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

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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-

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.”).
6. See sources cited supra note 5.
gram for low-income populations, Medicaid appears to be the perfect vehicle to address this issue. But a new line of cases may stand in the way.

These cases involve Section 1115 of the Social Security Act. 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. President Trump’s Secretary has used this waiver authority to approve states’ requests to run demonstration projects that include community engagement requirements. Kentucky’s was the first of these requests that the Secretary approved, and Kentucky Medicaid recipients immediately challenged the Secretary’s approval.

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

8. See infra Section II.A.
9. See infra Part III.
11. 42 U.S.C. § 1315(a) (2018); see also infra Section II.B.
12. See infra note 126 and accompanying text.
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 is one of several programs housed within the Social Security Act. The Social Security Act’s programs fit into two broad categories: (1) social insurance programs and (2) welfare assistance programs. Medicaid belongs in the second category; understanding why can shed light on the program itself.

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

By contrast, welfare assistance programs distribute benefits based on need. For this reason, welfare assistance programs belong in the “residual welfare” tradition. Programs in this tradition...
require individuals to exhaust their private resources before receiving public assistance. The Social Security Act’s welfare assistance programs include Supplemental Security Income and Medicaid.

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. In fact, some scholars trace the tradition to medieval Europe’s ecclesiastical poor relief. 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.

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.

30. Colby, supra note 29, at 10; see also Dobelstein, supra note 21, at 20. Dobelstein writes:


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

Welfare assistance also remained an entirely local enterprise. Despite activists’ efforts to secure federal involvement, local welfare administration prevailed throughout the 19th century. 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.

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

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.
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 immensity53 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 196560 have emerged as perhaps the most significant amendments.61 The 1965 amendment

50. DOBELSTEIN, supra note 21, at 2–3.
52. DOBELSTEIN, supra note 21, at 28.
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)).
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.”).
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) and Title XIX (Medicaid). 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.

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. 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. 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.

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

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63. Id. §§ 1396–1396w-5.
64. See Dobelstein, 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.”).
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”).
on January 1, 2014. But the Supreme Court forestalled the ACA’s mandatory Medicaid expansion in the 2012 case *National Federation of Independent Business v. Sebelius*. In that case, the Court held that the ACA’s Medicaid expansion must be optional for each state. Still, the ACA has succeeded in transforming American health care and continues to set the terms of national health care debates.

3. Medicaid’s Operation

The federal Medicaid statute (the “Medicaid Act”) defines Medicaid’s basic framework. The Medicaid Act requires each participating state to annually submit a state plan to the Centers for Medicare and Medicaid Services (“CMS”). A state plan

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73. *Id.*
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. CMS reviews each state plan and approves those that comply with the Medicaid Act. After approving a state plan, CMS disburses funds to the state according to its “federal medical assistance percentage.” The state then carries out its plan subject to CMS’s oversight.

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

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—to waive some of Medicaid’s provisions so
states can enact “demonstration projects.”\textsuperscript{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.\textsuperscript{91} By unhampering states from some of Medicaid's statutory requirements, Section 1115 encourages innovation in Medicaid.\textsuperscript{92}

The Secretary enjoys substantial\textsuperscript{93} waiver authority under Section 1115 but does not have \textit{carte blanche}.\textsuperscript{94} Section 1115 provides that the Secretary may approve a waiver request only to enact an “experimental, pilot, or demonstration project.”\textsuperscript{95} The Secretary must determine that the project “is likely to assist in promoting the objectives of’ Medicaid.\textsuperscript{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.”\textsuperscript{97} And the Secretary must consider the “costs of such project . . . expenditures under the [s]tate plan.”\textsuperscript{98} Lastly, CMS has issued guidance requir-
ing the Secretary to ensure that a proposed project is budget neutral to the federal government.99

Judicial review under the Administrative Procedure Act100 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/2Rj8IPG [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.”).


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))).


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)).


106. Id. § 431.408(a)(3).

107. Id. § 431.412(b).

108. Id. § 431.416(b).
comments it receives. Only then may CMS issue its final decision. After approving a waiver request, CMS monitors the implemented demonstration project for compliance with the terms and conditions of the approval.

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

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

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

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109. Id. § 431.416(d).
110. Id. § 431.416(e).
111. Id. § 431.420.
114. See supra notes 2–6 and accompanying text.
117. See id.
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. 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.

Before President Trump’s election, CMS was unwilling to approve Section 1115 waivers that would impose community engagement requirements on Medicaid recipients. 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. In his letter, Neale identified work and community engagement as “health determinants” that “may improve health outcomes.” He wrote that, like education, work and community engagement can contribute to people’s health and well-being.

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. 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 . . . .”).
124. Id. at 2.
125. Id.
challenge to the Secretary’s approval of these waiver requests.\footnote{127} And in each case, the court vacated the Secretary’s approval.\footnote{128}

C. Stewart v. Azar and the Definitions of “Medical Assistance”

I. Background

In January 2014, Kentucky’s then-Governor Steve Beshear expanded Kentucky’s Medicaid eligibility in line with the ACA’s directive.\footnote{129} The next year, Kentucky elected a new Governor, Matt Bevin, who promised to roll back the Medicaid expansion.\footnote{130} Governor Bevin’s weapon of choice was a comprehensive Section 1115 waiver request to include community engagement requirements in Kentucky’s Medicaid program.\footnote{131} Governor Bevin requested the waiver on August 24, 2016.\footnote{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.\footnote{133} A few


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. \textit{See Philbrick}, 2019 WL 3414376, at *2–3; Gresham, 363 F. Supp. 3d at 169 (discussing similarities with Stewart).


131. \textit{Id.}


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

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 requirements137 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-
tions and the case law to locate Medicaid’s objectives in the Medicaid Act’s appropriations provision. 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.’” The court focused its analysis almost exclusively on the first objective: furnishing medical assistance.

To define “medical assistance,” the court imported a definition from an opinion the D.C. Circuit Court of Appeals issued in 2008. 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.’” In other words, to provide Medicaid recipients with “medical assistance” is to finance their health care. 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. Because the Secretary had overlooked Medicaid’s central objective—health insurance coverage—the court concluded that the Secretary’s approval was arbitrary and capricious. Accordingly, the court vacated and remanded the Secretary’s approval.

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

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”).
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.\textsuperscript{151} After all, Kentucky HEALTH requires community engagement, and, according to the Secretary, community engagement improves people’s health and well-being.\textsuperscript{152} The court avoided this empirical question and instead attacked the Secretary’s fundamental premise—that Congress intended Medicaid to improve recipients’ health.\textsuperscript{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.\textsuperscript{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.\textsuperscript{155}

According to the court, Congress intended Medicaid to prevent situations like Dan’s; whether Medicaid would also make recipients healthier was an afterthought.\textsuperscript{156} Indeed, had Congress wanted Medicaid to directly improve recipients’ health, it could have required recipients to exercise or eat nutritious food.\textsuperscript{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.\textsuperscript{158}

\textsuperscript{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.”).

\textsuperscript{152} See Stewart, 313 F. Supp. 3d at 266.

\textsuperscript{153} See id. at 266–68.

\textsuperscript{154} Id. at 266 (“[The Secretary’s] focus on health is no substitute for considering Medicaid’s central concern: covering health costs.”).

\textsuperscript{155} Id. at 267.

\textsuperscript{156} Id. at 266–67.

\textsuperscript{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))).

\textsuperscript{158} Id. at 266–67.
4. Subsequent Developments

On November 20, 2018, the Secretary re-approved Kentucky’s remanded waiver request.\footnote{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/2S8mRpp [https://perma.cc/6BTU-Z9R2] (reapproving Kentucky’s waiver request and attaching Special Terms and Conditions).} Kentucky Medicaid recipients sued two months later, bringing the parties back to the U.S. District Court for the District of Columbia (“\textit{Stewart II}”).\footnote{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).} 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.\footnote{161. Stewart v. Azar, 366 F. Supp. 3d 125, 143–44 (D.D.C. 2019).} The court did not budge on this point.\footnote{162. \textit{Stewart}, 366 F. Supp. 3d at 143–45.} The Secretary’s non-health-related arguments fared no better with the court.\footnote{163. \textit{See id.} at 145–55 (rejecting the Secretary’s financial independence and fiscal sustainability arguments).} It once again vacated and remanded the Secretary’s approval of Kentucky HEALTH.\footnote{164. \textit{Id.} at 156.} But rather than review Kentucky’s waiver request once more, the Secretary filed a Notice of Appeal.\footnote{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, \textit{supra} note 127. As this Comment goes to print, the court’s opinion is still forthcoming.}

5. The Definitions of “Medical Assistance”

As noted above, the \textit{Stewart I} court defined “medical assistance” in purely financial terms.\footnote{166. \textit{Supra} notes 145–47 and accompanying text.} It drew its definition from \textit{Adena Reg’l Med. Ctr. v. Leavitt},\footnote{167. \textit{Adena Reg’l Med. Ctr. v. Leavitt}, 527 F.3d 125 (D.C. Cir. 2008).} a case the D.C. Circuit Court of Appeals decided in 2008.\footnote{168. \textit{Supra} notes 145–46 and accompanying text.} The \textit{Adena} court, in turn, drew its definition of “medical assistance” from 42 U.S.C § 1396d(a),\footnote{169. 42 U.S.C. § 1396d(a) (2006 & Supp. I 2008).} which in 2008 defined “medical assistance” as “payment of part or all of the cost of . . . care and services.”\footnote{170. In 2009, the House Committee on Energy and Commerce recognized a circuit split over the meaning of “medical assistance”}
within the Medicaid Act. Some circuits interpreted “medical assistance” to mean that states only had to finance recipients’ medical care. But the First Circuit Court of Appeals read “medical assistance” to imply that states must provide recipients’ care. Other circuits merely identified the definitional disagreement.

Congress officially amended the Medicaid Act’s definition of “medical assistance” when it passed the ACA, which President Obama signed into law in 2010. The amended definition embodied the House Committee on Energy and Commerce’s declaration that “medical assistance” means both financing and providing recipients’ health care. 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.

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).


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.\footnote{178} Other courts, however, continued to apply the pre-ACA definition of medical assistance\footnote{179}—including the Stewart I court.\footnote{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.\footnote{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.\footnote{182} The Secretary consistently pitched community engagement as an SDH, and the court addressed it as such.\footnote{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.\footnote{184}


\footnote{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.

\footnote{181. Infra Part III.


\footnote{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.

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. Indeed, in each case the court emphasized that improving health outcomes is not a Medicaid objective. 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.

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. 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. 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. Hospital workers could screen at-risk Medicaid recipients for nutritional deficiencies and then, when necessary, intervene with nutritional supple-

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197. See, e.g., Stewart, 366 F. Supp. 3d at 145; Stewart 313 F. Supp. 3d at 266–68.
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”).
The patients could also have the benefit of support staff both at the hospital and after discharge to teach them about their nutritional supplements.\textsuperscript{203} As described, this demonstration project’s objective is solely focused on addressing patients’ health outcomes.\textsuperscript{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.\textsuperscript{205} In fact, this illustration is based on a nutrition program that produced millions of dollars in savings.\textsuperscript{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.\textsuperscript{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.\textsuperscript{208} PHLP is a non-profit, non-government-affiliated organization that provides low-income Pennsylvanians with health care-related advice and advocacy.\textsuperscript{209} PHLP challenges Pennsylvanians’ denial and termination from public health insurance programs like Medicaid.\textsuperscript{210} It also litigates to help Pennsylvanians receive the care that Medicaid makes available to them.\textsuperscript{211}

\textsuperscript{202} Id. at 263 (“[T]he quality improvement program includes 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.”).
\textsuperscript{203} Id.
\textsuperscript{204} Id.
\textsuperscript{205} Id.
\textsuperscript{206} Id. (noting that “reduced 30-day readmissions and hospital stay[s] associated with nutrition intervention” produced these savings).
\textsuperscript{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).
\textsuperscript{210} See id.
\textsuperscript{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. 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. Also, like the nutrition program noted above, a legal services demonstration project can produce Medicaid savings to help cover the cost of recipients’ care. 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.

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.”

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