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## “Waiving” Goodbye to Medicaid as We Know It: Modern State Attempts to Transform Medicaid Programs Through Section 1115 Waivers

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# “Waiving” Goodbye to Medicaid as We Know It: Modern State Attempts to Transform Medicaid Programs Through Section 1115 Waivers

Chandler Gray\*

## *Abstract*

*This Note explores recent state efforts to reshape their respective Medicaid programs through Section 1115 waivers. Specifically, this Note looks at states that wish to convert their Medicaid program to a block grant through Section 1115 waivers. Examining the lawfulness of these waivers requires analyzing the language and application of both the Medicaid Act and the Administrative Procedure Act. This Note argues that any use of Section 1115 waivers to implement a block grant program would be a violation of the Medicaid Act and thus unlawful. Further, federal approval of such programs would be deemed arbitrary and capricious. To justify this conclusion, this Note considers three recent federal court decisions striking down states’ use of Section 1115 waivers to enforce Medicaid work requirements. This Note determines that any use of Section 1115 waivers to create a block grant program would face similar legal challenges as the work requirements cases.*

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\* J.D. Candidate, May 2021, Washington and Lee University School of Law. I would like to thank the *Washington and Lee Law Review* Editorial Board for their guidance. I would especially like to thank Professor Nora V. Demleitner for her thoughtful feedback and engaging conversations. Thank you also to my family for their endless encouragement and support. Finally, thank you to Lucy for being my constant cheerleader.

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*I. Introduction*

Six-year-old Asher lives with a chronic lung disease that required hospitalization four times in 2019 alone.<sup>1</sup> She depends on medication to help her breathe, and her family depends on Tennessee’s Medicaid program to assist with Asher’s medical coverage and costs.<sup>2</sup> In October 2019, Asher’s mother, along with approximately sixty-five other Tennesseans, crowded into a public library in East Knoxville, Tennessee to voice their concerns over Tennessee’s proposal to convert its current Medicaid funding into a block grant.<sup>3</sup> As part of this proposal, Tennessee plans to change some of its Medicaid benefits, including changing prescription drug coverage to exclude certain drugs.<sup>4</sup> Asher’s mother spoke at the public forum to call attention to this particular feature of the block grant proposal, and criticized the lack of specificity in the proposal regarding an appeals process.<sup>5</sup> Over the three days of public forums across the state, nobody spoke in favor of the block grant proposal.<sup>6</sup>

Tennessee’s proposal, known as Amendment 42, is part of a recent movement by conservative states to reshape their

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1. See Natalie Alison & Kristi Nelson, *In Second Day of Public Hearings, No One Speaks in Favor of Tennessee’s Block Grant Plan*, TENNESSEAN (Oct. 2, 2019, 6:21 PM), <https://perma.cc/4YN3-MVQP> (last updated Oct. 4, 2019, 9:51 AM) (discussing the health challenges faced by Asher).

2. See Jessica Bliss, *Lawmakers Discuss Ways to Support Families Raising Children with Severe Disabilities but Cost a Key Factor*, TENNESSEAN (Feb. 28, 2019, 11:49 AM), <https://perma.cc/X9DZ-X645> (last updated Feb. 28, 2019, 12:00 PM) (explaining the financial hardship faced by many families of children with disabilities due to expensive medical care).

3. See Alison & Nelson, *supra* note 1 (noting that Tennessee’s government held a series of public forums on the block grant proposal).

4. See TENN. DIV. OF TENNCARE, *TENNCARE II DEMONSTRATION: AMENDMENT 42*, at 15 (2019), <https://perma.cc/LK3A-G6LW> (PDF) (discussing the changes Tennessee wishes to make to certain classes of prescription drug coverage).

5. See Alison & Nelson, *supra* note 1 (“[Asher’s mother] is concerned about the state’s plan to cover fewer drugs under the block grant in order to negotiate lower prices with drug companies.”).

6. See Brett Kelman & Adam Friedman, *Tennessee’s Medicaid Block Grant: 3 Days, 3 Public Hearings, Zero Support*, TENNESSEAN (Oct. 3, 2019, 5:24 PM), <https://perma.cc/9TMQ-C9Y5> (last updated Oct. 4, 2019, 9:51 AM) (summarizing the results from the public hearings held by the Tennessee state government).

respective Medicaid programs.<sup>7</sup> These states employ what are known as Section 1115 waivers (so named for their location within the Social Security Act)<sup>8</sup> to propose demonstration projects that attempt to integrate market-based solutions to control Medicaid program costs.<sup>9</sup> However, as this Note will argue, many of the Section 1115 waivers and subsequent demonstration projects set forth by these states, including Amendment 42, are unlawful.<sup>10</sup>

Part II of this Note provides background information on the Medicaid Act as well as Section 1115 waivers. Part III examines two types of modern restrictive Section 1115 waiver programs: work requirements and block grants. This Note focuses on these two types of Section 1115 waivers because the Trump Administration is advocating for states to adopt these programs in its effort to transform Medicaid.<sup>11</sup> Specifically, this Note scrutinizes Kentucky's Section 1115 work requirements waiver, Kentucky HEALTH;<sup>12</sup> Tennessee's Section 1115 block grant proposal, Amendment 42;<sup>13</sup> and the Trump Administration's proposed Medicaid block grant program, Healthy Adult

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7. See Allison Baker & Linda Hunt, *Counterproductive Consequences of a Conservative Ideology: Medicaid Expansion and Personal Responsibility Requirements*, 106 AM. J. PUB. HEALTH 1181, 1181 (2016) (discussing the use of Section 1115 waivers by conservative states to alter their Medicaid programs rather than simply expanding Medicaid).

8. See 42 U.S.C. § 1315 (2018) (permitting demonstration projects under the Medicaid Act). This Note will refer to Medicaid waivers granted under § 1315 authority as "Section 1115" waivers.

9. See Baker & Hunt, *supra* note 7 (stating that conservative states use Section 1115 waivers to promote conservatives' ideas about health care).

10. See Rachel Sachs & Nicole Huberfeld, *The Problematic Law and Policy of Medicaid Block Grants*, HEALTH AFF. (July 24, 2019), <https://perma.cc/Q2DC-RBC7?type=image> (arguing that many modern Section 1115 waivers are an attempt to bypass the law).

11. See *id.* (discussing the Trump Administration's focus on the work requirement and block grant waivers).

12. See KY. DEPT OF MEDICAID SERVS., KY. HEALTH DEMONSTRATION 4 (2016), <https://perma.cc/5WRZ-P764> (PDF) (providing an overview of the Kentucky HEALTH waiver).

13. See TENN. DIV. OF TENNCARE, *supra* note 4, at iii (providing Tennessee's rationale for designing and requesting a block grant).

Opportunity (HAO).<sup>14</sup> Part IV analyzes the court’s reasoning from the Section 1115 work requirements cases *Stewart v. Azar*<sup>15</sup> (*Stewart II*) and *Gresham v. Azar*<sup>16</sup> (*Gresham II*) to illustrate how a court analyzes Section 1115 waiver proposals against both the Medicaid Act<sup>17</sup> and the Administrative Procedure Act (APA).<sup>18</sup> Future litigation against Section 1115 proposals such as Amendment 42 would likely raise similar arguments as those provided in the work requirements litigation.<sup>19</sup> Thus, in Part V, this Note will apply the legal reasoning in the work requirements cases to the issue of Section 1115 block grant proposals.<sup>20</sup> This Note concludes by recommending that the Secretary of Health and Human Services (Secretary) refuse to approve Amendment 42 and any HAO waiver proposals. This Note also predicts that if the Secretary were to approve these waiver proposals, courts would strike down such approval as both arbitrary and capricious and in violation of the Medicaid Act.

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14. See Letter from Calder Lynch, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs., SMD No. 20-001 (Jan. 30, 2020), <https://perma.cc/LF6E-76EH> (PDF) (encouraging states to apply for Medicaid as a block grant through Section 1115 waivers).

15. 366 F. Supp. 3d 125 (D.D.C. 2019).

16. 950 F.3d 93 (D.C. Cir. 2020).

17. See 42 U.S.C. § 1396-1 (2018) (creating the Medicaid program as part of the Social Security Act and requiring states to “furnish medical assistance” to populations in need).

18. See 5 U.S.C. § 500 (discussing the general provisions of administrative practice).

19. See Leonard Cuello, *Medicaid Waivers: Courts Must Step in When the Exception Becomes the Rule*, 46 J.L. MED. & ETHICS 892, 892 (2018) (arguing that Section 1115 grants HHS only narrow authority and does not permit the type of broad programs currently seen). *But see* Anthony Albanese, *The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid–Waiver Regime Today*, 128 YALE L.J. FORUM 827, 828 (2019) (arguing that Section 1115 grants permission to states to propose broad policies).

20. See Sachs & Huberfeld, *supra* note 10 (predicting that Section 1115 block grant litigation will follow the same patterns as, and that the government will fail to meet the legal standard articulated in, the Section 1115 work requirements litigation).

## II. Background on the Medicaid Act and Section 1115

### A. The Medicaid Act

In 1965, Congress passed the Medicaid Act as part of a monumental addition of health insurance programs to the Social Security Act (SSA).<sup>21</sup> Medicaid provides medical assistance to “categorically needy” persons, defined as those needing public assistance based on “family circumstances, age, or disability.”<sup>22</sup> The program depends on cooperative federalism, where the federal government provides open-ended matching funds to state Medicaid programs in exchange for compliance with federal requirements.<sup>23</sup> These requirements ensure that states provide coverage to certain populations based on factors such as income, disability, and pregnancy status.<sup>24</sup> The nature of Medicaid’s financing arrangement means that there is no pre-set limit to the amount of money paid by the federal

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21. See Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 14–15 (2013) [hereinafter *Endless Difficulties*] (stating that Congress amended the SSA to simultaneously include both Medicare and Medicaid in response to calls for health insurance for the elderly and poor); see also *Friedman v. Berger*, 409 F. Supp. 1225, 1226 (S.D.N.Y. 1976) (“The Medicaid [Act] is an aggravated assault on the English language, resistant to attempts to understand it.”).

22. *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981); see CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE & MEDICAID MILESTONES: 1937–2015, at 2 (2015), <https://perma.cc/H6ST-36C4> (PDF) (stating that Medicaid was originally passed to provide states “with the option of receiving federal funding for providing health care services to low-income children, their caretaker relatives, the blind, and individuals with disabilities”).

23. See *Endless Difficulties*, *supra* note 21, at 15 (discussing the Medicaid program as a carrot and stick arrangement between the federal government and the states); see also *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 625 (2012) (Ginsburg, J., concurring in part and dissenting in part) (“Medicaid is a prototypical example of federal–state cooperation in serving the Nation’s general welfare.”).

24. See 42 U.S.C. § 1395a (2018) (detailing different categories of eligibility for Medicaid assistance); Malcolm J. Harkins, *Be Careful What You Ask for: The Repeal of the Boren Amendment and Continuing Federal Responsibility to Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care*, 4 J. HEALTH CARE L. & POL’Y 159, 162 (2002) (“States that choose to participate, however, must administer their Medicaid program in conformance with the Medicaid Act and applicable federal regulations.”).

government to the states.<sup>25</sup> Further, this financing structure automatically adjusts state resources to account for “demographic and economic shifts, health care costs, public health emergencies, natural disasters and changing state priorities.”<sup>26</sup> Currently, all states participate in the Medicaid program.<sup>27</sup> The Medicaid program is designed to empower states with the ability to design and control their respective programs within the federally established parameters.<sup>28</sup>

### B. Section 1115

Although congressional intent regarding Section 1115 is murky,<sup>29</sup> Section 1115 waivers serve as opportunities for states to expand Medicaid eligibility to uninsured populations.<sup>30</sup> Specifically, Section 1115 waivers encourage states to design research and demonstration programs that “develop innovative solutions to a variety of health and welfare problems.”<sup>31</sup>

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25. See Robin Rudowitz et al., KAISER FAM. FOUND., MEDICAID FINANCING: THE BASICS 1 (2019), <https://perma.cc/AWR9-638M> (PDF) [hereinafter THE BASICS] (providing an overview of Medicaid’s financing structure).

26. *Id.*

27. See *Endless Difficulties*, *supra* note 21, at 15 (stating that every state participates in the Medicaid program and as a result of participation receives federal funds).

28. See Abbe Gluck & Nicole Huberfeld, *What is Federalism in Healthcare For?*, 70 STAN. L. REV. 1693, 1711 (2018) (characterizing Medicaid as a “state-driven” health care program).

29. See Jonathan Bolton, *The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program*, 37 COLUM. J.L. & SOC. PROBS. 91, 99 (2003) (“Section 1115 was enacted in 1962 with ‘virtually no legislative history’ to explain it.” (citing Sara Rosenbaum, *Mothers and Children Last: The Oregon Medicaid Experiment*, 18 AM. J.L. & MED. 97, 111 (1992)) [hereinafter *Mothers and Children Last*]).

30. See John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, HEALTH AFF. (Jan. 1, 1995), <https://perma.cc/H4PG-J5V8?type=image> (discussing ways states can expand the populations eligible for Medicaid as a way for states to enact state-level health reform).

31. *Id.* (discussing the unique characteristics of Section 1115 waivers as opposed to other methods by which states can expand Medicaid). See NICOLE HUBERFELD ET AL., THE LAW OF AMERICAN HEALTH CARE 93 (2d ed. 2018) (stating that the purpose of providing waivers is to encourage states to explore alternative ways of providing Medicaid coverage to beneficiaries while still



Although states use Section 1115 waivers to create state-specific policy approaches to improving Medicaid implementation in their respective states, the ultimate approval authority rests with the Secretary.<sup>32</sup> The Secretary may “waive the requirements of specific sections in the [Medicaid Act]”<sup>33</sup> so long as the state’s proposed programs are “likely to assist in promoting the objectives of the Medicaid program.”<sup>34</sup> Additionally, Section 1115 waivers and subsequent demonstration programs must be budget neutral to the federal government in order to receive approval.<sup>35</sup>

The Trump Administration has approved a wide variety of Section 1115 waivers, including waivers to promote healthy behavior incentives, waivers that extend Medicaid eligibility to new populations with behavioral health needs, and a waiver to address social determinants of health.<sup>36</sup> New administrations

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maintaining fidelity to Medicaid’s overarching purpose); *About Section 1115 Waivers*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://perma.cc/QZR5-WZUR> (describing the purpose of Section 1115 demonstration programs as finding state-specific policy solutions to serving Medicaid populations and introducing evidence-based solutions to promote better health outcomes).

32. See 42 U.S.C. § 1315 (2018) (vesting approval authority in the Secretary).

33. Bolton, *supra* note 29, at 98 (discussing specific sections which the Secretary may not waive compliance to in granting a state’s Section 1115 waiver).

34. *About Section 1115 Waivers*, *supra* note 31 (describing the balance between state-specific policies and federal oversight necessitated by Section 1115 programs).

35. See Letter from Timothy B. Hill, Acting Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. For Medicare & Medicaid Servs., to State Medicaid Dirs., SMD No. 18-009 (Aug. 22, 2018) (Re: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects), <https://perma.cc/3JV3-NLKP> (PDF) (“A budget neutral demonstration project does not result in Medicaid costs to the federal government that are greater than what the federal government’s Medicaid costs would likely have been absent the demonstration.”); see also Eleanor D. Kinney, *Clearing the Way for an Effective Federal-State Partnership in Health Reform*, 32 U. MICH. J.L. REFORM 899, 911 (1999) (stating that the budget neutrality rule gained prominence due to a Clinton administration policy change that encouraged the use of Section 1115 waivers to expand the Medicaid population).

36. See Elizabeth Hinton et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, KAISER FAM. FOUND. (Feb. 12, 2019), <https://perma.cc/W5FP-ZSKW> (describing the wide variety in approved Section 1115 waivers during the Trump Administration).

tend to build on the Section 1115 waiver trends of previous administrations when approving new waiver requests, as well as continuing ongoing Section 1115 waiver programs.<sup>37</sup>

Legal challenges to Section 1115 waivers usually focus on the requirement that the Secretary only approve those Section 1115 waivers that promote the objectives of the Medicaid Act.<sup>38</sup> However, courts generally interpret Section 1115 as granting broad approval authority to the Secretary as long as the Secretary indicates that the waiver will promote the objectives of the Medicaid Act.<sup>39</sup>

### *III. Examination of Restrictive Modern Section 1115 Waiver Programs*

#### *A. Work Requirements*

As part of the Patient Protection and Affordable Care Act,<sup>40</sup> Congress expanded Medicaid eligibility to include adults under sixty-five years old whose income did not exceed 138 percent of the federal poverty line.<sup>41</sup> In 2012, the United States Supreme

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37. *See id.* (noting that the Trump Administration continued approving “eligibility- and enrollment-related waiver provisions” approved by the Obama Administration).

38. *See Bolton, supra* note 29, at 100–02 (stating that historically courts have been “unwilling to limit the scope of the Secretary’s power to approve waivers”).

39. *Mothers and Children Last, supra* note 29, at 111 (emphasizing that courts will not interfere so long as the Secretary has made legitimate findings and followed the appropriate processes). *See C.K. v. N.J. Dep’t of Health & Human Servs.*, 92 F.3d 171, 183 (3d Cir. 1996) (viewing the Secretary’s consideration of relevant factors in approving the Section 1115 waiver at issue and compilation of a robust record to be sufficient as a valid exercise of the Secretary’s powers); *Aguayo v. Richardson*, 473 F.2d 1090, 1106–07 (2d Cir. 1973) (stating that the Secretary need only review sufficient materials to decide whether the Section 1115 program is “likely” to promote the objectives of Medicaid). *But see Greater N.Y. Hosp. Assoc. v. Blum*, 476 F. Supp. 234, 243 (E.D.N.Y. 1979) (finding that the Secretary’s approval of the Section 1115 program approved the waiver of a provision of the Medicaid Act which the Secretary, under § 1315, was not permitted to waive); *Cuello, supra* note 19, at 892 (arguing that Section 1115 grants HHS only narrow authority and does not permit the type of broad programs currently seen).

40. Pub. L. No. 111–148, 124 Stat. 119 (2010).

41. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018) (providing for Medicaid expansion starting in 2014).

Court ruled that Medicaid expansion was optional for states to participate in, rather than mandatory.<sup>42</sup> Although many states have still not expanded Medicaid,<sup>43</sup> several conservative states have used Section 1115 waivers to expand Medicaid eligibility to certain populations while implementing conservative reforms.<sup>44</sup>

Within the past four years, many states requested and received approval for Section 1115 waiver programs that include work requirements for able-bodied Medicaid recipients.<sup>45</sup> Although this work requirement policy was proposed in the past,<sup>46</sup> previous administrations refused to approve such waivers.<sup>47</sup> The Trump Administration signaled its

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42. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 587 (2012) (stating that states may voluntarily sign up to participate in Medicaid expansion, but that the federal government cannot force the states to accept expansion).

43. See *Status of State Action on Medicaid Expansion Decision*, KAISER FAM. FOUND., <https://perma.cc/G4SX-WWP9> (stating that 14 states have not expanded Medicaid at the time of this writing).

44. See Andrew Prokop, *The Battle Over Medicaid Expansion in 2013 and 2014, Explained*, VOX, <https://perma.cc/YFL3-VQYP> (last updated May 12, 2015) (detailing the conservative states that requested Section 1115 waivers to implement conservative reforms to their respective Medicaid programs).

45. See *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND., <https://perma.cc/54F8-9MMQ> (stating that the states with Medicaid work requirements are Arkansas, Indiana, Kentucky, and New Hampshire).

46. See Laura Hermer, *What to Expect When You're Expecting . . . TANF-Style Medicaid Waivers*, 27 ANN. HEALTH L. 37, 37–38 (2018) [hereinafter *What to Expect*] (providing examples of previously suggested work requirement policies to combat negative stereotypes about the typical Medicaid recipient); see also IND. FAMILY & SOC. SERVS. ADMIN., HIP 2.0 SECTION 1115 WAIVER APPLICATION (2014), <https://perma.cc/GU7Z-3SAH> (PDF) (proposing a Section 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) that would require certain subpopulations of Medicaid beneficiaries to work a certain number of hours in order to receive their benefits).

47. See Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Human Servs. (Nov. 1, 2016), <https://perma.cc/E4S5-8BR2> (PDF) (explaining that CMS will not approve demonstration projects that include work requirements because such requirements do not further the objectives of the Medicaid Act); Jessica Greene, *What Medicaid Recipients and Other Low-Income Adults Think About Medicaid Work Requirements*, HEALTH AFF. (Aug. 30, 2017), <https://perma.cc/44DB-KS7F?type=image> (stating that

amenability to approving Section 1115 waivers that implemented work requirements in state Medicaid programs, and the Administration even solicited such waiver proposals.<sup>48</sup>

Medicaid work requirements generally apply to able-bodied adults within the Medicaid expansion population<sup>49</sup> and require beneficiaries to verify their participation in activities such as “employment, job search, or job training programs, for a certain number of hours per week.”<sup>50</sup> Many legal scholars believe that work requirements do not further the objectives of the Medicaid Act because they are not directly related to providing medical assistance to people.<sup>51</sup> The reporting requirements for work requirements are often difficult for Medicaid beneficiaries to meet due to lack of access to technology or difficulty understanding technology.<sup>52</sup> Failure to properly comply with the

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the Obama Administration did not approve work requirements because they threatened access to medical care).

48. See Letter from Brian Neale, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs., SMD No. 18-002 (Jan. 11, 2018) (Re: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries), <https://perma.cc/HMT3-RB5J> (PDF) (explaining that the Centers for Medicare and Medicaid Services (CMS) will now support state efforts to attach a work requirement to receipt of Medicaid benefits pursuant to a Section 1115 waiver, signaling a reversal in policy from previous administrations who would deny such requirements).

49. See Joy Madubuonwu et al., *Work Requirements in Kentucky Medicaid: A Policy in Limbo*, COMMONWEALTH FUND (Sept. 27, 2019), <https://perma.cc/CU6X-5WJL> (stating that the work requirements portion of Kentucky HEALTH would apply to only nonelderly, non-disabled adults which is the typical population covered by Medicaid expansion).

50. Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work: What Does the Data Say?*, KAISER FAM. FOUND. (Aug. 8, 2019), <https://perma.cc/W6ZM-6C94>.

51. See Sara Rosenbaum, *Invented Purposes and Blue Sky Predictions: Why the Trump Administration Cannot Win the Medicaid Work Experiment Cases*, 29 HEALTH MATRIX 113, 118 (2019) [hereinafter *Invented Purposes*] (highlighting that Section 1115 demonstrations are confined to those projects which are likely to promote the objectives of the Medicaid Act); Sidney D. Watson, *Medicaid, Work, and the Courts: Reigning in HHS Overreach*, 46 J.L. MED. & ETHICS 887, 888 (2018) (arguing that the core objective of Medicaid is to “provide health insurance for those who qualify for it” and that work requirements reduce coverage for many beneficiaries).

52. See Garfield et al., *supra* note 50 (“Many Medicaid enrollees face barriers to work such as functional disabilities, serious medical conditions, school attendance, and care-taking responsibilities. Many Medicaid adults do

reporting requirements could cause beneficiaries to lose their Medicaid coverage, even though 63 percent of nonelderly adults on Medicaid are already working.<sup>53</sup> The Secretary's approval of Section 1115 work requirement waivers triggered immediate litigation from Medicaid beneficiaries alleging unlawful approval.<sup>54</sup>

### B. Block Grants

Conservative proposals to reform America's health care system often include changing the Medicaid funding structure from the current open-ended funding to block grants.<sup>55</sup> Block grants use a capped spending model where the federal government grants a lump sum of money to a state for a specific program and vests control and oversight of the program in the state rather than the federal government.<sup>56</sup> Other welfare programs use federal block grants, such as the Temporary Assistance for Needy Families (TANF) program.<sup>57</sup> Congress created the TANF block grant in 1996 to provide states with a

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not use computers, the internet or email, which could be a barrier in finding a job or complying with policies to report work or exemption status.”).

53. See *id.* (“Most Medicaid adults are already working; among those who are not working, most report barriers to work.”).

54. Brief for Petitioner at 1, *Rose v. Azar*, No. 1:19-cv-02848 (D.D.C. Sept. 23, 2019). See *Philbrick v. Azar*, No. 19-773, 2019 U.S. Dist. LEXIS 125675, at \*5 (D.D.C. Jul. 29, 2019) (stating that the Secretary of Health and Human Services, in approving this Section 1115 waiver, failed to consider the relevant factors as required by the APA); *Gresham v. Azar*, 363 F. Supp. 3d 165, 169 (D.D.C. 2019) (same); *Stewart v. Azar*, 366 F. Supp. 3d 125, 135–36 (D.D.C. 2019) (same).

55. See Vikki Wachino & Tim Gronniger, *The Insufficiency of Medicaid Block Grants: The Example of Puerto Rico*, HEALTH AFF. (Oct. 12, 2017), <https://perma.cc/P5X9-63T5?type=image> (“Medicaid block grants have been a centerpiece of Republican health proposals for more than a decade.”); see also Shefali Luthra, *Everything You Need to Know About Block Grants – The Heart of GOP’s Medicaid Plans*, KAISER HEALTH NEWS (Jan. 24, 2017), <https://perma.cc/V7RV-UKZA> (finding that Republican proposals to change Medicaid to a block grant program date back to the Reagan Administration).

56. See Sachs & Huberfeld, *supra* note 10 (“A block grant scheme would be very different from Medicaid’s statutorily required open-ended funding.”); Luthra, *supra* note 55 (stating that a Medicaid block grant scheme would involve “turning control of the program to states and capping what the federal government spends on it each year”).

57. 42 U.S.C. § 603 (2018).

greater degree of independence and flexibility in spending federal dollars.<sup>58</sup> However, many states have used the flexibility over TANF funds to shift the money to other parts of the state budget that do not directly help poor families.<sup>59</sup> Further, TANF’s block grant structure does not account for inflation, resulting in TANF having lost “one-third of its value since 1997.”<sup>60</sup> Another federal program that receives its funding through block grants is the Children’s Health Insurance Program (CHIP).<sup>61</sup> Congress must renew CHIP’s block grant every five years, leading to ongoing difficulties in ensuring the block grant is reauthorized in a timely manner.<sup>62</sup> Further, states often spend in excess of their allotted block grant portion, requiring additional federal funding to provide consistent coverage.<sup>63</sup>

For Medicaid specifically, a block grant program could take several forms, including states receiving a pre-determined amount of money from the federal government, or states receiving a sum of money based on the number of Medicaid

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58. See *What to Expect*, *supra* note 46, at 42–43 (“[S]tates also maintain considerable discretion to decide how to spend their block grants, whether on cash welfare to TANF recipients, work and training support, marriage promotion activities, child protective services, or otherwise.”).

59. See LIZ SCHOTT ET AL., *CTR. ON BUDGET AND POL’Y PRIORITIES, HOW STATES USE FEDERAL AND STATE FUNDS UNDER THE TANF BLOCK GRANT 1* (2015), <https://perma.cc/Z98Q-MGQ4> (PDF) (“TANF’s combination of broadly defined purposes and limited accountability for much of its spending has enabled states to divert funds from supporting the poorest families and use them instead to help fill state budget holes.”).

60. *Id.*

61. § 1397aa.

62. See Laura Hermer, *Hot Topics in Healthcare Compliance: Engage with Leaders: Medicaid: Welfare Program of Last Resort, or Safety Net?*, 44 WM. MITCHELL L. REV. 1203, 1216 (2018) (noting that CHIP faces struggles in “winning congressional reauthorization”); see also Sarah Kliff, *CHIP is Finally Getting Funded—After 114 Days Without a Budget*, VOX (Jan. 22, 2018), <https://perma.cc/X8AM-LNBF> (“Congress let CHIP’s long-term funding lapse 114 days ago.”).

63. See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 472 (2011) (noting that many states struggle with budgeting and spending block grant money appropriately).

beneficiaries in that state.<sup>64</sup> Under either model, the state would also gain greater control over the Medicaid program.<sup>65</sup>

In early 2020, the Trump Administration released guidance from the Centers for Medicare and Medicaid Services (CMS) indicating that the federal government is willing to receive Section 1115 waivers requesting Medicaid as a block grant.<sup>66</sup> This initiative, called the Healthy Adult Opportunity (HAO), would allow states to receive a lump sum of money to cover the Medicaid expansion population and other non-disabled adults.<sup>67</sup> States would choose whether to receive the money under a per capita annual federal spending cap, calculated on the number of Medicaid enrollees multiplied by the “maximum allowable spending per person,” or an aggregate annual federal spending cap, which would apply to the state regardless of fluctuations in Medicaid enrollment.<sup>68</sup> The block grant would require less federal oversight and provide states with the ability to limit available benefits as well as impose cost-sharing mechanisms on beneficiaries.<sup>69</sup> Health law experts predict that any proposals under the HAO initiative would face a “pretty quick litigation response” since the initiative likely violates the Medicaid Act.<sup>70</sup>

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64. See Sachs & Huberfeld, *supra* note 10 (describing the potential structure of a Medicaid block grant).

65. See Eliot Fishman & Joe Weissfeld, *Medicaid Policy and Partisan Politics: A New Dynamic*, HEALTH AFF. (Oct. 15, 2019), <https://perma.cc/J88K-9R9Z?type=image> (using Tennessee as an example of a state asking for Medicaid as a block grant with minimal federal oversight on spending).

66. See Lynch, *supra* note 14 (encouraging states to apply for Medicaid as a block grant through Section 1115 waivers).

67. See *id.* (discussing the structure of the Healthy Adult Opportunity initiative).

68. See Robin Rudowitz et al., *Implications of CMS’s New “Healthy Adult Opportunity” Demonstrations for Medicaid*, KAISER FAM. FOUND. (Feb. 5, 2020), <https://perma.cc/25ZW-9GSG> [hereinafter *Implications*] (detailing the difference in the two spending cap options available to states under HAO).

69. See *id.* (stating that this new initiative would be a change from past Medicaid proposals due to relaxing coverage requirements and federal oversight).

70. See Shira Stein, *Medicaid Block Grant Policy Could Face High Legal Hurdles*, BLOOMBERG L. (Jan. 28, 2020), <https://perma.cc/LJ2H-7QZU> (stating that the Healthy Adult Opportunity initiative is trying to waive many unwaivable parts of the Medicaid Act).

Congress intended for Section 1115 waivers to test innovations in Medicaid delivery.<sup>71</sup> However, changing Medicaid funding to a block grant would represent a marked departure from past Medicaid proposals despite Section 1115’s innovative nature.<sup>72</sup> While Section 1115 permits the Secretary to waive compliance with several parts of the Medicaid Act,<sup>73</sup> the Secretary cannot waive Section 1903, as would be required for a successful block grant demonstration.<sup>74</sup> Section 1903 delineates the funding structure of Medicaid, including the required unlimited federal matching system.<sup>75</sup> Many legal scholars argue that shifting Medicaid to a block grant program would raise similar arguments as the work requirements litigation because both programs violate the Medicaid Act.<sup>76</sup> As the first Section 1115 block grant proposal to move to the final round of approval by the CMS, Amendment 42 serves as test case for these block grant proposals.<sup>77</sup>

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71. See Sachs & Huberfeld, *supra* note 10 (identifying Section 1115 waivers as the most likely way for the government to experiment with providing Medicaid as a block grant).

72. See *Implications*, *supra* note 68 (characterizing the Trump Administration’s chosen policy changes to Medicaid, such as block grants, as marking a “new direction for Medicaid demonstrations”).

73. See 42 U.S.C. § 1315 (2018) (listing the specific provisions in the Medicaid Act that the Secretary may waive in approving a Section 1115 demonstration project).

74. *Id.* § 1396b.

75. See *id.* (discussing the payment system to states); see also Sachs & Huberfeld, *supra* note 10 (hypothesizing that the non-waivable nature of Section 1903 presents a death knell to block grants).

76. See Sara Rosenbaum, *What a Medicaid Block Grant Would Mean for Tennessee: An Update*, COMMONWEALTH FUND (May 30, 2019), <https://perma.cc/GE6T-ARX2> (last updated Sept. 25, 2019) [hereinafter *An Update*] (hypothesizing that, if the Secretary were to approve a block grant waiver, many of the litigation strategies would mirror those of the work requirements cases); Sachs & Huberfeld, *supra* note 10 (arguing that changing Medicaid to block grants is unlawful because it violates the language of Section 1115); Nicholas Bagley, *Tennessee Wants to Block Grant Medicaid. Is That Legal?*, THE INCIDENTAL ECONOMIST, (Sept. 17, 2019, 3:30 PM), <https://perma.cc/EJD4-GTC6> (doubting the ability of states to use Section 1115 waivers to alter Medicaid’s financing structure).

77. See Letter from Andrea J. Cash, Dir., Div. of Coverage & Expansion Demonstrations, Ctrs. for Medicare & Medicaid Servs., to John G. Roberts, Comm’r, Div. of TennCare, Tenn. State Gov’t (Nov. 26, 2019), <https://perma.cc>



*C. Comparing Amendment 42 with the Healthy Adult Opportunity Program*

The Tennessee government wrote Amendment 42 in the context of the current leadership of Health and Human Services (HHS) and CMS.<sup>78</sup> Since taking control in 2017, the Trump Administration has signaled that HHS and CMS are amenable to Section 1115 waiver proposals that previously would not have been approved.<sup>79</sup> Part of this shift is the Administration's desire to give more power over the Medicaid program to the states, rather than consolidating that power in CMS.<sup>80</sup> Thus, Tennessee proposed a Medicaid program in which the state would receive Medicaid funding in the form of a block grant.<sup>81</sup> Additionally, Tennessee's state legislature passed a bill requiring the state's Medicaid agency to submit a proposal to CMS asking to receive its Medicaid funds as a block grant.<sup>82</sup>

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/88H6-LGPN (PDF) (indicating that Tennessee's Amendment 42 proposal met the requirements for a Section 1115 demonstration project submission and would move to the next phase in obtaining CMS approval); *see also* Brett Kelman & Joel Ebert, *TennCare and the Trump Administration Have Drastically Different Block Grant Plans*, TENNESSEAN (Jan. 30, 2020), <https://perma.cc/QM22-ZAVQ> (highlighting that Tennessee is the first state to ask CMS for a block grant for the state's Medicaid funding).

78. *See* TENN. DIV. OF TENNCARE, *supra* note 4, at iii (stating Tennessee's rationale for moving to a block grant system); *see also* Stephanie Armour, *Tennessee Becomes First State to Embrace Block Grants for Medicaid Funding*, WALL ST. J., <https://perma.cc/7RMJ-JHNT> (last updated May 7, 2019, 2:46 PM) (noting that Tennessee is seeking approval from HHS and CMS of its Section 1115 waiver to convert the state's Medicaid program to a block grant).

79. *See* Neale, *supra* note 48 (explaining that CMS will now support state efforts to attach a work requirement to receipt of Medicaid benefits pursuant to a Section 1115 waiver, signaling a reversal in policy from previous administrations who would deny such requirements).

80. *See id.* ("Each state is different, and states are in the best position to determine which approaches are most likely to succeed, based on their specific populations and resources.").

81. *See* TENN. DIV. OF TENNCARE, *supra* note 4, at iii (discussing the reasons Tennessee feels Amendment 42 serves the best interests of the state). *But see* Sara Rosenbaum et al., *Inside Tennessee's Final 1115 Medicaid Block Grant Proposal*, HEALTH AFF. (Dec. 6, 2019), <https://perma.cc/B7X2-NTFU?type=image> ("According to the *Nashville Tennessean*, the original proposal drew over 1800 public comments, 11 of them positive.").

82. *See* Letter from John G. Roberts, Comm'r, Div. of TennCare, Tenn. State Gov't, to Randy McNally, Lieutenant Governor & Speaker of the Senate,

Specifically, the proposed amendment explicitly requests to change Tennessee’s Medicaid program into a block grant.<sup>83</sup> Tennessee wishes to pursue this change because of freedom from federal oversight afforded to the state through a block grant.<sup>84</sup> The proposal pushes for broad state authority over benefit reduction and expansion,<sup>85</sup> exemption from any potential future federal mandates regarding Medicaid coverage,<sup>86</sup> the ability to spend (or not spend) any expenditure as the state wishes,<sup>87</sup> and exemption from federal oversight processes, including federal review of the demonstration.<sup>88</sup> Critics note the proposal is “long on generalized arguments and rhetorical positioning and short on detail.”<sup>89</sup> Although legal advocacy organizations asked CMS to refrain from approving Amendment 42 until Tennessee provided more detail,<sup>90</sup> CMS

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Tenn. Gen. Assembly, & Cameron Sexton, Speaker of the House of Representatives, Tenn. Gen. Assembly, (Sept. 17, 2019) (Re: TennCare Amendment 42 Submission), <https://perma.cc/4SGF-KRLJ> (PDF) (“In 2019, the Tennessee General Assembly enacted Public Chapter No. 481, directing TennCare to submit a waiver amendment to CMS to provide medical assistance to the TennCare population by means of a block grant.”).

83. See TENN. DIV. OF TENNCARE, *supra* note 4, at 4 (“The proposed demonstration will transform the traditional Medicaid financing structure in Tennessee to a block grant.”).

84. See *id.* at 13 (explaining Tennessee’s reasoning for making this request to the federal government).

85. See Rosenbaum et al., *supra* note 81 (“[T]he state continues to position itself to reduce coverage within any benefit category.”).

86. See *id.* (“[T]he state continues to seek exemption from ‘any new federal mandates over the life of the demonstration that could have a material impact on the state’s Medicaid expenditures’ offering examples such as mandated eligibility and benefit expansions.”).

87. See *id.* (stating that non-expenditure of federal program surpluses can be an issue).

88. See *id.* (“The state also . . . seeks extensive waivers of the federal oversight process, including approval of managed care contracts, state arrangements with MCOs on delivery system reforms, limits on risk contracting, and federal certification of actuarially sound capitation rates.”).

89. *Id.* For the state’s perspective on this point, see TENN. DIV. OF TENNCARE, *supra* note 4, at 13 (stating that the state will not “enumerate in detail in this document every innovation, reform, or policy change that might take place over the life of the demonstration, since the purpose of the block grant is precisely to give the state a range of autonomy . . .”).

90. See Letter from Jane Perkins, Legal Dir., Nat’l Health Law Program, to Seema Verma, Adm’r, Ctrs. for Medicare & Medicaid Servs. (Nov. 26, 2019)

issued a letter stating that Tennessee's new Section 1115 waiver was in the final stages of approval.<sup>91</sup>

Amendment 42 differs from the HAO program in that the programs target different populations of Medicaid beneficiaries.<sup>92</sup> Amendment 42 would impact the entire Medicaid beneficiary population in Tennessee, while the HAO program would focus only on the Medicaid expansion population of healthy, non-disabled adults.<sup>93</sup> The Medicaid expansion population consists of childless adults aged 19–64 with incomes under 138 percent of the federal poverty line who generally do not have a complex medical condition or disability that would otherwise make them eligible for Medicaid.<sup>94</sup> In contrast, Amendment 42 would impact all 1.6 million people enrolled in Tennessee's Medicaid program, including children with special needs, nursing home residents, and people with intellectual and developmental disabilities.<sup>95</sup> Thus, Amendment 42 would have a much wider impact on low-income and disabled individuals requiring medical assistance than the HAO program would have on the expansion population.<sup>96</sup> Since Tennessee has not

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(Re: TennCare II Demonstration), <https://perma.cc/8WHE-J8EF> (PDF) (“[W]e ask that CMS not issue a letter of completeness until the State submits a waiver application with sufficient content and specificity to allow for meaningful public review and comment.”).

91. See Cash, *supra* note 77 (indicating that Tennessee's Amendment 42 proposal met the requirements for a Section 1115 demonstration project submission and would move to the next phase in obtaining CMS approval).

92. See Kelman & Ebert, *supra* note 77 (stating that the Healthy Adult Opportunity initiative has a much narrower focus than Amendment 42).

93. See *id.* (“TennCare and the federal government have dramatically different visions for how block grants can be used to transform Medicaid programs. Both visions would cap funding in exchange for giving states more authority over Medicaid, but the people who would be affected are not the same.”).

94. See Elizabeth Weeks Leonard, *Medicaid Matters: Crafting a Narrative for the Red State Option*, 102 KY. L.J. 381, 394 (2013) (discussing the demographics of the Medicaid expansion population as generally low-income, working adults).

95. See *Medicaid's Role in Tennessee*, KAISER FAM. FOUND. (Jul. 21, 2017), <https://perma.cc/WS6T-DQUN> (discussing the demographics that make up Tennessee's Medicaid population).

96. See Kelman & Ebert, *supra* note 77 (noting the differences in the populations affected by Amendment 42 and the Healthy Adult Opportunity program).

chosen to expand Medicaid, the HAO program would have limited reach in the state.<sup>97</sup>

#### *IV. Recent Case Law on Section 1115 Waiver Programs*

Before approving Medicaid block grants, the federal government should carefully evaluate whether such programs satisfy the objectives of the Medicaid Act or comply with the APA.<sup>98</sup> As mentioned earlier, Section 1115 litigation looks to whether the program in question advances the objectives of the Medicaid Act and thus whether the Secretary was justified in his approval.<sup>99</sup> The fundamental requirement that Section 1115 waivers promote the objectives of the Medicaid Act applies to all types of waiver programs, making the courts’ reasoning in the work requirements cases instructive to future block grant cases.<sup>100</sup>

In 2018, the United States District Court for the District of Columbia issued its first full Section 1115 waiver opinion in *Stewart v. Azar*<sup>101</sup> (*Stewart I*) in which the district court vacated the Secretary’s approval of Kentucky HEALTH.<sup>102</sup> After providing the Secretary with the opportunity to reconsider his approval of Kentucky’s Section 1115 waiver, the district court again struck down the Secretary’s approval of the work requirements waiver in 2019 in *Stewart II*.<sup>103</sup> On the same day, the district court issued another Section 1115 work requirements decision in *Gresham v. Azar*<sup>104</sup> (*Gresham I*) where

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97. See *id.* (stating that Tennessee has not expanded Medicaid).

98. See *An Update, supra* note 76 (hypothesizing that any legal challenge to block grants would likely follow the same formula as the legal challenges to work requirements).

99. See *supra* Part I.

100. See *An Update, supra* note 76 (discussing the similarities between the Section 1115 waivers for work requirements and a Section 1115 waiver for block grants).

101. 313 F. Supp. 3d 237 (D.D.C. 2018).

102. See *id.* at 273 (finding that the Secretary’s failure to consider the effect of Kentucky HEALTH on providing medical coverage voided the Secretary’s approval).

103. See *Stewart v. Azar (Stewart II)*, 366 F. Supp. 3d 125, 130–31 (D.D.C. 2019) (discussing the procedural history of this case since the Secretary approved Kentucky’s Section 1115 waiver in 2018).

104. 363 F. Supp. 3d 165 (D.D.C. 2019).

the court relied on its reasoning in both *Stewart I* and *Stewart II* to strike down Arkansas's Section 1115 work requirement waiver.<sup>105</sup> In early 2020, the United States Court of Appeals for the District of Columbia Circuit unanimously affirmed the district court's rulings in the Section 1115 work requirements cases in *Gresham v. Azar (Gresham II)*.<sup>106</sup>

#### A. *Stewart v. Azar*

In 2016, Kentucky sought approval from CMS for the first Section 1115 demonstration project that would impose work requirements on able-bodied Medicaid beneficiaries, titled Kentucky HEALTH.<sup>107</sup> Since Kentucky received approval, seventeen other states, including Arkansas, have filed Section 1115 waivers seeking to incorporate work requirements into their Medicaid programs.<sup>108</sup> The Secretary's approval of these Section 1115 demonstration projects prompted Medicaid beneficiaries in Arkansas, Indiana, Kentucky, and New Hampshire to file suit in the United States District Court for the District of Columbia against the federal government for bypassing "the legislative process and act[ing] unilaterally to fundamentally transform Medicaid" as well as for violation of the APA.<sup>109</sup>

In 2018, sixteen Kentucky Medicaid beneficiaries brought suit against HHS and CMS for allegedly violating the APA by

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105. See *id.* at 172–73 (discussing the role of the Kentucky cases in the court's decision striking down the Arkansas work requirements).

106. See *Gresham v. Azar (Gresham II)*, 950 F.3d 93, 96 (D.C. Cir. 2020) (agreeing with the district court that the Secretary's approval of the Section 1115 work requirements waivers was arbitrary and capricious).

107. See Letter from Matthew Bevin, Gov., Ky., to Sylvia Burwell, Sec'y, Dep't of Health & Hum. Servs. (Aug. 24, 2016), <https://perma.cc/JTV3-6CL7> (PDF) (requesting approval from HHS for the Section 1115 demonstration project).

108. See *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, *supra* note 45 (detailing the number of Section 1115 waivers by topic).

109. Brief for Petitioner, *supra* note 54, at 1; see *Philbrick v. Azar*, No. 19-773, 2019 U.S. Dist. LEXIS 125675, at \*5 (D.D.C. Jul. 29, 2019) (stating that the Secretary of Health and Human Services, in approving this Section 1115 waiver, failed to consider the relevant factors as required by the APA); *Gresham I*, 363 F. Supp. 3d at 169 (same); *Stewart II*, 366 F. Supp. 3d at 135–36 (same).

approving Kentucky’s Section 1115 waiver imposing work requirements on the Medicaid population.<sup>110</sup> Initially, the district court issued an opinion denying the federal government’s request to transfer the suit to the Eastern District of Kentucky.<sup>111</sup> A few months later, the district court issued an opinion denying defendants’ motion for summary judgment and remanded the issue back to HHS for an additional notice-and-comment period.<sup>112</sup> Finally, the district court heard the case again after the Secretary approved Kentucky’s Section 1115 program a second time.<sup>113</sup>

In striking down Kentucky’s Section 1115 program, the district court evaluated two arguments: one, that the Secretary violated the Medicaid Act by improperly approving Kentucky’s program; and two, the Secretary’s approval of Kentucky’s program violated the APA because the Secretary acted in a way that was arbitrary and capricious.<sup>114</sup>

### 1. *The Medicaid Act*

The objective of the Medicaid Act is to provide medical assistance to people “whose income and resources are insufficient to meet the costs of necessary medical services.”<sup>115</sup>

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110. See *Stewart v. Azar*, 308 F. Supp. 3d 239, 242 (D.D.C. 2018) (discussing the factual background of the case).

111. See *id.* at 250 (denying the defendants’ request to transfer the case to Kentucky district court).

112. See *Stewart I*, 313 F. Supp. 3d at 272–74 (D.D.C. 2018) (discussing the appropriate remedy in this scenario as remanding back to the agency for continued deliberation).

113. See *Stewart II*, 366 F. Supp. 3d at 131 (“Plaintiffs now challenge the reapproval, contending principally that the Secretary has not remedied the defects that rendered his prior action unlawful. Specifically, they maintain that he has still not adequately considered Kentucky HEALTH’s likelihood to cause significant coverage loss.”).

114. See *id.* at 135 (discussing two of the arguments that plaintiffs make against defendants’ actions); see also *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983) (stating that arbitrary and capricious action occurs when “the agency entirely failed to consider an important aspect of the problem [or] offered an explanation for its decision that runs counter to the evidence before the agency”).

115. 42 U.S.C. § 1396-1 (2018). See *Covenant Health Sys. v. Sebelius*, 820 F. Supp. 2d 4, 9–10 (D.D.C. 2011) (“According to the Medicaid statute, ‘medical assistance’ is ‘payment of part or all of the cost’ of medical ‘care and services’

The court in *Stewart II* stated that courts define medical assistance as “payment in part or all of the costs of medical care and services for a defined set of individuals.”<sup>116</sup> During oral arguments for *Stewart II*, the federal government conceded that this objective of Medicaid applies equally to the expansion population.<sup>117</sup>

The Medicaid Act requires that the Secretary only approve demonstration projects that support the objectives of the Medicaid Act.<sup>118</sup> The statute thus makes clear that the responsibility is on the Secretary to exercise his or her best judgment on whether the proposed project is likely to promote the objectives of Medicaid.<sup>119</sup>

In *Stewart II*, the Secretary argued that there are three main objectives of the Medicaid Act in addition to providing medical assistance to the needy: 1) promoting health, 2) financial independence, and 3) fiscal sustainability.<sup>120</sup> The district court evaluated each of these purported objectives in

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for a defined set of individuals.’ This defined group of individuals consists of patients who fall within one of thirteen categories of individuals to whom states may (or must) extend Medicaid benefits.”).

116. See *Stewart II*, 366 F. Supp. 3d 125, 135 (D.D.C. 2019) (quoting *Adena Reg’l Med. Ctr. v. Leavitt*, 527 F.3d 176, 180 (D.C. Cir. 2008)) (providing the statutory definition of medical assistance); see also *Harris v. McRae*, 448 U.S. 297, 301 (1980) (“The Medicaid program was created . . . for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.”).

117. See *Stewart II*, 366 F. Supp. 3d at 138–39 (referencing the federal government’s agreement that the purposes of Medicaid apply to the expansion population in question in Kentucky).

118. See § 1315 (discussing the requirements for the Secretary’s approval of demonstration projects); see also *Invented Purposes*, *supra* note 51, at 115–16 (examining *Stewart* with an emphasis on the purpose of the Medicaid Act).

119. See § 1315 (stating that the Secretary has final approval of each demonstration project).

120. See *Stewart II*, 366 F. Supp. 3d at 139 (discussing the Secretary’s inclusion of more than the single objective of the Medicaid Act); see also Letter from Paul Mango, Chief Principal Deputy Administrator, Ctrs. for Medicare & Medicaid Servs., to Carol H. Steckel, Commissioner, Ky. Dep’t for Medicaid Servs., (Nov. 20, 2018), <https://perma.cc/M6CF-MZFZ> (PDF) (discussing CMS’s position on the objectives of the Medicaid program in light of the earlier *Stewart* cases).

turn, starting with the objective of furnishing medical assistance.<sup>121</sup>

*a. Furnishing Medical Assistance*

The court found that the objective of furnishing medical assistance had two elements: “whether the project would cause recipients to lose coverage” and “whether the project would help promote coverage.”<sup>122</sup> In order to be “legally adequate,” the Secretary’s approval of a Section 1115 waiver program must include an adequate analysis of the effect of the program on Medicaid coverage.<sup>123</sup> The district court did not propose a bright-line test for satisfying these two elements but rather suggested that a court would need to employ a more fact-specific determination when evaluating whether the Secretary has satisfied these elements.<sup>124</sup> The Secretary is not required to know the exact number of Medicaid beneficiaries who will be affected by the Secretary’s approval of the program.<sup>125</sup> In terms of coverage promotion, the district court looked for evidence that the Secretary had weighed the Section 1115 waiver program’s

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121. See *Stewart II*, 366 F. Supp. 3d at 139 (stating that the district court will examine each of the Secretary’s assertions that the three added objectives of the Medicaid Act are valid and can be used to justify approval of Kentucky HEALTH).

122. See *id.* at 140 (quoting *Stewart I*, 313 F. Supp. 3d 237, 262 (D.D.C. 2018)) (restating the district court’s findings from the previous proceeding about the elements of the first objective of the Medicaid Act).

123. See *id.* (suggesting that the Secretary is required to provide a numerical estimate of how many people would lose their Medicaid coverage as a result of the Section 1115 waiver program); see also *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017) (providing another instance where the court looked for a Secretary’s adequate analysis when changing course in an agency’s decision-making).

124. See *Stewart II*, 366 F. Supp. 3d at 140 (focusing on the specific number of beneficiaries enrolled in Kentucky’s Medicaid program that would be affected by Kentucky HEALTH to determine the outcome of the coverage elements).

125. See *Stewart II*, 366 F. Supp. 3d at 141 (“As the D.C. Circuit acknowledged when a petitioner challenged the potential imprecision of an agency’s numbers, even “in the best of circumstances,” the agency “has no access to infallible data.” (quoting *Cablevision Sys. Corp. v. FCC*, 597 F.3d 1306, 1314 (D.C. Cir. 2010))).



coverage promotion against the quantified coverage loss.<sup>126</sup> The district court evaluated the Secretary's actions against these two elements of furnishing medical assistance.<sup>127</sup>

*b. Promoting Beneficiary Health*

Upon reapproval of Kentucky HEALTH, the Secretary argued that promoting health was a standalone objective of the Medicaid program.<sup>128</sup> The district court applied the *Chevron*<sup>129</sup> two-step analysis to the Secretary's interpretation of health as an objective of the Medicaid Act.<sup>130</sup> The district court concluded that the Secretary's inclusion of health as an objective "fails at step two [of the *Chevron* analysis] because it falls outside 'the

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126. See *Stewart II*, 366 F. Supp. 3d at 143 ("In light of the failure to weigh any coverage promotion in the face of the likelihood of substantial coverage loss, the Secretary did not 'adequately analyze the . . . consequences' of the [waiver] reapproval.")

127. See *id.* at 139 (discussing the Secretary's actions in light of the Medicaid objective of furnishing medical assistance).

128. See *Mango*, *supra* note 120 ("But there is little intrinsic value in paying for [Medicaid] services if those services are not advancing the health and wellness of the individual receiving them."); see also *Stewart I*, 313 F. Supp. 3d 237, 262 (D.D.C. 2018) (discussing the Secretary's argument that health promotion is a core objective of the Medicaid Act).

129. *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 842–43 (1984).

130. See *Stewart II*, 366 F. Supp. 3d 125, 144 (D.D.C. 2019) (finding that the court must apply the *Chevron* test to the Secretary's articulation of Medicaid's objectives); see also *Chevron*, 467 U.S. at 842–43 (providing the standard by which agency interpretation of a statute is measured)

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

bounds of reasonableness.”<sup>131</sup> To make this determination, the district court looked to Congress’s intent behind enacting the Medicaid Act as well as the Affordable Care Act to decide that the Secretary’s addition of “health” to the objectives of Medicaid was erroneous, finding that Congress and the Affordable Care Act sought to make health care more affordable for needy populations.<sup>132</sup> The Secretary’s broadening of the Medicaid Act objectives to include “health” was impermissible.<sup>133</sup>

*c. Promoting Beneficiary Financial Independence*

The district court addressed the Secretary’s contention that another objective of the Medicaid Act was granting Medicaid beneficiaries greater understanding of financial independence in a similar manner as the Secretary’s other arguments.<sup>134</sup> Applying *Chevron*, the district court found that the Secretary’s assertion that financial independence is part of furnishing medical assistance was an unreasonable reading of Section 1115.<sup>135</sup> It is necessary for an agency to ground its interpretation of objectives of congressional acts in a statutory

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131. See *Stewart II*, 366 F. Supp. 3d at 144 (“[T]he Court cannot sustain the Secretary’s generalization of health from the Act’s objective of furnishing medical care.” (quoting *Abbott Labs. v. Young*, 920 F.2d 984, 988 (D.C. Cir. 1990))).

132. See *id.* (looking to Congressional intent behind enactment of the Medicaid Act and Affordable Care Act); see also *Stewart I*, 313 F. Supp. 3d at 267 (D.D.C. 2018) (“[Congress] . . . had an interest in making health care more affordable for such people.”).

133. See *Stewart II*, 366 F. Supp. 3d at 144 (“The Secretary is not free instead to extrapolate the objectives of the statute to a higher level of generality and pursue that aim in the way he prefers.”).

134. See *id.* at 145 (discussing the Secretary’s inclusion of promoting beneficiary financial independence as a Medicaid objective).

135. See *id.* at 146 (“As the Court found before, financial self-sufficiency is not an independent objective of the Act and, as such, cannot undergird the Secretary’s finding under [Section 1115] that the project promotes the Act’s goals.”); see also *Goldstein v. SEC*, 451 F.3d 873, 881 (D.C. Cir. 2006) (“The ‘reasonableness’ of an agency’s construction depends,” in part, “on the construction’s ‘fit’ with the statutory language, as well as its conformity to statutory purposes.” (quoting *Abbott Labs v. Young*, 920 F.2d 984, 988 (D.C. Cir. 1990))).

basis.<sup>136</sup> The state whose population is affected by the Secretary's approval of a program may offer justifications for an agency's approval of a program, but if the Secretary does not specifically rely on those assertions when approving the program, the state's argument does not carry weight in the court's consideration.<sup>137</sup> Specifically in the Medicaid context, the agency is still obligated to weigh the potential costs of Medicaid coverage against the benefits of promoting the financial independence of beneficiaries.<sup>138</sup>

*d. Ensuring Fiscal Sustainability of the Medicaid Program*

In approving Kentucky's Section 1115 waiver, the Secretary stated that such demonstration projects give states a way to experiment with policies that "ensure the fiscal sustainability of the Medicaid program," which then enables the state to provide medical assistance to a wider range of populations.<sup>139</sup> The Secretary reasoned that approving Kentucky HEALTH saved Kentucky money in the long-term, and therefore provided the state with the ability to offer Medicaid coverage to a larger population of people.<sup>140</sup> The district court analyzed the Secretary's argument about fiscal sustainability as both an

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136. See *Stewart II*, 366 F. Supp. 3d at 146 (stating that an agency "must employ the means Congress prescribed to tackle the problem it identified" in an act or program).

137. See *id.* at 146 (acknowledging the Commonwealth of Kentucky's argument in favor of finding that financial independence is part of Medicaid's objectives, but noting that the Secretary did not rely on these arguments in approving Kentucky's Section 1115 waiver program).

138. See *id.* at 148 (noting that the Secretary failed to weigh the costs of Kentucky HEALTH against the potential benefits in increasing beneficiary financial independence).

139. See *Mango*, *supra* note 120 (quoting 42 U.S.C. § 1396 (2018)) (finding that fiscal sustainability of the Medicaid program in general can be considered an objective of the Medicaid Act).

140. See *Stewart II*, 366 F. Supp. 3d at 148 (discussing the Secretary's argument that fiscal sustainability is a key component of the Medicaid Act because it enables states such as Kentucky to provide Medicaid coverage to expansion populations).

independent objective of Medicaid as well as a sub-objective of Medicaid coverage promotion.<sup>141</sup>

(1) *Fiscal Sustainability as an Independent Objective of the Medicaid Program*

*Chevron* deference is granted any time an agency interprets the objectives of a statute which the agency is charged with executing.<sup>142</sup> The district court found that the word “objectives” as used in the text of the law was ambiguous, so the court moved to step two of the *Chevron* analysis.<sup>143</sup> The district court looked to the statutory language to determine whether the Secretary’s interpretation of “objectives” was reasonable and concluded that the Secretary’s interpretation was permissible.<sup>144</sup>

In addition to satisfying the *Chevron* test, however, the agency must also justify why approval of the particular Section 1115 waiver program will advance the objective of fiscal sustainability and its potential adverse effect on the other objectives of Medicaid.<sup>145</sup> The district court pointed to the Secretary’s lack of substantial evidence that Kentucky HEALTH would improve the fiscal sustainability of Medicaid.<sup>146</sup> Without this type of evidence, the Secretary’s approval of such

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141. *See id.* (stating that the Secretary did not specify whether he saw fiscal sustainability as its own objective of the Medicaid program or as falling under the umbrella of another objective of the Medicaid program).

142. *See Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 842–43 (1984) (describing the appropriate two-step analysis for courts when evaluating agency interpretation of statutes).

143. *See Stewart II*, 366 F. Supp. 3d 125, 149 (D.D.C. 2019) (stating that the Secretary satisfied the requirement that the word “objectives” in the statute is ambiguous).

144. *See id.* (finding that the word “practicable” in § 1396-1 is “at least a qualifier of the extent to which states must furnish medical assistance”); *see also* 42 U.S.C. § 1396-1 (2018) (using the phrase “as far as practicable under the conditions in such State” to qualify the requirement that states must furnish medical assistance to needy populations).

145. *See Stewart II*, 366 F. Supp. 3d at 149 (reiterating that the Secretary cannot simply satisfy the *Chevron* test but must look closely at the effect of approving a particular Section 1115 waiver).

146. *See id.* at 149–50 (indicating that the Secretary must be able to back up his assertions of additional goals of the Medicaid Act with reasonable proof).

waiver programs is deemed arbitrary and capricious by the courts.<sup>147</sup>

*(2) Fiscal Sustainability as a Sub-Objective of Providing Medicaid Coverage*

Section 1115 focuses the Secretary's evaluation of specific demonstration projects' impact on furthering the objectives of Medicaid.<sup>148</sup> The district court found that Section 1115 assumes a good-faith compliance with the larger Medicaid Act when permitting the Secretary to waive states' compliance with certain parts of the Medicaid Act in order to carry out their waiver programs.<sup>149</sup> In *Stewart II*, Kentucky threatened to de-expand Medicaid if its Section 1115 waiver was not approved.<sup>150</sup> The court highlighted that the Secretary cannot move on evaluating whether Kentucky's Section 1115 program promoted the objectives of the Medicaid Act when the program did not have baseline compliance with the Medicaid Act.<sup>151</sup> Thus, the defendants' argument that approval of Kentucky HEALTH promoted Medicaid coverage fails, since the alternative proposition was that Kentucky cease compliance with the Medicaid Act in total.<sup>152</sup>

*2. The Administrative Procedure Act*

In *Stewart II*, the district court also struck down the Secretary's approval of Kentucky HEALTH on the grounds that

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147. See *infra* Part IV.A.2.

148. See § 1315 (focusing on the demonstration projects within the larger context of the Medicaid Act).

149. See *Stewart II*, 366 F. Supp. 3d at 154 (dismissing the defendants' argument for Kentucky HEALTH approval because, if the program were not approved, Kentucky would allegedly de-expand its Medicaid program, which would not be a good-faith compliance with the Medicaid Act).

150. See *id.* at 153 (presenting Kentucky's argument that, without the work requirements from Kentucky HEALTH, Kentucky would not be able to financially sustain its Medicaid expansion population).

151. See *id.* (finding that defendants' argument lacked a limiting principle and that baseline compliance with the Medicaid Act is necessary for the Secretary's approval of a waiver program to be reasonable).

152. See *id.* ("This coverage-promotion argument, in fact, does not depend on fiscal sustainability at all.").

this approval was arbitrary and capricious.<sup>153</sup> The Administrative Procedure Act<sup>154</sup> provides that when a court is reviewing an agency action, the court shall “hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.”<sup>155</sup> To determine whether an action is arbitrary and capricious, “the court must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.”<sup>156</sup> This evaluation also examines whether the Secretary followed the “necessary procedural requirements” when taking the agency action.<sup>157</sup> Further, the reviewing court must only consider the grounds on which the agency made its decision; the court cannot substitute “what it considers to be a more adequate or proper basis” for the agency’s action.<sup>158</sup>

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153. See *id.* at 131 (“As a consequence, once again finding the reapproval was both contrary to the Act and arbitrary and capricious, the Court will vacate it and remand to HHS for further review.”); see also *Invented Purposes*, *supra* note 51, at 118 (“Under the Administrative Procedure Act’s ‘arbitrary and capricious’ standard governing judicial review, the court concluded that its duty was to review the legality of the work experiment (known as Kentucky HEALTH) ‘as a whole,’ rather than approaching each experimental element piecemeal.”).

154. 5 U.S.C. §§ 500–59, 701–06 (2018).

155. *Id.* § 706.

156. *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). See *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42–43 (1983) (“[A] court is not to substitute its judgment for that of the agency. Nevertheless, the agency must examine the relevant data and articulate a satisfactory explanation for its action including a ‘rational connection between the facts found and the choice made.’” (quoting *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962))).

157. See *Citizens to Preserve Overton Park, Inc.*, 401 U.S. at 416 (adding that the arbitrary and capricious standard of review is a narrow standard); see also *Motor Vehicle Mfrs. Ass’n*, 463 U.S. at 43

Normally, an agency rule would be 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 of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

158. See *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947) (stating that, to maintain the proper separation of powers balance, a court must only consider

In this case, the court used the conclusion that the Secretary's approval violated the Medicaid Act as evidence that the Secretary's approval was arbitrary and capricious.<sup>159</sup> The district court focused on the fact that the Secretary did not adequately consider the loss in Medicaid coverage for beneficiaries resulting from Kentucky HEALTH when making his approval determination.<sup>160</sup> The district court pointed to the Secretary's failure to weigh the alleged health benefits of Kentucky HEALTH against the concerning amount of coverage loss as evidence of the Secretary's arbitrary and capricious decision.<sup>161</sup> The district court noted that the Secretary also failed to weigh the alleged benefits of beneficiary financial independence against widespread coverage loss.<sup>162</sup> The Secretary's failure to consider coverage loss when approving Kentucky HEALTH indicated that the approval was arbitrary and capricious, notwithstanding the Secretary's argument in favor of promoting Medicaid fiscal sustainability.<sup>163</sup>

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the rationale that an agency sets forth and may not read in the court's own basis for an action).

159. See *Stewart II*, 366 F. Supp. 3d 125, 137 (finding that, since the Secretary did not adequately consider the objectives of the Medicaid Act as required by 42 U.S.C. § 1315 in his approval of Kentucky HEALTH, the Secretary's approval is arbitrary and capricious).

160. See *id.* at 140 (noting that the Secretary had not conducted the type of "reasoned decision-making" required of him regarding estimated coverage loss numbers); see also *Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015) (citing *Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 374 (1998)) (stating that an agency's decision-making process must be reasoned, logical, and rational).

161. See *Stewart II*, 366 F. Supp. 3d at 145 (stating that the Secretary's reasoning that Kentucky HEALTH promotes the health of Medicaid beneficiaries ignores the fact that Kentucky HEALTH will cause widespread Medicaid coverage loss, thus affecting the health of those beneficiaries).

162. See *id.* at 148 ("Even if some number of beneficiaries were to gain independence, the Secretary does not weigh the benefits of their self-sufficiency against the consequences of coverage loss, which would harm and undermine the financial self-sufficiency of others.").

163. See *id.* ("[The Secretary] unreasonably prioritized program savings without weighing those against the consequences of lost coverage, rendering his determination arbitrary and capricious."); see also *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (finding that approval of a Medicaid waiver under 42 U.S.C. § 1315 is arbitrary and capricious if the purpose of approval is to save the Medicaid program money).

*B. Gresham v. Azar*

In 2017, Arkansas amended its existing Section 1115 waiver to include the state’s work requirements program, Arkansas Works.<sup>164</sup> The work requirement applied to members of the Medicaid expansion population aged nineteen to forty-nine, requiring beneficiaries to record eighty hours per month of activities such as work, school, volunteering, or searching for a job.<sup>165</sup> Failure to report satisfactory activities for three months would result in the beneficiary losing Medicaid coverage for the rest of the calendar year.<sup>166</sup> However, many beneficiaries reported difficulty using the system Arkansas created for reporting work requirements, including having their accounts suspended for entering the wrong data, as well as basic technology illiteracy problems such as understanding how to create an online account and having regular access to a computer.<sup>167</sup> Ultimately, over 18,000 Medicaid beneficiaries in Arkansas lost their coverage due to the work requirements rule.<sup>168</sup> As a result, a group of Medicaid beneficiaries in Arkansas filed suit challenging the Secretary’s approval of Arkansas’s Section 1115 waiver.<sup>169</sup>

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164. See *Gresham II*, 950 F.3d 93, 96–97 (D.C. Cir. 2020) (providing background on Arkansas’s work requirements program).

165. See Erin Brantley & Leighton Ku, *A First Glance at Medicaid Work Requirements in Arkansas: More Than One-Quarter Did Not Meet Requirement*, HEALTH AFF. (Aug. 13, 2018), <https://perma.cc/6RSR-9VBT?type=image> (discussing the specific reporting requirements to satisfy the program’s work requirements).

166. See *id.* (noting the implications of failing to properly report qualifying activities).

167. See Jacqueline Froelich, *In Arkansas, Thousands of People Have Lost Medicaid Coverage Over New Work Requirements*, NPR (Feb. 18, 2019), <https://perma.cc/CT5U-K5VG> (highlighting the difficulty in the logistics of implementing the work requirements program and the effect these difficulties have on Medicaid coverage).

168. See Abby Goodnough, *Appeals Court Rejects Trump Medicaid Work Requirements in Arkansas*, N.Y. TIMES (Feb. 14, 2020), <https://perma.cc/FXE6-TXKU> (explaining the drastic loss in coverage experienced by Arkansas Medicaid beneficiaries). For a more thorough evaluation of Arkansas’s Medicaid work requirements program, see Brantley & Ku, *supra* note 165 (analyzing the impact of Arkansas’s Section 1115 work requirements waiver on the Medicaid population before the program was halted).

169. See *Gresham I*, 363 F. Supp. 3d 165, 168–69 (D.D.C. 2019) (discussing the plaintiffs’ background in bringing this case).



The court of appeals consolidated the appeals for both *Stewart II* and *Gresham I* into *Gresham II*, although Kentucky voluntarily dismissed its appeal after oral arguments.<sup>170</sup> Judge David Sentelle, writing the unanimous opinion, first established that the Secretary's approval of Section 1115 waivers is subject to judicial review.<sup>171</sup> The court then addressed whether the district court correctly identified the objectives of the Medicaid Act and whether the Secretary's approval of Arkansas's Section 1115 violated the APA.<sup>172</sup>

### 1. *The Medicaid Act*

The court of appeals affirmed the district court's finding that the primary objective of Medicaid is to provide health care coverage.<sup>173</sup> In making this ruling, the court of appeals emphasized that at least four other courts of appeals as well as the United States Supreme Court had all made similar findings about the objective of Medicaid.<sup>174</sup> In the letter initially

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170. See *Gresham II*, 950 F.3d at 96–97 (providing the procedural history for the case); see also Letter from Andy Beshear, Gov., Ky., to Andrea Casart, Dir., Div. of Medicaid Expansion Demonstrations, Ctrs. for Medicare & Medicaid Servs. (Dec. 16, 2019), <https://perma.cc/6LNR-UP9U> (PDF) (stating that, due to Kentucky's gubernatorial election resulting in a new governor, the state would be terminating its work requirements program).

171. See *Gresham II*, 950 F.3d at 98 (rejecting the government's argument that courts cannot review the Secretary's approval of Section 1115 waivers); see also *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 410 (1971) (stating that judicial review is appropriate in all cases except where Congress has expressly prohibited it).

172. See *Gresham II*, 950 F.3d at 99 (stating that the court will review the district court's decision *de novo*).

173. See *id.* (agreeing with the district court that Section 1115 waivers should be measured against whether they promote health care coverage).

174. See *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006) ("The Medicaid program . . . provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs."); *Pharm. Research & Mfrs. Of Am. v. Concannon*, 249 F. 3d 66, 75 (1st Cir. 2001) (stating that the main purpose of Medicaid is to provide medical services to those who cannot provide for themselves); *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F. 2d 11, 20 (3d Cir. 1989) ("We recognize, of course, that the primary purpose of Medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it."); *Price v. Medicaid Dir.*, 838 F. 3d 739, 742 (6th Cir. 2016) (stating that Medicaid permits the government to give money to states to pay for the medical costs of

approving Arkansas Works, CMS evaluated Arkansas Works against three additional objectives of Medicaid similar to those the district court addressed in *Stewart II*.<sup>175</sup> The court of appeals dismissed these alternate objectives as lacking textual support in the Medicaid Act.<sup>176</sup> Rather, the statute only calls for the “furnish[ing of] medical assistance” to the poor.<sup>177</sup> Additionally, the court of appeals noted that Congress amended several social welfare programs in the 1990s to include work requirements, including TANF.<sup>178</sup> Given that Congress did not similarly amend Medicaid at this time, Congress did not intend for Medicaid to have work requirements.<sup>179</sup> Thus, the court of appeals held that the primary objective of Medicaid is providing health care coverage without any additional restrictions.<sup>180</sup>

## 2. *The Administrative Procedure Act*

The court of appeals affirmed the district court’s finding that the Secretary’s approval of the Section 1115 work requirements waiver was arbitrary and capricious.<sup>181</sup> When deciding whether to approve a waiver or not, the Secretary must show that he has considered all “important aspect[s] of the

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needy people); *Univ. of Wash. Med. Ctr. v. Sebelius*, 634 F. 3d 1029, 1031 (9th Cir. 2011) (describing Medicaid as a federal grant program that provides medical services to those who cannot afford them).

175. See Letter from Seema Verma, Adm’r, Ctrs. for Medicare & Medicaid Servs., to Asa Hutchinson, Governor, Arkansas, (March 5, 2018), <https://perma.cc/DF38-7GUB> (PDF) (identifying the objectives of the Medicaid Act as improving health outcomes, addressing factors that affect health outcomes, and engaging beneficiaries in their own care).

176. See *Gresham II*, 950 F.3d 93, 101 (D.C. Cir. 2020) (“These three alternative objectives all point to better health outcomes as the objective of Medicaid, but that alternative objective lacks textual support. Indeed, the statute makes no mention of that objective.”).

177. 42 U.S.C. § 1396-1 (2018).

178. See *Gresham II*, 950 F.3d at 102 (citing Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, sec. 103, § 407, 110 Stat. 2105, 2129–34) (stating that Congress has a history of amending social welfare programs to implement work requirements).

179. See *id.* (discussing Congressional intent behind amending certain social welfare programs).

180. See *id.* (affirming the district court’s ruling in *Stewart II*).

181. See *id.* (finding that the Secretary’s failure to consider coverage loss renders his approval arbitrary and capricious).

problem.”<sup>182</sup> In *Gresham II*, the court focused on the Secretary’s failure to consider the impact of Arkansas Works on beneficiary coverage, specifically whether the waiver program would cause coverage loss.<sup>183</sup> The court of appeals viewed coverage loss as directly related to the Medicaid objective of providing health care coverage, and found that the Secretary provided no in-depth analysis regarding this objective.<sup>184</sup> Instead, the Secretary’s approval centered around the alternative objectives of Medicaid he identified, such as promoting beneficiaries’ engagement with their health care.<sup>185</sup> Since the Secretary disregarded the Section 1115 waiver program’s impact on beneficiaries’ health care coverage, the court of appeals held that the Secretary’s action was arbitrary and capricious.<sup>186</sup>

The court of appeals’ opinion in *Gresham II* is particularly notable because Judge David Sentelle authored the opinion.<sup>187</sup> Judge Sentelle is often referred to as “one of the most conservative judges in the country” and serves as a mentor to his prior clerk Justice Neil Gorsuch.<sup>188</sup> Some legal scholars posit that the Trump Administration may abandon Section 1115 programs such as Arkansas Works because such a respected

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182. See *Motor Vehicles Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (discussing reasons why a court may find an agency action arbitrary and capricious).

183. See *Gresham II*, 950 F.3d at 103 (noting that the Secretary dismissed the concerns about coverage loss rather than engage directly with the issue).

184. See *id.* (“In total, the Secretary’s analysis of the substantial and important problem is to note the concerns of others and dismiss those concerns in a handful of conclusory sentences.”).

185. See Verma, *supra* note 175 (evaluating Arkansas Works based on alternative measures rather than focusing on the program’s effect on Medicaid coverage).

186. See *Gresham II*, 950 F.3d at 104 (holding that it is arbitrary and capricious to “prioritize non-statutory objectives to the exclusion of the statutory purpose”).

187. See *id.* at 94 (noting the three judges who heard the case and the judge who authored the opinion).

188. Ian Millhiser, *Trump Just Got Bad News From Neil Gorsuch’s Mentor in a Big Medicaid Case*, VOX (Feb. 14, 2020), <https://perma.cc/P5PK-X39N>; see Alexander Somodevilla & Sara Rosenbaum, *Inside the D.C. Circuit’s Opinion in Gresham v. Azar*, HEALTH AFF. (Feb. 20, 2020), <https://perma.cc/M5YK-T76A?type=image> (referring to Judge Sentelle as one of the most conservative members of the D.C. Circuit).

conservative judge issued a strong condemnation of the program.<sup>189</sup>

*V. Application of Current Case Law to Amendment 42 and the Healthy Adult Opportunity Program*

The courts’ rulings in *Stewart II* and *Gresham II* are important because they provide a framework for courts to use when faced with future challenges to the Secretary’s Section 1115 waiver authority.<sup>190</sup> This Note will first apply the reasoning in *Stewart II* and *Gresham II* to Amendment 42.<sup>191</sup> Next, this Note will turn to the Trump Administration’s recently released guidance to states on drafting Section 1115 waivers asking for Medicaid block grants.<sup>192</sup> Under the *Gresham II* court’s logic, the Secretary should not approve either Amendment 42 or HAO waivers because such approval would be unlawful and immediately struck down by the courts.<sup>193</sup>

*A. Amendment 42*

*1. Promoting the Objectives of Medicaid*

Section 1115 waivers must further the objectives of the Medicaid Act.<sup>194</sup> The *Gresham II* court noted that the principal

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189. See Somodevilla & Rosenbaum, *supra* note 188 (hypothesizing about the Trump Administration’s next move regarding Section 1115 work requirements programs).

190. See Sachs & Huberfeld, *supra* note 10 (suggesting that CMS’ solicitation of block grant proposals, and states submission of such proposals, is “courting yet another legal battle” in light of *Stewart*).

191. See Tony Pugh, *Tennessee Seeks Federal Approval to Block Grant Medicaid Program*, BLOOMBERG L. (Nov. 20, 2019), <https://perma.cc/SN3S-WGTC> (reporting that Tennessee filed its proposal with CMS on November 20, 2019 and that CMS approval of the proposal would be the first of its kind).

192. See Lynch, *supra* note 14 (explaining that CMS will now support state proposals to receive Medicaid as a block grant through Section 1115 waiver programs).

193. See Alice Hall-Partyka et al., *Tennessee Proposes First of Its Kind Block Grant Program for Medicaid*, C&M HEALTH L. (Sept 24, 2019), <https://perma.cc/YN42-FGBR> (“Approval of Tennessee’s proposal would likely trigger similar litigation against CMS.”).

194. See *infra* Part IV and accompanying text; see also 42 U.S.C. § 1315 (2018) (mandating that the Secretary only approve demonstration projects that “are likely to assist in promoting the objectives” of the Medicaid Act).

objective of the Medicaid Act is to provide medical assistance to needy populations.<sup>195</sup> This objective has two elements: whether the project causes beneficiaries to lose coverage and whether the project promotes Medicaid coverage.<sup>196</sup>

The experimental nature of Amendment 42 does not “sanction a demonstration that would result in significant coverage loss, nor does it relieve the Secretary of his obligation to consider the magnitude of coverage loss.”<sup>197</sup> When considering whether to approve Amendment 42, the Secretary must adequately consider the impact of the proposal on beneficiary coverage.<sup>198</sup> However, Amendment 42 does not explicitly address the potential impact of the demonstration project on enrollment for current beneficiaries.<sup>199</sup> In fact, Amendment 42 requests that Tennessee be preemptively exempted from any federal coverage mandate that may arise during the lifetime of the demonstration project.<sup>200</sup> The proposal even goes so far as to acknowledge that Tennessee is not providing the federal government with specific information and metrics about the impact of Amendment 42 on beneficiary coverage.<sup>201</sup> Given the

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195. See *Gresham II*, 950 F.3d 93, 95 (D.C. Cir. 2020) (stating that the primary objective of Medicaid is to provide medical assistance).

196. See *Stewart II*, 366 F. Supp. 3d 125, 140 (D.D.C. 2019) (quoting *Stewart I*, 313 F. Supp. 3d 237, 262 (D.D.C. 2018)) (restating the district court’s findings from the previous proceeding about the elements of the first objective of the Medicaid Act).

197. *Id.*

198. See *Humane Soc’y v. Zinke*, 865 F.3d 585, 607 (D.C. Cir. 2017) (stating that the Secretary must consider all “salient factors” when making an agency decision).

199. Compare *An Update*, *supra* note 76 (noting that the proposal does not address the potential impact of Amendment 42 on current beneficiaries), with *Stewart II*, 366 F. Supp. 3d at 141 (stating that Kentucky provided an estimated beneficiary coverage loss should the state’s Section 1115 waiver take effect); see also *Perkins*, *supra* note 90 (“[T]he document is extremely vague on the specifics of what the State is proposing to do and how those proposals will affect stakeholders, from enrollees to managed care organizations.”).

200. See *TENN. DIV. OF TENNCARE*, *supra* note 4, at 12 (“[I]t is expected that Tennessee will be exempt from any new federal mandates over the life of the demonstration that could have a material impact on the state’s Medicaid expenditures (e.g., mandates concerning eligibility or covered benefits).”).

201. See *id.* at 13 (“[I]t is not the intention of the state to enumerate in detail in this document every innovation, reform, or policy change that might take place over the life of the demonstration.”).

lack of specific information about the potential loss of coverage beneficiaries would face due to Amendment 42, the Secretary should not approve Tennessee’s proposal.<sup>202</sup>

The second element in furnishing medical assistance is whether the Section 1115 waiver program promotes Medicaid coverage.<sup>203</sup> In the proposal, Tennessee provides a list of alleged health reform benefits of shifting to a block grant model, but notably does not include coverage expansion as one such benefit.<sup>204</sup> Tennessee does mention “covering additional needy individuals” as a priority of Amendment 42, but provides no additional details on how exactly the state plans to achieve this goal.<sup>205</sup> Thus, the Secretary cannot approve Amendment 42 on the grounds that the demonstration project promotes Medicaid coverage because Tennessee has given the Secretary little information and evidence to evaluate.<sup>206</sup>

When reviewing Amendment 42 for approval, the Secretary should not consider whether the proposal promotes other alternative objectives identified by the Secretary.<sup>207</sup> The *Gresham II* court did not directly address the *Stewart II* court’s consideration of fiscal sustainability as another potential

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202. See *Gresham II*, 950 F.3d at 102 (citing the Secretary’s failure to account for the significant coverage loss as a crucial error).

203. See *Stewart II*, 366 F. Supp. 3d at 140 (D.D.C. 2019) (finding that coverage promotion is an important component of providing medical assistance to needy populations).

204. See TENN. DIV. OF TENNCARE, *supra* note 4, at 3 (providing several “core health care reform principles” that the state would expand under the Medicaid block grant).

205. See *id.* at 24 (listing several priorities for the demonstration project).

206. See *Stewart II*, 366 F. Supp. 3d at 143 (discussing the importance of the Secretary’s ability to evaluate whether or not a Section 1115 demonstration project promotes Medicaid coverage); see also *Gresham II*, 950 F.3d 93, 103 (D.C. Cir. 2020) (noting that, notwithstanding the fact that Arkansas did not provide any coverage loss analysis, the Secretary had enough information to realize that such an analysis was required).

207. See *Gresham II*, 950 F.3d at 100–01 (dismissing the Secretary’s evaluation of Arkansas Works against alternative objectives of Medicaid as unrelated to the primary objective of Medicaid); *Stewart II*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019) (finding that promotion of either health or financial independence is not a valid objective of the Medicaid Act).

objective of Medicaid.<sup>208</sup> Under the *Stewart II* ruling, however, the Secretary may be able to consider Amendment 42's impact on the fiscal sustainability on Tennessee's Medicaid program when evaluating whether to approve the project or not.<sup>209</sup>

One of the main goals of Amendment 42 is to "demonstrate that an alternative model of federal participation in state Medicaid programs will lead to Medicaid programs that are more financially sustainable for states and the federal government . . . ." <sup>210</sup> The proposed block grant model will permit Tennessee to reinvest unspent federal dollars back into "the state's needy populations."<sup>211</sup> However, other than a few sentences naming fiscal sustainability of Medicaid as a goal of Amendment 42, Tennessee provides no specific details for the Secretary on how precisely Amendment 42 will make Medicaid more sustainable.<sup>212</sup> As the court stated in *Stewart II*, the Secretary "must give an adequate explanation" for why Amendment 42 supports the objectives of the Medicaid Act that is "supported by substantial evidence."<sup>213</sup> Even if Tennessee provided more information about the fiscal sustainability objective, the Secretary would still be required to weigh this positive against potential coverage loss from Amendment 42.<sup>214</sup> Tennessee contends that the format of the block grant encourages the state to save money because any savings are

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208. See *Gresham II*, 950 F.3d at 98–99 (stating that the court granted Kentucky's motion to dismiss the *Stewart II* appeal and so the court of appeals never reached the questions presented in that case about fiscal sustainability); see also Somodevilla & Rosenbaum, *supra* note 188 (noting that the court of appeals did not consider the fiscal sustainability argument as it was not raised in the Arkansas case).

209. See *Stewart II*, 366 F. Supp. 3d at 149 ("Defendants may, as a result, take into account fiscal sustainability in determining under § 1315 whether a demonstration project promotes the objectives of the [Medicaid] Act.").

210. TENN. DIV. OF TENNCARE, *supra* note 4, at 26.

211. See *id.* at 4 (describing the proposed incentives for the state to wisely spend its Medicaid dollars under the block grant model).

212. See *An Update*, *supra* note 76 (noting that Tennessee's proposal provides little detail on how the state will accomplish its goals).

213. *Stewart II*, 366 F. Supp. 3d at 149.

214. See *Gresham II*, 950 F.3d at 103 (finding that the Secretary did not engage in adequate analysis regarding potential coverage loss); *Stewart II*, 366 F. Supp. 3d at 149 (stating that the Secretary must do more than identify an objective of Medicaid, he must show how the demonstration project specifically furthers that objective).

split between the state and the federal government.<sup>215</sup> However, opponents of Amendment 42 argue that the shared savings model incentivizes Tennessee to “cut Medicaid benefits and services.”<sup>216</sup> Any such cuts should prominently factor into the Secretary’s balancing test in considering whether Tennessee’s promotion of fiscal sustainability meets the requirement that Section 1115 waivers must further the objectives of the Medicaid Act.<sup>217</sup>

## 2. *The Administrative Procedure Act*

As discussed previously,<sup>218</sup> the Secretary should not approve Amendment 42 or similar block grant Section 1115 waivers because they do not further the objectives of the Medicaid Act.<sup>219</sup> If the Secretary were to approve a demonstration project such as Amendment 42, the courts would likely strike down such an approval as arbitrary and capricious because the demonstration project does not further the objectives of the Medicaid Act.<sup>220</sup> The Secretary would have to prove to the court that, in making his decision to approve Amendment 42, he properly considered “the relevant factors”

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215. See TENN. DIV. OF TENNCARE, *supra* note 4, at iii (“Tennessee proposes that in any year in which the state underspends its block grant, the state and the federal government share in the resulting savings.”).

216. See Pugh, *supra* note 191 (providing potential cuts Tennessee may make to Medicaid services due to the structure of the block grant).

217. See *Gresham II*, 950 F.3d 93, 104 (D.C. Cir. 2020) (noting that the Secretary disregarded the primary objective of Medicaid in his approval of Arkansas Works); *Stewart II*, 366 F. Supp. 3d at 152 (“[T]he Secretary must engage in considered analysis of the fiscal-sustainability concern . . .”); see also 42 U.S.C. § 1315 (2018) (stating that the Secretary’s judgment determines whether a demonstration project furthers the objectives of the Medicaid Act).

218. See *supra* Part IV.

219. See Sachs & Huberfeld, *supra* note 10 (arguing that any block grant model would violate the objectives of the Medicaid Act because it would incentivize disenrolling beneficiaries from the program).

220. See *Gresham II*, 950 F.3d at 104 (stating that to avoid a finding of arbitrary and capricious review, the Secretary needs to analyze the loss of beneficiary coverage); *Stewart II*, 366 F. Supp. 3d 125, 137 (D.D.C. 2019) (using the Secretary’s failure to properly consider the objectives of the Medicaid Act as evidence that the Secretary’s approval of Kentucky’s waiver was arbitrary and capricious).



and available data.<sup>221</sup> Because Tennessee provided such sparse details about Amendment 42's potential impact on Medicaid coverage, as well as how Amendment 42 would promote fiscal sustainability, the Secretary would find it difficult to produce a robust record and appropriately weigh the factors relevant to his approval.<sup>222</sup>

### *B. Healthy Adult Opportunity Waiver Program*

#### *1. Promoting the Objectives of the Medicaid Act*

In the Letter to State Medicaid Directors concerning the HAO program, CMS specifically calls for states to submit proposals for Section 1115 block grant projects that “are likely to assist in promoting the objectives of the Medicaid program.”<sup>223</sup> Instead of stating that the objective of Medicaid is to provide medical assistance to needy populations,<sup>224</sup> the letter identifies the objective of Medicaid as “the furnishing of medical assistance in a manner that promotes the sustainability of government health care spending . . . .”<sup>225</sup> However, the court in *Gresham II* emphasized that the text of the Medicaid Act “specifically addresses only coverage” as the objective of statute, and to go beyond this clear objective is not permitted.<sup>226</sup> Although the district court in *Stewart II* acknowledged that

221. See *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971) (requiring the Secretary to properly consider the evidence before him when making an agency decision).

222. See *Newton-Nations v. Betlach*, 660 F.3d 370, 381 (9th Cir. 2011) (finding the Secretary's approval of a Section 1115 waiver arbitrary and capricious because the Secretary produced no record indicating that they had actually made findings about the program's impact on the objectives of the Medicaid Act); see also *Beno v. Shalala*, 30 F.3d 1057, 1074 (9th Cir. 1994) (stating that the Secretary needs to provide evidence that they considered the impact of the Section 1115 waiver project on the state's Medicaid population).

223. See *Lynch*, *supra* note 14 (discussing the requirements for successful Section 1115 demonstration projects).

224. See 42 U.S.C. § 1315 (2018) (discussing the objective of the Medicaid Act).

225. *Id.*

226. See *Gresham II*, 950 F.3d at 100–01 (refusing to recognize the Secretary's identified additional objectives of Medicaid as legitimate because Congress intended for providing medical coverage to be the primary Medicaid objective).

fiscal sustainability may be an objective that the Secretary can consider,<sup>227</sup> the court of appeals did not consider this issue on appeal.<sup>228</sup> The HAO letter’s failure to specify the provision of health coverage to low-income individuals as the objective of Medicaid indicates that a court should strike down any HAO approvals.<sup>229</sup> As the *Stewart II* court addressed, the effect of the Section 1115 program on beneficiary coverage is a key aspect of promoting the objective of Medicaid.<sup>230</sup>

Importantly, HAO initiatives only apply to adults who are not already eligible for Medicaid under a state’s normal Medicaid plan, such as the Medicaid expansion population.<sup>231</sup> For some states, the ability to receive certain portions of Medicaid as a block grant may incentivize them to expand Medicaid, thus providing health coverage to more individuals and promoting the objective of Medicaid.<sup>232</sup> However, the Kentucky HEALTH work requirements also applied to the expansion population and the district court still struck the waiver down as violating the objectives of Medicaid due to the resulting coverage loss.<sup>233</sup> If HAO demonstration projects also result in significant coverage loss, they would similarly be struck down by the courts regardless of which Medicaid

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227. See *Stewart II*, 366 F. Supp. 3d at 149 (finding that the Secretary’s consideration of fiscal sustainability was not an unreasonable interpretation of Medicaid’s objectives).

228. See Somodevilla & Rosenbaum, *supra* note 189 (stating that fiscal sustainability may be a legitimate argument since the court of appeals did not definitively rule on this issue).

229. See Rudowitz et al., *supra* note 68 (“[Work requirements] lawsuits have been decided based on the finding that the primary objective of the Medicaid program is to provide affordable coverage to low-income people, which is not highlighted as a program objective for the HAOs.”).

230. See *Stewart II*, 366 F. Supp. 3d at 140 (discussing the role of beneficiary coverage in furnishing medical assistance to the needy).

231. See Lynch, *supra* note 14 (“We expect that coverage under an HAO demonstration will focus on adults under age 65 who are not eligible for coverage under the state plan.”).

232. See 42 U.S.C. § 1315 (2018) (stating that the purpose of Medicaid is to provide coverage to needy populations).

233. See *Stewart II*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019) (noting that the objective of Medicaid applies equally to both the non-expansion and expansion population).

population the project applied to.<sup>234</sup> The coverage loss could result from states who seek to transition an existing Medicaid population to an HAO demonstration project.<sup>235</sup> Additionally, the HAO demonstration project itself could implement such changes as capping total Medicaid enrollment, imposing cost-sharing requirements on beneficiaries, restricting the drugs covered by Medicaid, and restricting Medicaid coverage to those with certain medical diagnoses.<sup>236</sup> Further, under the HAO initiative states can also impose work requirements, eliminate retroactive eligibility, and suspend coverage for those beneficiaries who do not pay their premiums.<sup>237</sup> While the letter includes a process for “transitioning existing Section 1115 demonstrations into a state’s HAO demonstration,” the letter does not provide any information about protecting against coverage loss.<sup>238</sup>

## 2. Administrative Procedure Act

As the court stated in *Gresham II*, the failure of CMS and the Secretary to account for coverage loss ultimately rendered approval of such Section 1115 waiver programs arbitrary and capricious.<sup>239</sup> To avoid such an outcome, the Secretary would have to carefully consider data submitted by states with their HAO program proposals about the programs’ potential impact

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234. See *Gresham II*, 950 F.3d 93, 102 (D.C. Cir. 2020) (“[T]he loss of coverage for beneficiaries is an important aspect of the demonstration approval because coverage is a principal objective of Medicaid . . .”).

235. See *Lynch*, *supra* note 14 (stating that states can transfer existing Medicaid beneficiaries to this new program).

236. See Paige Winfield Cunningham, *The Trump Administration Calls It ‘Healthy Adult Opportunity.’ Critics Call It Less Medicaid*, WASH. POST (Jan. 31, 2020, 7:18 AM), <https://perma.cc/RES9-CG59> (discussing the significant changes an HAO demonstration could impose on Medicaid beneficiaries).

237. See Rudowitz, et al., *supra* note 68 (discussing ways in which the HAO program permits states to limit Medicaid coverage).

238. See *Lynch*, *supra* note 14 (providing guidance on transitioning coverage from one Section 1115 demonstration to another, but failing to suggest safeguards against significant coverage loss).

239. See *Gresham II*, 950 F.3d at 102–03 (focusing on the Secretary’s failure to analyze potential coverage loss from Arkansas Works).

on coverage.<sup>240</sup> However, the HAO letter does not specifically encourage states to analyze and present such data to the Secretary, resulting in courts ruling that any approval of an HAO program is arbitrary and capricious.<sup>241</sup>

## VI. Conclusion

If current health care and political trends continue, many states are likely to submit controversial Section 1115 proposals that potentially violate the Medicaid Act as interpreted in *Stewart II* and *Gresham II*.<sup>242</sup> By ruling against both Arkansas’s and Kentucky’s Section 1115 waivers, the courts have taken a clear stance on which types of proposals are permissible and which are not.<sup>243</sup> The court ruling had a profound effect on the Medicaid landscape in Kentucky, as the current governor has terminated the Kentucky HEALTH program based on the court’s decision.<sup>244</sup> The courts should continue to enforce the Medicaid Act and the APA and strike down any Section 1115 proposals seeking to convert Medicaid into a block grant.<sup>245</sup> Although the Medicaid Act and Section 1115 waivers permit a

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240. See *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971) (stating that the Secretary must evaluate relevant data in making a decision).

241. See *Somodevilla & Rosenbaum*, *supra* note 188 (noting that any coverage losses stemming from approval of a Section 1115 program should be central to the Secretary’s decision to approve such a program).

242. See *Lynch*, *supra* note 14 (inviting states to apply for Section 1115 waivers that would convert Medicaid into a block grant program); see also *Gresham II*, 950 F.3d at 96 (holding that the Secretary’s approval of these Section 1115 waivers is arbitrary and capricious); *Stewart II*, 366 F. Supp. 3d at 131 (finding that the Secretary’s action in approving the Section 1115 waiver violates the Medicaid Act).

243. See *Fishman & Weissfeld*, *supra* note 65 (discussing the impact of the successful work requirements litigation on other Section 1115 waiver proposals).

244. See *Beshear*, *supra* note 170 (terminating the Kentucky HEALTH demonstration project based on the ruling in *Stewart v. Azar*).

245. See *Gresham II*, 950 F.3d 93, 103 (D.C. Cir. 2020) (finding the Secretary’s analysis of the impact of Arkansas Works on beneficiary coverage to be no more than a few sentences); *Stewart II*, 366 F. Supp. 3d 125, 131 (D.D.C. 2019) (finding that, since Kentucky HEALTH did not advance the objectives of the Medicaid Act, the Secretary’s approval of the program was arbitrary and capricious).

degree of innovation and flexibility,<sup>246</sup> it is up to the courts to protect the interests of Medicaid beneficiaries and ensure that any decisions made by the Secretary are based on a robust record that ensures adequate coverage protection.<sup>247</sup> Otherwise, beneficiaries like six year-old Asher will be left without medically necessary treatment and their families will be forced into financial hardship.<sup>248</sup>

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246. See 42 U.S.C. § 1315 (2018) (noting that Section 1115 programs are experimental in nature).

247. See *Stewart II*, 366 F. Supp. 3d at 143 (stating that the Secretary failed to provide enough detail about how Kentucky HEALTH would advance coverage promotion).

248. See *Bliss*, *supra* note 2 (stating that Asher, after contracting a serious respiratory illness due to her disabilities, received a \$1.8 million medical bill from her required medical treatments).