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Predetermined? The Prospect of Social Determinant-Based Section 1115 Waivers After *Stewart v. Azar*

Griffin Schoenbaum*

ABSTRACT

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services (the "Secretary") to waive some of Medicaid's requirements so states can enact "demonstration projects." A demonstration project is an experiment a state can conduct by modifying aspects of its Medicaid program. To waive Medicaid's requirements for this purpose, the Secretary must determine that the proposed demonstration project will likely assist in promoting Medicaid's objectives.

Using this standard, President Trump's Secretary has approved waiver requests to enact demonstration projects that contain "community engagement" requirements. The U.S. District Court for the District of Columbia has heard each challenge to the Secretary's approval of these waiver requests. In each case, the court found that the proposed demonstration project was unlikely to assist in promoting Medicaid's objectives—due in large part to the community engagement requirements.

Throughout these cases, the Secretary argued that community engagement would likely make beneficiaries healthier. But the court responded that improving beneficiaries' health is not a Medicaid objective and is thus an improper basis upon which to approve a waiver request. Another theme in these cases was the court's mantra that Medicaid's chief objective is to finance recipients' care. Yet, to complicate matters, a different line of cases identifies Medicaid's chief objective as not only financing recipients' care but also ensuring its provision. If these are the objectives that a demonstration project must likely promote, many

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demonstration projects intended to improve health may not survive judicial scrutiny.

This Comment discusses the leading community engagement requirement case, *Stewart v. Azar*. It does so with an eye toward the consequences that *Stewart* may have for social determinant of health-based demonstration projects. This Comment argues the courts should allow the Secretary to approve at least some of these projects, despite the roadblocks that *Stewart* appears to present.

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I. INTRODUCTION

"[A]s it relates to our health, our zip code may be more important than our genetic code," wrote James S. Marks, the Robert Wood Johnson Foundation's former Executive Vice President.[1] Indeed, the quality of our nutrition,[2] education,[3] housing,[4] and many other socioeconomic resources greatly influences our health.[5] The health care literature refers to these health-affecting socioeconomic resources as the social determinants of health ("SDHs").[6] Low-income populations often lack high-quality socioeconomic resources, and their health suffers accordingly.[7] As a medical assistance pro-

1. James S. Marks, *Why Your Zip Code May Be More Important to Your Health Than Your Genetic Code*, HUFFPOST, http://bit.ly/2V2pLAO [https://perma.cc/XGA6-BLZZ] (last updated May 25, 2011).

2. *See, e.g.*, Stefanie Winston Rinehart et al., *Building a Connection Between Senior Hunger and Health Outcomes*, 116 J. ACAD. NUTRITION & DIETETICS 759, 759 (2016) (citations omitted) ("Malnourished patients have worse health outcomes when compared with well-nourished patients, including increased physician visits, longer hospital stays and readmissions, decreased function and quality of life, and increased health care costs.").

3. *See, e.g.*, Emily B. Zimmerman et al., *Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives*, *in* POPULATION HEALTH: BEHAVIORAL AND SOCIAL SCIENCE INSIGHTS 347, 348 (Robert M. Kaplan et al. eds., 2015), http://bit.ly/2tmIVFs [https://perma.cc/ANW6-Z72N] ("Of the various social determinants of health that explain health disparities by geography or demographic characteristics (e.g., age, gender, race-ethnicity), the literature has always pointed prominently to education.").

4. *See, e.g.*, Michael Weitzman et al., *Housing and Child Health*, 43 CURRENT PROBS. PEDIATRIC & ADOLESCENT HEALTH CARE 187, 187 (2013) (citation omitted) ("The connection between housing and health is well established.").

5. *See generally Social Determinants of Health*, HEALTHY PEOPLE 2020, http://bit.ly/2S5hjyO [https://perma.cc/42KF-MELG] (last visited Nov. 20, 2019) (providing an overview of the social determinants of health); Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KAISER FAM. FOUND. (May 10, 2018), http://bit.ly/2pkbqoN [https://perma.cc/9FFG-ZC4V] (same).

6. *See* sources cited *supra* note 5.

7. *See* STEVEN H. WOOLF ET AL., URBAN INST., & CTR. ON SOC'Y & HEALTH, HOW ARE INCOME AND WEALTH LINKED TO HEALTH AND LONGEVITY? 6 (2015), https://urbn.is/2BNoKWb [https://perma.cc/W6LH-PCFC].

gram for low-income populations, Medicaid appears to be the perfect vehicle to address this issue.[8] But a new line of cases may stand in the way.[9]

These cases involve Section 1115 of the Social Security Act.[10] This section allows the Secretary of the U.S. Department of Health and Human Services (the "Secretary") to waive some of Medicaid's requirements so states can experiment with their Medicaid programs.[11] President Trump's Secretary has used this waiver authority to approve states' requests to run demonstration projects that include community engagement requirements.[12] Kentucky's was the first of these requests that the Secretary approved, and Kentucky Medicaid recipients immediately challenged the Secretary's approval.[13]

Part II of this Comment describes Medicaid's origins, development, and operation.[14] Part II then discusses Section 1115 waivers and how they can address the SDHs.[15] Next, Part II summarizes the litigation surrounding the Secretary's approval of Kentucky's waiver request and notes a lingering definitional question.[16] Part III theorizes that the litigation could hinder the future of SDH-based demonstration projects.[17] Part III then argues that, though things look grim, courts should still permit the Secretary to approve at least some SDH-based demonstration projects.[18]

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8. *See infra* Section II.A.

9. *See infra* Part III.

10. 42 U.S.C. § 1315(a) (2018). This Comment follows the administrative and scholarly practice of referring to these waivers by their Social Security Act designation (Section 1115), not their United States Code designation (§ 1315(a)). *See, e.g.*, Sidney D. Watson, *Premiums and Section 1115 Waivers: What Cost Medicaid Expansion?*, 9 ST. LOUIS U. J. HEALTH L. & POL'Y 265, 265 (2016); *About Section 1115 Demonstrations*, MEDICAID.GOV, http://bit.ly/2SC8phr [https://perma.cc/UK58-7XHK] (last visited Nov. 20, 2019).

11. 42 U.S.C. § 1315(a) (2018); *see also infra* Section II.B.

12. *See infra* note 126 and accompanying text.

13. Benjy Sarlin, *First-in-Nation Medicaid Work Requirements Approved for Kentucky*, NBC NEWS, https://nbcnews.to/2SHmnhZ [https://perma.cc/NZX6-XV6T] (last updated Jan. 12, 2018, 4:06 PM); *see also infra* Section II.C.

14. *See infra* Section II.A.

15. *See infra* Section II.B.

16. *See infra* Section II.C.

17. *See infra* Section III.A.

18. *See infra* Section III.B.

II. BACKGROUND

A. Understanding Medicaid

1. The Social Security Act: Social Insurance and Welfare Assistance Programs

Medicaid[19] is one of several programs housed within the Social Security Act.[20] The Social Security Act's programs fit into two broad categories: (1) social insurance programs and (2) welfare assistance programs.[21] Medicaid belongs in the second category; understanding why can shed light on the program itself.[22]

Social insurance programs spread the financial risk associated with uncertainties like death, illness, and unemployment.[23] The programs distribute benefits only to those who contribute to them[24]—regardless of their wealth or income.[25] The Social Security Act's social insurance programs include Federal Old Age, Survivors, and Disability Insurance[26] and Medicare.[27]

By contrast, welfare assistance programs distribute benefits based on need.[28] For this reason, welfare assistance programs belong in the "residual welfare" tradition.[29] Programs in this tradition

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19. 42 U.S.C. §§ 1396–1396w-5 (2018).

20. Social Security Act, Pub. L. No. 74-271, 49 Stat. 620 (1935) (codified as amended at 42 U.S.C. §§ 301–1397mm (2018)). The Social Security Act is Title 42, Chapter 7 of the United States Code; the Act's programs comprise the various subchapters within Chapter 7. *Id.*

21. ANDREW W. DOBELSTEIN, UNDERSTANDING THE SOCIAL SECURITY ACT: THE FOUNDATION OF SOCIAL WELFARE FOR AMERICA IN THE TWENTY-FIRST CENTURY 15 (2009); Elva Marquard, *Social Insurance and Public Assistance Payments*, 6 SOC. SECURITY BULL. 16, 16 (1944), http://bit.ly/2VXEhLM [https://perma.cc/F6G7-M68L] (discussing the Social Security Act's programs in terms of "insurance and assistance programs").

22. *See infra* Section II.A.2.

23. *About the National Academy of Social Insurance*, NAT'L ACAD. OF SOC. INS., http://bit.ly/2yRgIcV [https://perma.cc/6H52-CZRD] (last visited Nov. 20, 2019); *Historical Background and Development of Social Security*, SOC. SEC. ADMIN., http://bit.ly/2V0wafw [https://perma.cc/K3AX-5G38] (last visited Nov. 20, 2019) [hereinafter *Historical Background*].

24. *Social Insurance Programs*, INST. FOR RESEARCH ON POVERTY, UNIV. OF WISCONSIN-MADISON, http://bit.ly/2YWn9G1 [https://perma.cc/UNQ6-JSPJ] (last visited Nov. 20, 2019).

25. DOBELSTEIN, *supra* note 21, at 20 ("Eligibility to the *social insurance* programs is an entitlement to those people (and their family members) who contributed to the program as defined in the law, regardless of economic need.").

26. 42 U.S.C. §§ 401–434 (2018) (Title II of the Social Security Act).

27. *Id.* §§ 1395–1395*lll* (Title XVIII of the Social Security Act).

28. Marquard, *supra* note 21, at 17; *see also* DOBELSTEIN, *supra* note 21, at 20; *id.* at 131 ("[Welfare assistance] requires highly discretionary decisions about those who seek relief and how much relief they need.").

29. *See* Ira Colby, *Chapter 1 Social Welfare Policy as a Form of Social Justice*, *in* SOCIAL WORK AND SOCIAL POLICY: ADVANCING THE PRINCIPLES OF ECO-

require individuals to exhaust their private resources before receiving public assistance.[30] The Social Security Act's welfare assistance programs include Supplemental Security Income[31] and Medicaid.[32]

2. A Brief History of Medicaid

a. Welfare Assistance Before the Social Security Act

The residual welfare tradition long predates the Social Security Act and its welfare assistance programs.[33] In fact, some scholars trace the tradition to medieval Europe's ecclesiastical poor relief.[34] But the Elizabethan Poor Laws serve as an acceptable starting point, as scholars consistently cite these laws as having directly influenced colonial American welfare assistance.[35]

NOMIC AND SOCIAL JUSTICE 1, 10 (Ira C. Colby et al. eds., 2013) ("*Residual* welfare . . . only includes public assistance or policies related to the poor. Residual services carry a stigma; are time-limited, means-tested, and emergency-based; and are generally provided when all other forms of assistance are unavailable. Welfare services come into play only when all other systems have broken down or proven to be inadequate.").

30. Colby, *supra* note 29, at 10; s*ee also* DOBELSTEIN, *supra* note 21, at 20. Dobelstein writes:

> Assistance programs satisfy "residual" social welfare issues by providing money for those who are unable to maintain sufficient income or gain access to necessary services using their own financial resources. . . . Because people are expected to take care of themselves or the family or friends are expected to help out in times of need, when these options are not available, then welfare is given in the form of assistance, "residual welfare."

Id.

31. 42 U.S.C. §§ 1381–1385 (2018) (Title XVI of the Social Security Act).

32. *Id.* §§ 1396–1396w-5 (Title XIX of the Social Security Act).

33. *See* DOBELSTEIN, *supra* note 21, at 20 ("Residual welfare is the oldest of all welfare ideas.").

34. *See, e.g.*, TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 67 (2003) (noting that the Elizabethan Poor Laws, which would go on to influence American welfare assistance, evolved from 14th century laws that targeted people in poverty); Larry Catá Backer, *Medieval Poor Law in Twentieth Century America: Looking Back Towards a General Theory of Modern American Poor Relief*, 44 CASE W. RES. L. REV. 871, 938–53 (1995) (recounting "the development of Anglo-American [assistance] systems from their origins in the medieval system of ecclesiastical relief to their modern manifestation as state general assistance systems").

35. *See, e.g.*, Bruce Jansson, *Chapter 2 Reconceptualizing the Evolution of the American Welfare State*, *in* SOCIAL WORK AND SOCIAL POLICY: ADVANCING THE PRINCIPLES OF ECONOMIC AND SOCIAL JUSTICE 21, 28–29 (Ira C. Colby et al. eds., 2013); Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 439 (2011); Philip Harvey, *Joblessness and the Law Before the New Deal*, 6 GEO. J. POVERTY L. & POL'Y 1, 18 (1999); Backer, *supra* note 34, at 964–65; *Historical Background*, *supra* note 23.

The Elizabethan Poor Laws emerged in England between 1597 and 1601.[36] Making a moral distinction "between the 'deserving' and the 'undeserving' poor,"[37] they obligated local churches to assist the vulnerable and punished the "paupers who were capable of working."[38] The Elizabethan Poor Laws greatly influenced the American colonies.[39] Each colony enacted laws that were nearly identical[40]—both in their welfare aims and moral overtones.[41] And even as welfare assistance evolved throughout early American history,[42] it retained the stigma it inherited.[43]

Welfare assistance also remained an entirely local enterprise.[44] Despite activists' efforts to secure federal involvement, local welfare administration prevailed throughout the 19th century.[45] But the 19th century also ushered in the Industrial Revolution, which spawned new demands for welfare assistance as people flooded cities and life expectancy increased.[46]

The early 20th century saw a pair of tangible advances in welfare assistance.[47] Social reformers pushed President Theodore Roosevelt to create the White House Conference on Children, which produced the Children's Bureau in 1912.[48] Reformers also influenced President Harding to sign legislation[49] in 1921 that allo-

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36. JOST, *supra* note 34, at 67; Harvey, *supra* note 35, at 18.

37. *Historical Background*, *supra* note 23.

38. JOST, *supra* note 34, at 67.

39. *See* sources cited *supra* note 35.

40. Harvey, *supra* note 35, at 21.

41. *See id.*

42. *See id.* at 21–22 (identifying several forms of early American welfare assistance).

43. *See Historical Background*, *supra* note 23 ("Those receiving relief could lose their personal property, the right to vote, the right to move, and in some cases were required to wear a large 'P' on their clothing to announce their status.").

44. Harvey, *supra* note 35, at 30–31 (describing local control over who could receive welfare assistance and how much they could receive with little state oversight); DOBELSTEIN, *supra* note 21, at 133 ("Pre-Social Security Act welfare was locally provided . . . .").

45. *See, e.g.*, DOBELSTEIN, *supra* note 21, at 1–2. One such activist was Dorothea Dix, a social reformer motivated by the deplorable condition of mental health treatment in America. *Id.* at 1. Dix persuaded several state legislatures to create hospitals for people with mental illnesses. *Id.* Next, Dix petitioned Congress to approve federal land grants to states, allowing them to build additional hospitals. *Id.* at 1–2. Congress drafted and presented legislation to President Franklin Pierce. *Id.* But President Pierce vetoed the legislation: "[I]n summary, Pierce said welfare is not the responsibility of the federal government." *Id.* at 2.

46. *See Historical Background*, *supra* note 23.

47. *See* DOBELSTEIN, *supra* note 21, at 2–3.

48. *Id.* at 2.

49. Sheppard-Towner Maternity and Infancy Act, ch. 135, Pub. L. No. 67-97, 42 Stat. 224 (repealed 1929).

cated federal funds to various maternal- and children's-health-related programs.[50]

Then, in October of 1929, the New York Stock Exchange crashed: The Great Depression had begun.[51] At that time, local governments provided the majority of welfare assistance, with private entities providing the rest.[52] But the Great Depression's immensity[53] soon required the federal government's involvement in welfare assistance matters.[54]

b. From the Social Security Act to Medicaid's Enactment

The Social Security Act of 1935 marked a critical turn in welfare legislation.[55] Though the Act's social insurance program may be the most notable of the original programs,[56] the Act also created several welfare assistance programs.[57] Yet the Act in its original form left gaping holes through which sizable groups of needy people fell,[58] provoking calls for amendment.[59]

Though Congress has amended the Social Security Act many times, the Social Security Amendments of 1965[60] have emerged as perhaps the most significant amendments.[61] The 1965 amendment

50. DOBELSTEIN, *supra* note 21, at 2–3.

51. ROBERT F. HIMMELBERG, THE GREAT DEPRESSION AND THE NEW DEAL 4 (2001).

52. DOBELSTEIN, *supra* note 21, at 28.

53. *See* Donald M. Fisk, *American Labor in the 20th Century*, COMPENSATION & WORKING CONDITIONS (Fall 2001), at 2, http://bit.ly/2S4npPV [https://perma.cc/3MJ9-HE8B] ("In 1933, there were more than 12 million workers unemployed; and the unemployment rate averaged 24.9 percent.").

54. DOBELSTEIN, *supra* note 21, at 28 (noting that appeals for federal involvement escalated as the unemployment rate increased).

55. *Historical Background*, *supra* note 23.

56. *See id.* ("It was Title II that was the new social insurance program we now think of as Social Security.").

57. DOBELSTEIN, *supra* note 21, at 132 (identifying these original welfare assistance programs as Aid to the Aged (Title I), Aid to the Blind (Title X), and Aid to Dependent Children (Title IV)).

58. *See* Matthew Diller, *Entitlement and Exclusion: The Role of Disability in the Social Welfare System*, 44 UCLA L. REV. 361, 410 (1996) (noting the limited assistance that the 1935 Act afforded people with disabilities).

59. *See* DOBELSTEIN, *supra* note 21, at 144 ("[P]ressure to expand Title II Social Security continued until Disability Insurance was finally established as part of Title II in 1956.").

60. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended primarily in scattered sections of 26 and 42 U.S.C.) (creating Medicare and Medicaid).

61. *See* DOBELSTEIN, *supra* note 21, at 219 ("Next to the creation of the Social Security Act itself, the 1965 Amendments to the Social Security Act constitute a lasting social welfare landmark.").

added both Title XVIII (Medicare Parts A and B)[62] and Title XIX (Medicaid).[63] Medicare and Medicaid both address access to health care, but they do so very differently: Medicare functions as a social insurance program, and Medicaid functions as a welfare assistance program.[64]

c. From Medicaid's Enactment to the Present

Since Medicaid's enactment, Congress has made important amendments to the program's benefits and eligibility requirements.[65] Just two years after Medicaid's enactment, for example, Congress added the Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") benefit for enrollees under age 21.[66] And in 1989, Congress expanded Medicaid eligibility to all pregnant women and all dependent children in families with incomes below 133 percent of the Federal Poverty Line.[67]

The Patient Protection and Affordable Care Act (ACA)[68] expanded Medicaid eligibility even further.[69] As enacted, the ACA required every state to begin covering nearly all non-elderly adults whose incomes fell below 133 percent[70] of the Federal Poverty Line

62. 42 U.S.C. §§ 1395–1395*lll* (2018).

63. *Id.* §§ 1396–1396w-5.

64. *See* DOBELSEIN, *supra* note 21, at 255 ("[T]he 1965 amendments continued the tradition of creating two fundamentally different kinds of social welfare programs, social insurance and assistance, with the same purpose in mind: health care."); Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare for?*, 70 STAN. L. REV. 1693, 1712 (2018) ("[T]he distinction between social insurance and welfare that was encoded in the first Social Security Act was carried through into the statutory principles that underlie the differences between Medicare and Medicaid.").

65. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 627 (2012) (GINSBURG, J., dissenting) ("Since 1965, Congress has amended the Medicaid program on more than 50 occasions, sometimes quite sizably."); *Federal Legislative Milestones in Medicaid and CHIP*, MACPAC, http://bit.ly/2X1ppMu [https://perma.cc/YF93-PJ6U] (last visited Nov. 20, 2019) (listing and describing the major federal legislation affecting Medicaid).

66. Social Security Act Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821 (codified as amended at 42 U.S.C. § 1396d(r) (2018)).

67. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6401, 103 Stat. 2106, 2258.

68. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended primarily in scattered sections of 26 and 42 U.S.C.).

69. Nat'l Fed'n of Indep. Bus., 567 U.S. at 542 (explaining that "[t]he Affordable Care Act expands the scope of the Medicaid program and increases the number of individuals the States must cover").

70. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018). Though the ACA set "the eligibility threshold for Medicaid at 133 percent of the [Federal Poverty Line], . . . [5] percent of [Medicaid] applicants' income is disregarded, raising the effective threshold to 138 percent of the [Federal Poverty Line]." *Estimates for the Insur-*

on January 1, 2014.[71] But the Supreme Court forestalled the ACA's mandatory Medicaid expansion in the 2012 case *National Federation of Independent Business v. Sebelius*.[72] In that case, the Court held that the ACA's Medicaid expansion must be optional for each state.[73] Still, the ACA has succeeded in transforming American health care[74] and continues to set the terms of national health care debates.[75]

3. Medicaid's Operation

The federal Medicaid statute (the "Medicaid Act") defines Medicaid's basic framework.[76] The Medicaid Act requires each participating[77] state to annually submit a state plan[78] to the Centers for Medicare and Medicaid Services ("CMS").[79] A state plan

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ance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, CONG. BUDGET OFF. 7 n.13 (2012), http://bit.ly/2Eb9MuC [https://perma.cc/2T9F-KHBR].

71. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018); *see also* Nat'l Fed'n of Indep. Bus., 567 U.S. at 576.

72. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

73. *Id.* As of November 15, 2019, 37 states (including the District of Columbia) have chosen to expand their Medicaid coverage in accordance with the ACA's standard. *Status of State Action on the Medicaid Expansion Decision*, KAISER FAM. FOUND. (Nov. 15, 2019), http://bit.ly/2tkbELk [https://perma.cc/6UDA-APV9].

74. *See Summary of the Affordable Care Act*, KAISER FAM. FOUND. (Apr. 25, 2013), http://bit.ly/2Ece30H [https://perma.cc/5NXK-U27F] (summarizing a number of the ACA's major changes to various sectors of American health care).

75. *See, e.g.*, Rakesh Singh & Craig Palosky, *Poll: Most Democrats Prefer a Presidential Candidate Who Wants to Build on the Affordable Care Act*, KAISER FAM. FOUND. (Sept. 12, 2019), http://bit.ly/2lQMzap [https://perma.cc/98M4-7GU8] (discussing data from a poll that asked Democrats and Democratic-leaning independents whether they support presidential candidates who would build on the ACA or seek to replace it).

76. 42 U.S.C. §§ 1396–1396w-5 (2018).

77. Harris v. McRae, 448 U.S. 297, 301 (1980) ("Although participation in the Medicaid program is entirely optional, once a [s]tate elects to participate, it must comply with the requirements of Title XIX."). Each state and the District of Columbia participate in Medicaid. *See Program History*, MEDICAID.GOV, http://bit.ly/2BEwbyH [https://perma.cc/7QS8-453E] (last visited Nov. 20, 2019).

78. 42 C.F.R. § 430.10 (2019) ("The [s]tate plan is a comprehensive written statement submitted by the [state] agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in . . . Chapter IV [of Title 42], and other applicable official issuances of [the U.S. Department of Health and Human Services]. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.").

79. Christ the King Manor, Inc. v. Sec'y U.S. Dep't of Health & Human Servs., 730 F.3d 291, 297 (3d Cir. 2013) ("CMS is the division of HHS [the U.S. Department of Health and Human Services] tasked with ensuring that state plans comply with those and other requirements of the Medicaid Act.").

shows how the state intends to observe the Medicaid Act's requirements and specifies any optional eligibility or benefit allowances the state intends to provide.[80] CMS reviews each state plan and approves those that comply with the Medicaid Act.[81] After approving a state plan, CMS disburses funds to the state according to its "federal medical assistance percentage."[82] The state then carries out its plan subject to CMS's oversight.[83]

States have significant freedom to customize their state plans.[84] Each state can adjust eligibility requirements, decide which optional benefits to cover, and experiment with systems of provider payment and health care delivery.[85] A state can also amend its state plan after CMS has approved it.[86] But perhaps the broadest grant of authority to change a state's Medicaid program lies in Section 1115 of the Social Security Act.[87]

B. Section 1115 Waivers and the Social Determinants of Health

1. Section 1115 Waivers

Section 1115 of the Social Security Act allows the Secretary—CMS in practice[88]—to waive some of Medicaid's[89] provisions so

80. 42 U.S.C. § 1396a (2018); Nazareth Hosp. v. Sec'y U.S. Dep't of Health & Human Servs., 747 F.3d 172, 175 (3d Cir. 2014); 42 C.F.R. § 430.10 (2019).

81. 42 U.S.C. § 1396a(b) (2018); 42 C.F.R. § 430.14 (2019).

82. 42 U.S.C. § 1396b (2018); *see also id.* § 1396d(b) (outlining the process by which each state's federal medical assistance percentage is calculated). The "federal medical assistance percentage" is an annual calculation of the federal government's share of Medicaid funds disbursed to each state. *Id.* § 1396b. The calculation is different for each state because it is based on each state's per capita income relative to the national average. *See id.*

83. *Id.* § 1396c.

84. Pharm. Research & Mfrs. of Am. v. Walsh, 538 U.S. 644, 686 (2003) (O'Connor, J., dissenting) ("Congress has afforded States broad flexibility in tailoring the scope and coverage of their Medicaid programs . . . ."); Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options*, KAISER FAM. FOUND. (Jan. 31, 2017), http://bit.ly/2DHkSpC [https://perma.cc/YR68-57V6] ("Each state Medicaid program is unique, reflecting states' use of existing program flexibility and waiver authority to design their programs to meet their specific needs and priorities.").

85. Artiga et al., *supra* note 84.

86. Christ the King Manor, Inc. v. Sec'y U.S. Dep't of Health & Human Servs., 730 F.3d 291, 297 (3d Cir. 2013) ("A state may . . . amend an approved [Medicaid] plan, but any amendments must also be submitted to CMS, and the agency must 'determine whether the [amended] plan continues to meet the requirements for approval.'" (quoting 42 C.F.R. § 430.12(c)(2)(i))).

87. *See* NAT'L ASS'N OF MEDICAID DIRS., MEDICAID SECTION 1115 WAIVER TRENDS IN AN ERA OF STATE FLEXIBILITY 1 (2018), http://bit.ly/2tlTKI9 [https://perma.cc/E6VP-N7SH].

88. *See* Stewart v. Azar, 313 F. Supp. 3d 237, 245 (D.D.C. 2018) (emphasis added) ("[D]uring the 50-plus years of Medicaid, *CMS* has not previously ap-

states can enact "demonstration projects."[90] States have enacted demonstration projects to test methods of prescription drug funding, address substance use disorders, and provide integrative care for beneficiaries also enrolled in Medicare.[91] By unhampering states from some of Medicaid's statutory requirements, Section 1115 encourages innovation in Medicaid.[92]

The Secretary enjoys substantial[93] waiver authority under Section 1115 but does not have *carte blanche*.[94] Section 1115 provides that the Secretary may approve a waiver request only to enact an "experimental, pilot, or demonstration project."[95] The Secretary must determine that the project "is likely to assist in promoting the objectives of" Medicaid.[96] Even then, the Secretary can only waive Medicaid's requirements "to the extent and for the period . . . necessary to enable [the s]tate . . . to carry out such project."[97] And the Secretary must consider the "costs of such project . . . expenditures under the [s]tate plan."[98] Lastly, CMS has issued guidance requir-

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proved a community-engagement or work requirement as a condition of Medicaid eligibility."); 42 C.F.R. § 431.416 (2019) (providing that *CMS* is responsible for approving Section 1115 waiver requests).

89. 42 U.S.C. § 1315(a)(1) (2018) (providing that the Secretary can waive the Medicaid requirements housed in 42 U.S.C. § 1396a). Section 1115 does not limit the Secretary's waiver authority to Medicaid. *Id.* In fact, Congress added Section 1115 to the Social Security Act three years before it added Medicaid. *See* Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 122, 76 Stat. 172, 192.

90. 42 U.S.C. § 1315 (2018). The D.C. Circuit Court of Appeals has defined a "demonstration project" as follows:

> [A] plan for which some of the regulations imposed on Medicaid plans under subchapter XIX are waived in order to "enable the states to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients."

Cookeville Reg'l Med. Ctr. v. Leavitt, 531 F.3d 844, 845 (D.C. Cir. 2008) (quoting 42 C.F.R. § 430.25); *see also About Section 1115 Demonstrations*, *supra* note 10.

91. NAT'L ASS'N OF MEDICAID DIRS., *supra* note 87, at 2–3, 5.

92. *See* S. REP. NO. 87-1589, at 19–20 (1962) (describing Section 1115 waivers as a means of removing statutory constraints, thus allowing states to experiment with the ways in which they address public welfare concerns).

93. Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994) (noting that "the Secretary has considerable discretion" in approving Section 1115 waivers).

94. C.K. v. N.J. Dep't of Health & Human Servs., 92 F.3d 171, 187 (3d Cir. 1996) ("We are well aware of our proper deference to the Secretary with regard to the issuance of [Section 1115] waivers. However, that deference is not absolute.").

95. 42 U.S.C. § 1315(a) (2018).

96. *Id.*

97. *Id.* § (a)(1).

98. *Id.* § (a)(2)(A).

ing the Secretary to ensure that a proposed project is budget neutral to the federal government.[99]

Judicial review under the Administrative Procedure Act[100] can further constrain the Secretary's discretion.[101] A court may reverse the Secretary's approval of a Section 1115 waiver request if it deems the approval "arbitrary and capricious."[102] This standard of review requires a court to examine the administrative record that the Secretary considered.[103] The court may vacate and remand the Secretary's approval if it deems the approval unreasonable in light of the administrative record and Section 1115's requirements.[104]

Before a state can request a Section 1115 waiver, it must receive public input on its proposed demonstration project by publicizing and holding a notice and comment period.[105] The state must also hold at least two public hearings.[106] It may then submit its waiver request to CMS.[107] If CMS deems the state's request satisfactory, CMS solicits further public comments on the demonstration project.[108] CMS must publish, review, and consider the public

99. *See* Letter from Timothy B. Hill, Acting Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Directors 1 (Aug. 22, 2018), http://bit.ly/2Rj8lPG [https://perma.cc/5QV6-MUF6] ("Currently, CMS will not approve a demonstration project under section 1115(a) of the Act unless the project is expected to be budget neutral to the federal government. 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.").

100. 5 U.S.C. §§ 551–559, 701–706 (2018).

101. *See* 5 U.S.C. § 701(a) (2018) (providing a presumption that agency actions are subject to judicial review). For a more comprehensive discussion, see generally EDWARD C. LIU & JENNIFER A. STAMAN, CONG. RESEARCH SERV., JUDICIAL REVIEW OF MEDICAID WORK REQUIREMENTS UNDER SECTION 1115 DEMONSTRATIONS (Mar. 28, 2017), http://bit.ly/2krOaCY [https://perma.cc/U2FA-3WXT] (discussing judicial review of Section 1115 waivers).

102. *See* 5 U.S.C. § 706(2)(A) (requiring courts to "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"); Newton-Nations v. Betlach, 660 F.3d 370, 378 (9th Cir. 2011) ("We may reverse an agency action only if it is contrary to law or 'arbitrary and capricious' in that: '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.'" (quoting Motor Vehicle Mfrs. Ass'n v. State Farm Ins., 463 U.S. 29, 44 (1983))).

103. C.K. v. N.J. Dep't of Health & Human Servs., 92 F.3d 171, 182 (3d Cir. 1996).

104. *See C.K.*, 92 F.3d at 182 (citing Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416, 420 (1971)).

105. 42 C.F.R. § 431.408(a)(1)–(2) (2019).

106. *Id.* § 431.408(a)(3).

107. *Id.* § 431.412(b).

108. *Id.* § 431.416(b).

comments it receives.[109] Only then may CMS issue its final decision.[110] After approving a waiver request, CMS monitors the implemented demonstration project for compliance with the terms and conditions of the approval.[111]

2. *Using Section 1115 Waivers to Address the Social Determinants of Health*

States have used Section 1115 waivers to address the SDHs,[112] albeit indirectly.[113] The SDHs are socioeconomic factors that affect people's health outcomes.[114] Recognizing the benefits of addressing health-harming SDHs, Rhode Island and Massachusetts have requested and received waivers to create Accountable Care Organizations ("ACO").[115] These ACOs screen Medicaid recipients for health-harming social needs, including housing, nutrition, and utilities issues.[116] The ACOs then refer the recipients to social service organizations within their networks.[117]

Many ideas for SDH-based demonstration projects have so far remained untested, such as using Medicaid funding to create legal services organizations.[118] Access to legal services is an SDH,[119] as litigation and legal counseling can help people access health-bene-

109. *Id.* § 431.416(d).

110. *Id.* § 431.416(e).

111. *Id.* § 431.420.

112. DIANA CRUMLEY ET AL., CTR. FOR HEALTH CARE STRATEGIES, ADDRESSING SOCIAL DETERMINANTS OF HEALTH VIA MEDICAID MANAGED CARE CONTRACTS AND SECTION 1115 DEMONSTRATIONS 8–11 (2018), http://bit.ly/2GNPqcn [https://perma.cc/WUM3-WM8F].

113. ELIZABETH HINTON ET AL., SECTION 1115 MEDICAID DEMONSTRATION WAIVERS: THE CURRENT LANDSCAPE OF APPROVED AND PENDING WAIVERS, KAISER FAM. FOUND. 11 n.27 (2019), http://bit.ly/2kKacRP [https://perma.cc/5S7R-C22R]. "Medicaid funds typically cannot be used to pay directly for non-medical interventions that target the social determinants of health." *Id.* at 5.

114. *See supra* notes 2–6 and accompanying text.

115. CRUMLEY ET AL., *supra* note 112, at 25–27. For more information on ACOs, see *Accountable Care Organizations (ACOs): General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://bit.ly/2X8Pg5l [https://perma.cc/6MFE-CNAC] (last updated Nov. 27, 2019).

116. *See* CRUMLEY ET AL., *supra* note 112, at 25–27.

117. *See id.*

118. *See* Cerin M. Lindgrensavage, *Model Fairness and Advocacy for Interested Recipients (FAIR) Act*, 2014 N.Y.U. J. LEGIS. & PUB. POL'Y QUORUM 76, 80–81 (2014).

119. *See* Wendy E. Parmet et al., *Social Determinants, Health Disparities and the Role of* Law, *in* POVERTY, HEALTH AND LAW: READINGS AND CASES FOR MEDICAL-LEGAL PARTNERSHIP 3, 25 (Elizabeth Tobin Tyler et al. eds., 2011) ("Lawyers and advocates can use a variety of techniques, including client education, advocacy with government officials, negotiation and even litigation to alter the social conditions faced by specific individual . . . clients, thereby improving their health.").

fiting socioeconomic resources, including medical care.[120] Though no state has implemented a legal services demonstration project, this fact alone does not render such projects impossible. Indeed, the Trump administration's endorsement of community engagement waiver requests is an entirely new phenomenon.[121]

Before President Trump's election, CMS was unwilling to approve Section 1115 waivers that would impose community engagement requirements on Medicaid recipients.[122] CMS changed direction on January 11, 2018, when then-CMS director Brian Neale sent a letter to the state governors suggesting that they experiment with "work and community engagement" Medicaid requirements.[123] In his letter, Neale identified work and community engagement as "health determinants" that "may improve health outcomes."[124] He wrote that, like education, work and community engagement can contribute to people's health and well-being.[125]

As of November 11, 2019, 18 states have submitted waiver requests to implement projects with community engagement requirements, and the Secretary has approved 9 states' requests.[126] The U.S. District Court for the District of Columbia has reviewed each

120. *See id.*; *infra* Section III.B.2.

121. *See* Letter from Brian Neale, Dir., Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., to State Medicaid Dirs. 1 (Jan. 11, 2018) [hereinafter Neale Letter], http://bit.ly/2SATRyr [https://perma.cc/4YAB-D68F] ("CMS will support state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act . . . .").

122. *Fiscal Year 2017 HHS Budget: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 114th Cong. 35 (2016) (statement of Sec'y Burwell), http://bit.ly/2X3t64a [https://perma.cc/Z9EC-M5W7] ("[D]emonstration projects [must] promote the objectives of the Medicaid and CHIP programs. However, requiring Medicaid beneficiaries to work or receive job training is not an objective of Title XIX.").

123. Neale Letter, *supra* note 121, at 1.

124. *Id.* at 2.

125. *Id.*

126. *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Nov. 11, 2019), http://bit.ly/2X6Y77E [https://perma.cc/K5AJ-RTEJ].

challenge to the Secretary's approval of these waiver requests.[127] And in each case, the court vacated the Secretary's approval.[128]

C. Stewart v. Azar *and the Definitions of "Medical Assistance"*

1. Background

In January 2014, Kentucky's then-Governor Steve Beshear expanded Kentucky's Medicaid eligibility in line with the ACA's directive.[129] The next year, Kentucky elected a new Governor, Matt Bevin, who promised to roll back the Medicaid expansion.[130] Governor Bevin's weapon of choice was a comprehensive Section 1115 waiver request to include community engagement requirements in Kentucky's Medicaid program.[131] Governor Bevin requested the waiver on August 24, 2016.[132] When the Trump administration took over in 2017, then-Secretary Tom Price and current CMS Administrator Seema Verma signaled their willingness to approve community engagement requirements under Section 1115.[133] A few

127. *See generally* Philbrick v. Azar, No. 19-773, 2019 WL 3414376 (D.D.C. July 29, 2019); Gresham v. Azar, 363 F. Supp. 3d 165 (D.D.C. 2019); Stewart v. Azar, 366 F. Supp. 3d 125 (D.D.C. 2019); Stewart v. Azar, 313 F. Supp. 3d 237 (D.D.C. 2018). On September 23, 2019, Indiana Medicaid recipients sued in the same court to challenge the Secretary's approval of Indiana's community engagement waiver request. Complaint for Declaratory and Injunctive Relief at 46, Rose v. Azar, No. 1:19-cv-02848 (D.D.C. Sept. 23, 2019). The D.C. Circuit Court of Appeals will soon become the second court to review the Secretary's approval of a community engagement waiver request. *See* James Romoser, *Federal Appeals Court Appears Dubious of Medicaid Work Requirements*, INSIDE HEALTH POLICY (Oct. 11, 2019), https://bit.ly/35zcPaV [https://perma.cc/B9F3-6XTD] (noting that the D.C. Circuit Court of Appeals heard consolidated oral arguments in *Stewart* and *Gresham* on October 11, 2019).

128. *Philbrick*, 2019 WL 3414376, at *52; *Stewart*, 366 F. Supp. 3d at 156; *Stewart*, 313 F. Supp. 3d at 274; *see Gresham*, 363 F. Supp. 3d at 182. This Comment clearly focuses on *Stewart*; discussing *Gresham* and *Philbrick* would be superfluous because the court's reasoning in those cases was nearly identical to its reasoning in *Stewart*. *See Philbrick*, 2019 WL 3414376, at *2–3; *Gresham*, 363 F. Supp. 3d at 169 (discussing similarities with *Stewart*).

129. Joseph A. Benitez et al., *Kentucky's Medicaid Expansion Showing Early Promise on Coverage and Access to Care*, 35 HEALTH AFFAIRS 528, 528 (2016), http://bit.ly/2SZiTGK [https://perma.cc/77LD-4RFR].

130. *See Proposed Changes to Medicaid Expansion in Kentucky*, KAISER FAM. FOUND (Aug. 4, 2017), http://bit.ly/2V1B4Jd [https://perma.cc/US3T-9K8A].

131. *Id.*

132. *See generally* Letter from Matthew G. Bevin, Governor, Ky., to Sylvia Burwell, Sec'y, U.S. Dep't of Health & Human Servs. (Aug. 24, 2016), http://bit.ly/2nLnezq [https://perma.cc/7NQ4-LR5J] (attaching Kentucky's Section 1115 waiver request).

133. Letter from Thomas E. Price, Sec'y, Sec'y U.S. Dep't of Health & Human Servs., & Seema Verma, Admin., Ctrs. for Medicare & Medicaid Servs., to the U.S. Governors 2 (Mar. 14, 2017), http://bit.ly/2SDEK7g [https://perma.cc/Z3ZV-UB9N].

months later, Governor Bevin submitted a modified Section 1115 waiver request to CMS.[134] On January 12, 2018, CMS for the first time approved a Section 1115 waiver request to include community engagement requirements in a Medicaid program.[135]

2. Stewart v. Azar*: The First Community Engagement Requirement Case*

On January 24, 2018, Kentucky Medicaid recipients challenged the Secretary's approval of their state's Section 1115 waiver request ("*Stewart I*").[136] They specifically challenged the Secretary's approval of "Kentucky HEALTH," a suite of requirements[137] within the more general demonstration project that Kentucky sought to implement.[138] So Kentucky HEALTH served as the operative demonstration project for purposes of the court's review.[139]

The court framed the primary issue as "whether the Secretary acted arbitrarily or capriciously in concluding that Kentucky HEALTH was 'likely to assist in promoting the objectives' of the Medicaid Act."[140] Though the parties disagreed about Medicaid's objectives,[141] the court found enough overlap between their posi-

134. *See generally* Letter from Matthew G. Bevin, Governor, Ky., to Brian Neale, Dir., Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs. (July 3, 2017), http://bit.ly/2nPJ7h9 [https://perma.cc/R2TL-EDQ5] (attaching modifications to Section 1115 waiver request).

135. *See generally* Letter from Brian Neale, Dir., Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., to Adam Meier, Deputy Chief of Staff, Office of Governor Matthew Bevin (Jan. 12, 2018), http://bit.ly/2nO373D [https://perma.cc/P7KK-5Q9H] (approving Kentucky's modified Section 1115 waiver request and attaching Special Terms and Conditions).

136. *See generally* Class Action Complaint for Declaratory and Injunctive Relief, Stewart v. Hargan, 313 F. Supp 3d 237, No. 1:18-cv-152 (D.D.C. Jan 24, 2018) (outlining the bases for plaintiffs' challenge).

137. *Stewart*, 313 F. Supp. 3d 237, 246–47 (D.D.C. 2018) (noting that Kentucky HEALTH includes (1) a community-engagement requirement, (2) limits on retroactive eligibility, (3) monthly premiums, (4) limits on non-emergency medical transportation, (5) reporting requirements, and (6) lockouts).

138. *See id.* at 257–59 (defining the scope of the plaintiffs' challenge).

139. *Id.*

140. *Id.* at 259 (quoting 42 U.S.C. § 1315(a)). The Secretary initially contended that his approval of Kentucky's waiver request was not subject to judicial review. *Id.* at 254. But the court noted that the Administrative Procedure Act only precludes judicial review of agency actions when the statute underlying the agency action lacks adjudicative standards. *See id.* Here, the court found that Section 1115 of the Social Security Act provides the necessary adjudicative standards. *Id.*

141. *Compare* Plaintiffs' Memorandum in Support of Motion for Summary Judgment at 16, Stewart v. Azar, 313 F. Supp. 3d 237 (D.D.C. 2018) (No. 1:18-cv-152) ("[T]he purpose of the [Medicaid] Act is to enable states to furnish medical, rehabilitative, and other health care services."), *with* Memorandum in Support of Federal Defendants' Motion to Dismiss or, in the Alternative, for Summary Judg-

tions and the case law to locate Medicaid's objectives in the Medicaid Act's appropriations provision.[142] From this provision, the court extracted "two related objectives: allowing states, 'as far as practicable,' to 'furnish (1) medical assistance' and (2) 'rehabilitation and other services' designed to 'help individuals retain a capacity for independence.'"[143] The court focused its analysis almost exclusively on the first objective: furnishing medical assistance.[144]

To define "medical assistance," the court imported a definition from an opinion the D.C. Circuit Court of Appeals issued in 2008.[145] The *Stewart I* court thus stated that "[t]he Medicaid statute 'defines "medical assistance" as "payment of part or all of the cost" of medical "care and services" for a defined set of individuals.'"[146] In other words, to provide Medicaid recipients with "medical assistance" is to finance their health care.[147] Reviewing the administrative record, the court found that the Secretary had considered neither the estimated 95,000 Kentuckians who would *lose* their coverage nor whether Kentucky HEALTH would help *promote* coverage.[148] Because the Secretary had overlooked Medicaid's central objective—health insurance coverage—the court concluded that the Secretary's approval was arbitrary and capricious.[149] Accordingly, the court vacated and remanded the Secretary's approval.[150]

3. The Stewart I *Court's Treatment of Improved Health Outcomes as a Medicaid Objective*

The Secretary argued that Medicaid's fundamental objective is to improve recipients' health outcomes and that Kentucky

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ment, and in Opposition to Plaintiffs' Motion for Partial Summary Judgment at 20, Stewart v. Azar, 313 F. Supp. 3d. 237 (D.D.C. 2018) (No. 1:18-cv-152) ("The Act's overarching purpose, of course, is to promote public health and well-being.").

142. *Stewart*, 313 F. Supp. 3d 237 at 260.

143. *Id.* (quoting 42 U.S.C. § 1396-1).

144. *Compare id.* at 243–44, 260–61, 263, 265–66, 268–72 (making about 25 references to furnishing or providing medical assistance as being Medicaid's intention, objective, purpose, or goal), *with id.* at 260, 266, 271 (making about five references to furnishing rehabilitation and other services); *see also* Stewart v. Azar, 366 F. Supp. 3d 125, 155 (calling "the furnishing of medical assistance" the Medicaid Act's "prime objective").

145. *Stewart*, 313 F. Supp. 3d at 260 (quoting Adena Reg'l Med. Ctr. v. Leavitt, 527 F.3d 176, 180, (D.C. Cir. 2008) (citing 42 U.S.C. § 1396d(a))).

146. *Id.*

147. *See id.* at 260–61 (citations omitted).

148. *Id.* at 262–65.

149. *Id.* at 259–60, 265.

150. *Id.* at 274.

HEALTH was likely to assist in furthering that objective.[151] After all, Kentucky HEALTH requires community engagement, and, according to the Secretary, community engagement improves people's health and well-being.[152] The court avoided this empirical question and instead attacked the Secretary's fundamental premise—that Congress intended Medicaid to improve recipients' health.[153] Indeed, the court had already established that Medicaid's aim is not to advance recipient's health outcomes but to finance recipient's health care.[154]

To illustrate the difference, the court offered the following hypothetical:

> [I]magine two Kentuckians, Joe and Dan. Both are diagnosed with Hodgkin's Lymphoma. Joe has health insurance and is able to receive treatment for a co-pay of $100. Dan has no health insurance. He, too, is able to receive treatment, but he must pay out of pocket for the treatment costing tens of thousands of dollars. To do this, he and his wife must sell the family ranch, which had been in Dan's family for over four generations. After 18 months, both Joe and Dan are cancer free; in other words, they are equally healthy. But Dan, unlike Joe, is in financial ruin.[155]

According to the court, Congress intended Medicaid to prevent situations like Dan's; whether Medicaid would also make recipients healthier was an afterthought.[156] Indeed, had Congress wanted Medicaid to *directly* improve recipients' health, it could have required recipients to exercise or eat nutritious food.[157] But Congress did no such thing, so the court concluded that Medicaid's overarching concern is to furnish "medical assistance," which the court defined as financing recipients' health care.[158]

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151. *Id.* at 266; *see also* Sidney D. Watson, *Medicaid, Work, and the Courts: Reigning in HHS Overreach*, 46 J.L. MED. & ETHICS 887, 889 (2018) ("Seema Verma and other Trump Administration officials at HHS have taken the position that the ultimate purpose of Medicaid is to promote health and wellbeing.").

152. *See Stewart*, 313 F. Supp. 3d at 266.

153. *See id.* at 266–68.

154. *Id.* at 266 ("[The Secretary's] focus on health is no substitute for considering Medicaid's central concern: covering health *costs*.").

155. *Id.* at 267.

156. *Id.* at 266–67.

157. *Id.* at 268 ("Either of those conditions could promote 'health' or 'well-being' . . . but both are far afield of the basic purpose of Medicaid: 'reimburs[ing] certain costs of medical treatment for needy persons.'" (quoting Harris v. McRae, 448 U.S. 297, 301 (1980)).

158. *Id.* at 266–67.

4. Subsequent Developments

On November 20, 2018, the Secretary re-approved Kentucky's remanded waiver request.[159] Kentucky Medicaid recipients sued two months later, bringing the parties back to the U.S. District Court for the District of Columbia ("*Stewart II*").[160] Relevant to this Comment, the Secretary continued to argue that Kentucky HEALTH would likely assist in furthering Medicaid's objectives because it would improve recipients' health.[161] The court did not budge on this point.[162] The Secretary's non-health-related arguments fared no better with the court.[163] It once again vacated and remanded the Secretary's approval of Kentucky HEALTH.[164] But rather than review Kentucky's waiver request once more, the Secretary filed a Notice of Appeal.[165]

5. The Definitions of "Medical Assistance"

As noted above, the *Stewart I* court defined "medical assistance" in purely financial terms.[166] It drew its definition from *Adena Reg'l Med. Ctr. v. Leavitt*,[167] a case the D.C. Circuit Court of Appeals decided in 2008.[168] The *Adena* court, in turn, drew its definition of "medical assistance" from 42 U.S.C § 1396d(a),[169] which in 2008 defined "medical assistance" as "payment of part or all of the cost of . . . care and services."[170]

In 2009, the House Committee on Energy and Commerce recognized a circuit split over the meaning of "medical assistance"

159. *See generally* Letter from Paul Mango, Chief Principal Deputy Adm'r, Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., to Carol H. Steckel, Comm'r, Dept. for Medicaid Servs., Commonwealth of Ky. (Nov. 20, 2018), http://bit.ly/2SCmRpp [https://perma.cc/6BTU-Z9R2] (reapproving Kentucky's waiver request and attaching Special Terms and Conditions).

160. First Amended Class Action Complaint for Declaratory and Injunctive Relief, Stewart v. Azar, 366 F. Supp. 3d 125, No. 1:18-cv-152 (D.D.C. Jan. 14, 2019).

161. Stewart v. Azar, 366 F. Supp. 3d 125, 143–44 (D.D.C. 2019).

162. *Stewart*, 366 F. Supp. 3d at 143–45.

163. *See id.* at 145–55 (rejecting the Secretary's financial independence and fiscal sustainability arguments).

164. *Id.* at 156.

165. Notice of Appeal, Stewart v. Azar, 366 F. Supp. 3d 125, No. 1:18-cv-152 (D.D.C. Apr. 10, 2019). The D.C. Circuit Court of Appeals heard oral arguments on October 11, 2019. Romoser, *supra* note 127. As this Comment goes to print, the court's opinion is still forthcoming.

166. *Supra* notes 145–47 and accompanying text.

167. Adena Reg'l Med. Ctr. v. Leavitt, 527 F.3d 176 (D.C. Cir. 2008).

168. *Supra* notes 145–46 and accompanying text.

169. *Adena*, 527 F.3d at 180.

170. 42 U.S.C. § 1396d(a) (2006 & Supp. I 2008).

within the Medicaid Act.[171] Some circuits interpreted "medical assistance" to mean that states only had to *finance* recipients' medical care.[172] But the First Circuit Court of Appeals read "medical assistance" to imply that states must *provide* recipients' care.[173] Other circuits merely identified the definitional disagreement.[174]

Congress officially amended the Medicaid Act's definition of "medical assistance" when it passed the ACA,[175] which President Obama signed into law in 2010.[176] The amended definition embodied the House Committee on Energy and Commerce's declaration that "medical assistance" means both financing *and* providing recipients' health care.[177] Congress's amendment had a clear impact on some courts, which applied the post-ACA definition of medical as-

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171. H.R. REP. NO. 299, 111th Cong., 1st Sess. 2009, at 649–50 (Oct. 14, 2009). The House Committee on Energy and Commerce wrote:

> [Medical assistance] is expressly defined to refer to payment but has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves. The Committee, which has legislative jurisdiction over Title XIX of the Social Security Act, has always understood the term to have this combined meaning. Four decades of regulations and guidance from the program's administering agency, the Department of Health and Human Services, have presumed such an understanding and the Congress has never given contrary indications. . . . The Circuit Courts are split on this issue and the Supreme Court has declined to review the question. To correct any misunderstandings as to the meaning of the term, and to avoid additional litigation, the bill would revise section 1905(a) . . . to conform this definition to the longstanding administrative use and understanding of the term.

Id.

172. Michael C. Danna, *Medicaid Reform, Prison Healthcare, and the Due Process Right to a Fair Hearing*, 40 N.Y.U. REV. L. & SOC. CHANGE 429, 451–52 (2016) (describing a circuit split over the definition of "medical assistance" and Congress's effort to address it). As Danna points out, the definition of "medical assistance" is significant because "the term 'medical assistance' is used over 225 times in [42 U.S.C.] § 1396a," which is the section that governs states' Medicaid plans. *Id.* at 451.

173. *See id.*

174. *Id.* at 452.

175. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2304, 124 Stat. 296 (2010) (amending 42 U.S.C. § 1396d(a)). For purposes of Medicaid, "[m]edical assistance" now means "payment of part or all of the cost of the following care and services or the care and services themselves, or both." 42 U.S.C. § 1396d(a) (2018).

176. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. TIMES (Mar. 23, 2010), https://nyti.ms/2MwMXW8 [https://perma.cc/8ZF5-SCKB].

177. *Supra* note 171; *accord* NICOLE HUBERFELD ET AL., THE LAW OF AMERICAN HEALTH CARE 90 (2d ed. 2018) ("'Medical assistance' indicates Medicaid is more than just money. . . . Congress intended that participating states would be responsible for providing specified medical services to beneficiaries; in other words, states cannot agree to pay for care with Medicaid funds without ensuring beneficiaries receive promised care.").

sistance.[178] Other courts, however, continued to apply the pre-ACA definition of medical assistance[179]—including the *Stewart I* court.[180] Whether a court selects the pre-ACA or post-ACA definition of "medical assistance" should determine what the administrative record must show for the Secretary's approval to withstand arbitrary and capricious review.[181]

III. ANALYSIS

A. Stewart's *Implications for Social Determinant of Health-Based Demonstration Projects*

The way the court treated community engagement requirements in *Stewart I* and *Stewart II* offers a preview of how courts could treat other SDH-based demonstration projects approved under Section 1115.[182] The Secretary consistently pitched community engagement as an SDH, and the court addressed it as such.[183] Hence, as Professor David A. Super has warned, it may turn out that community engagement requirements and other SDH-based pursuits have a "rise together, fall together" relationship:

> A wide range of factors—from safe housing to good nutrition to education—have been found to improve health outcomes. If the current [community engagement] waivers pass muster, no principled basis would exist to stop future administrations from allowing states to expand food assistance or housing programs with Medicaid funds under section 1115.[184]

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178. *See, e.g.*, Jefferson Cmty. Health Care Ctrs., Inc. v. Jefferson Parish Gov't, 849 F.3d 615, 625 (5th Cir. 2017); O.B. v. Norwood, 838 F.3d 837, 843 (7th Cir. 2016); Dunakin v. Quigley, 99 F. Supp. 3d 1297, 1321 (W.D. Wash. 2015).

179. *See, e.g.*, Phoenix Mem'l Hosp. v. Sebelius, 622 F.3d 1219, 1226 (9th Cir. 2010); Covenant Health Sys. v. Sebelius, 820 F. Supp. 2d 4, 9 (D.D.C. 2011).

180. *See supra* notes 145–47 and accompanying text. Yet the *Stewart I* court did acknowledge the amended definition upon Kentucky's prompting. *See* Stewart v. Azar, 366 F. Supp. 3d 125, 144–45 (D.D.C. 2019). Kentucky averred that improving beneficiaries' health became a Medicaid objective when Congress broadened definition of "medical assistance" to include ensuring the provision of care. *Id.* at 144. By contrast, this Comment understands the broadened definition as effectively raising the bar that the Secretary must meet to properly approve a waiver request. *See infra* Part III. The *Stewart I* court did not address this potential implication. *See Stewart*, 366 F. Supp. 3d at 144–45.

181. *Infra* Part III.

182. *See* David A. Super, *A Hiatus in Soft-Power Administrative Law: The Case of Medicaid Eligibility Waivers*, 65 UCLA L. REV. 1590, 1607 (2018) (noting that states could enact a variety of SDH-based demonstration projects under Section 1115 if community engagement requirements survive judicial review).

183. *See* Stewart v. Azar, 313 F. Supp. 3d 237, 266–68 (D.D.C. 2018); *supra* Section II.C.3.

184. Super, *supra* note 182, at 1607.

This Comment's concern is the inverse of Professor Super's; hopefully, diagnosing the pitfalls of community engagement waiver requests can *help* the Secretary shepherd other SDH-based projects through judicial review.[185]

Recall that courts subject the Secretary's approval of Medicaid waiver requests to arbitrary and capricious review.[186] Under this standard of review, courts ask whether the administrative record shows that the Secretary considered, among other things, whether the proposed demonstration project is likely to assist in furthering Medicaid's objectives.[187] Courts must identify Medicaid's objectives to make this determination.[188] According to the court in *Stewart I* and *Stewart II*, Medicaid's essential objective is furnishing medical assistance.[189]

The next question is what "medical assistance" means.[190] As discussed above, courts can answer this question in two ways.[191] Courts might define "medical assistance" as financing recipients' medical care (the "pre-ACA definition").[192] Or courts might define "medical assistance" to mean both financing and ensuring the provision of recipients' care (the "post-ACA definition").[193]

Courts that apply the pre-ACA definition should ask whether the Secretary reasonably determined that a proposed demonstration project will likely assist in financing Medicaid recipients' care.[194] Courts that apply the post-ACA definition should *also* ask whether the Secretary reasonably determined that the proposed project will likely assist in ensuring that recipients receive their care.[195] In this way, the definition of "medical assistance" that a court adopts should set the standard to which it holds the Secretary under arbitrary and capricious review.

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185. *Cf. id.*

186. *Supra* notes 102–04 and accompanying text.

187. *Supra* note 140 and accompanying text.

188. *Stewart*, 313 F. Supp. 3d at 259–60 ("begin[ning] with the basic 'objectives' of Medicaid" after discussing arbitrary and capricious review).

189. Stewart v. Azar, 366 F. Supp. 3d 125, 155 (D.D.C. 2019) (calling "the furnishing of medical assistance" the "prime objective of the [Medicaid] Act"); *see Stewart*, 313 F. Supp. 3d at 272 (concluding that the Secretary's approval was arbitrary and capricious for failing to address whether the Kentucky's proposed demonstration project would help furnish medical assistance).

190. *Stewart*, 313 F. Supp. 3d at 260 ("So what does 'furnish[ing] . . . medical assistance' mean?").

191. *Supra* Section II.C.5.

192. *See supra* notes 167–70 and accompanying text.

193. *Supra* notes 175–77 and accompanying text.

194. *See supra* notes 186–89, 192 and accompanying text.

195. *See supra* notes 186–89, 193 and accompanying text.

B. How Social Determinant of Health-Based Demonstration Projects Can Survive Arbitrary and Capricious Review

Stewart I and *Stewart II* contain ominous language about the future of SDH-based demonstration projects.[196] Indeed, in each case the court emphasized that improving health outcomes is not a Medicaid objective.[197] But the lesson from those cases is *not* that all SDH-based demonstration projects must fail. Rather, the lesson is that the Secretary cannot tout a demonstration project's health-improving features without reckoning with the project's implications for furnishing medical assistance.[198]

But suppose the Secretary had reviewed Kentucky HEALTH and reasonably concluded that *no* Kentuckians stood to lose coverage. Would health-improvement then constitute a justifiable basis upon which to approve an SDH-based demonstration project? Those facts were not before the court.[199] So *Stewart I* and *Stewart II* offer no guidance as to whether an SDH-based demonstration project must help furnish "medical assistance" or simply refrain from significantly hindering that goal. In any case, there are some potential SDH-based demonstration projects that could improve health and, as a happy consequence, help furnish "medical assistance"—under the pre- or post-ACA definition.[200] The following illustrations give a sense of what such demonstration projects might look like.

1. The Pre-ACA Definition of "Medical Assistance"

A state may propose a demonstration project to run a nutrition-intervention program at in-state hospitals.[201] Hospital workers could screen at-risk Medicaid recipients for nutritional deficiencies and then, when necessary, intervene with nutritional supple-

196. *See* Stewart v. Azar, 366 F. Supp. 3d 125, 145 (D.D.C. 2019) ("[T]he Court finds that health is not a freestanding objective of the [Medicaid] statute, . . . [and] if that is so, the Secretary's consideration of it cannot support his [Section 1115] analysis."); Stewart v. Azar, 313 F. Supp. 3d 237, 266–68 (D.D.C. 2018)

197. *See, e.g.*, *Stewart*, 366 F. Supp. 3d at 145; *Stewart* 313 F. Supp. 3d at 266–68.

198. *Stewart*, 366 F. Supp. 3d at 145.

199. *See id.* at 140 (noting that, in theory, a demonstration project may be lawful even if it results in *some* coverage loss, but Kentucky HEALTH would result in "significant coverage loss").

200. *Infra* Sections III.B.1–2.

201. *See* Suela Sulo et al., *Budget Impact of a Comprehensive Nutrition-Focused Quality Improvement Program for Malnourished Hospitalized Patients*, 10 AM. HEALTH & DRUG BENEFITS 262, 262 (2017).

ments.[202] The patients could also have the benefit of support staff both at the hospital and after discharge to teach them about their nutritional supplements.[203]

As described, this demonstration project's objective is solely focused on addressing patients' health outcomes.[204] But the project could also furnish "medical assistance" under the pre-ACA definition; that is, it could help finance the cost of recipients' care.[205] In fact, this illustration is based on a nutrition program that produced millions of dollars in savings.[206] States that run such nutrition programs could funnel their savings back into their Medicaid programs to help finance recipients' care—subject to applicable CMS rules.[207] Courts applying the pre-ACA definition of "medical assistance" should allow the Secretary to approve programs that can improve recipients' health outcomes while helping finance recipients' care.

2. The Post-ACA Definition of "Medical Assistance"

A state may propose a demonstration project to create a legal services organization to help Medicaid beneficiaries secure their benefits. The Pennsylvania Health Law Project ("PHLP") is illustrative.[208] PHLP is a non-profit, non-government-affiliated organization that provides low-income Pennsylvanians with health care-related advice and advocacy.[209] PHLP challenges Pennsylvanians' denial and termination from public health insurance programs like Medicaid.[210] It also litigates to help Pennsylvanians receive the care that Medicaid makes available to them.[211]

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202. *Id.* at 263 ("[T]he quality improvement program include[s] malnutrition risk screening at admission, prompt initiation of oral nutritional supplementation for at-risk patients, and nutrition support and education for patients during the hospital stay and postdischarge.").

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.* (noting that "reduced 30-day readmissions and hospital stay[s] associated with nutrition intervention" produced these savings).

207. *See generally* Letter from Timothy B. Hill, *supra* note 99 (outlining CMS's budget neutrality policies for demonstration projects enacted under Section 1115). A state interested in running the proposed nutrition project would likely request waiver under Section 1115(a)(2), but that analysis is beyond the scope of this Comment. *See* 42 U.S.C. § 1315(a)(2) (2018).

208. PA. HEALTH L. PROJECT, http://bit.ly/2Igi6gr [https://perma.cc/R4GA-59TL] (last visited Nov. 20, 2019).

209. *See About Us*, PA. HEALTH L. PROJECT, http://bit.ly/2EcgccL [https://perma.cc/EL34-SYJW] (last visited Nov. 20, 2019).

210. See *id.*

211. *See id.*

Because PHLP contests denials of Medicaid eligibility and covered Medical services, the organization is likely to assist in helping recipients receive their care.[212] PHLP also engages in education and outreach, advising potential Medicaid recipients of their rights and encouraging recipients to advocate for themselves, which may help beneficiaries receive covered services.[213] Also, like the nutrition program noted above, a legal services demonstration project can produce Medicaid savings to help cover the cost of recipients' care.[214] Courts applying the post-ACA definition of "medical assistance" should allow the Secretary to approve programs like PHLP. Such programs not only promote improved health outcomes for beneficiaries but are also likely to help beneficiaries receive their care.[215]

IV. CONCLUSION

Section 1115 waivers provide states with a great source of flexibility in shaping their Medicaid programs. But courts may prevent the Secretary from allowing states to address the SDHs in their Medicaid programs. Restricting the Secretary in this way could deprive low-income populations of important health-improving programs and innovations.

This Comment analyzed *Stewart I* and *Stewart II* and complicated the understanding of "medical assistance" in light of that term's amended definition. It then analyzed the potential impact of *Stewart I* and *Stewart II* on future SDH-based waivers. Lastly, it offered a couple modest examples of the types of SDH-based demonstration projects that should survive judicial scrutiny in light of *Stewart I* and *Stewart II* and the pre- and post-ACA definitions of "medical assistance."

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212. *See* Troutman v. Cohen, 661 F. Supp. 802, 812 (E.D. Pa. 1987) (finding that the state's regulations impermissibly denied Medicaid recipients access to skilled nursing services); *Services: Individual Representation*, PA. HEALTH L. PROJECT, http://bit.ly/2Ebc90u [https://perma.cc/4JBK-5CC6] (last visited Nov. 20, 2019).

213. *See Services: Education & Outreach*, PA. HEALTH L. PROJECT, http://bit.ly/2DHxfC7 [https://perma.cc/8K8J-6WZN] (last visited Nov. 20, 2019).

214. *See Fiscal Year 2018 Budget Request*, LEGAL SERVS. CORP., http://bit.ly/2R0QHlM [https://perma.cc/5KEV-JY2J] (last visited Nov. 20, 2019) (listing several states' savings from their civil legal aid programs).

215. *See supra* notes 209–13 and accompanying text.