. Thus, failure on the part of a state to bring the PCA and its membership into the development of a waiver

proposal, could be contrary to policy articulated by CMS as a basis for approving such waivers.

--At least one federal appeals court has enjoined a states's implementation of an approved Section 1115 waiver, because CMS did not appear to have taken into consideration objections of Medicaid recipients to the waiver proposal. Beno v. Shalala 30 F.3rd 1057 (9th Cir. 1994).

--The Congressional Budget Office has been critical of CMS approving Section 1115 waivers in which a state directs its unspent SCHIP funds toward expansion of Medicaid eligibility for uninsured single adults—CBO's reasoning being that provision of services to this population is not consistent with the objectives of the SCHIP program, which is to expand health care services to children.

--There are a number of pending or soon-to-be filed legal challenges to recent state increases in patient cost-sharing. These challenges are based on a variety of arguments one of which is that the Medicaid statute does not allow for even a 1115 waiver of certain patient cost-sharing protections. A suit raising these issues has been filed in federal District Court in Oregon, and similar litigation is anticipated in Arizona, Washington, and possibly Connecticut.

In summary, while CMS and states have a fair amount of leeway in establishing Section 1115 demonstration programs, PCAs and other advocates may have some legal handles as leverage in questioning and affecting the contents of these waivers if and when they threaten to adversely impact health centers and their patients.

The best defense is a good offense—PCAs and their members may also want to consider whether to talk to their state Medicaid agency about initiating a Section 1115 waiver in which FQHCs are prominent or sole participating providers. For example, if a state is considering dropping an existing service, such as certain mental health services or adult dental services, the PCA and its membership might suggest that the state consider constructing a Section 1115 demonstration waiver application to submit to CMS in which FQHCs would be the sole provider of these services in the state, or in a particular geographic area of the state. The demonstration nature of the project could relate to the savings of funds, increase in the breadth of services and/or increased access, and budget neutrality may not be an issue if the state had been covering the cost of the service in the past Obviously, such a proposal must be thought-out carefully before it is presented to the state agency, however, it may offer an alternative to the state that will save it money while benefiting health centers and maintaining patient access to services.