Medicaid Waivers: Courts Must Step in When the Exception Becomes the Rule

Leonardo Cuello

More than fifty years of established Medicaid policy — based in law — is now at risk of subversion due to a basic misunderstanding of the purpose of one statutory provision, section 1115 of the Social Security Act. Although the narrow statutory purpose and limits of section 1115 are clear, states and some federal policymakers mistakenly construe it as a provision enabling broad "state flexibility" to alter the Medicaid program. While this has been a concern for decades, recent uses of section 1115 are completely untethered from the statute and striking at the core precepts of Medicaid. At stake is the Medicaid health care coverage of 70 million individuals, who may one day be terminated from coverage or effectively see their access to care eviscerated based on this legal error.

Section 1115 and the Medicaid Act

State flexibility is explicitly and inherently part of the Medicaid program. States may cover optional populations, they may add services, they may choose to structure their Medicaid programs using any one of a number of managed care systems, they may provide home and community based services as alternatives to institutional care, and they have control over innumerable administrative details, including setting payment rates.[1]

While the structure of Medicaid is premised on state flexibility, however, Section 1115 of the Social Security Act is *not* a Medicaid flexibility provision. Section 1115 is a pilot program authority. According to the text of the statute itself, it only authorizes the Secretary of Health and Human Services (HHS) to waive some federal Medicaid requirements to conduct an "experimental, pilot, or demonstration project."[2] Congress specified these should be "experimental projects designed to test out new ideas" and only "selectively approved."[3] Subsequently, Congress has noted that approval of waivers is "contingent upon development of a detailed research methodology and comprehensive evaluation for the demonstration."[4] Courts have given meaning to this statutory language, finding that the agency must "make some judgment that the project has a research or a demonstration value."[5]

Despite the unambiguous statutory language and Congressional intent, states — often with the com-

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plicity of HHS — have come to view the authority as "just another way of doing business." And HHS has approved waivers which have no plausible experimental value and thus no permissible basis in law. These approvals are often discussed through the lens state flexibility, when the statutory design for section 1115 has nothing to do with state flexibility. In fact, construing Section 1115 as a state flexibility authority renders the entire statutory structure nonsensical. The statute is designed to give states requirements and *options* for designing their Medicaid state plan. States have flexibility precisely because the act of taking such an option is entirely discretionary for a state. It would make no sense whatsoever for Congress to write a statute setting out such requirements and discretionary options, and then add an additional authority to waive the requirements with no limiting principle other than redundant state flexibility. Section 1115 can only be understood, as the words of the statute require, as an experimental authority with a clear limiting principle in its application.

More importantly, the statute also requires that all waiver projects be "likely to assist in promoting the objectives" of Medicaid.[6] The Medicaid Act itself defines the purpose of Medicaid as "enabling each State ... to furnish (1) medical assistance ... and (2) rehabilitation and other services" on behalf of enrollees.[7] Therefore, the statute requires there to be a valid experimental purpose *and* that experiment must help furnish access to health services. These are unambiguous limiting principles that make it entirely implausible that this authority has anything to do with state flexibility. It is an authority designed to test innovations that further the interests of the Medicaid program. The statutory language, intent, and design demand that it be interpreted in that way.

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Authority, Abused

HHS's (and states') application of Section 1115 ignores the clear limits of the authority. Over the past 40 years, HHS has approved an ever growing number of waivers that have become more of a default way of doing business than proper use of an authority to experiment.[8] For example, although Congress envisioned that experiments would be small scale — Congress said they "usually cannot be statewide in operation" — the majority of approved projects are large and statewide.[9] Although the statutory text requires waiver projects be only "for the period...necessary to enable such State or States to carry out such project," some waivers have been approved for 35 years and counting.[10] More recently HHS has approved several waivers (to be discussed later) that have no experimental value whatsoever — not even if they *were* small-scale temporary waivers.

In addition to directly conflicting with the letter of the law, these HHS approvals ignore the logical function this authority should play. Section 1115 experiments should lead to innovations that *Congress* recognizes and which would then lead Congress to amend the statute to include the lessons in Medicaid permanently.[11] In fact, that has happened. Congress has amended the statute numerous times to make permanent state options based on 1115 lessons — in areas such as managed care and coverage expansions for adults.[12] However, despite the fact that Congress has periodically and recently amended the statute, HHS continues approving and re-approving and re-re-approving waivers. Though HHS and states may not feel like Congress has done enough to update the statute, Congress has repeatedly updated the statute to the specifications that *Congress* wants. HHS and states have no authority to "update" the statute on behalf of Congress and run the program outside of the statutory framework. HHS only retains the limited authority to conduct legitimate experiments that can inform future Congressional updates.

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Unfortunately, the most recent trend in waivers has gravely worsened matters. Not only have recent waivers approved by HHS strayed from the requirement to test an experiment, they have failed to comply with the statutory requirement that Section 1115 waivers promote the objectives of Medicaid — in many cases the waivers directly violate the purposes of Medicaid. Although the purpose of Medicaid is to furnish health services, some recently approved waivers only eliminate health services. Nowhere was this more apparent than in the first major waiver package approved by the Trump administration for Kentucky in January 2018. The approval — vacated by a judge in June 2018[13] — included locking individuals out of coverage for three different reasons; adding premiums, waiting periods, and terminations for not proving work; and taking away retroactive coverage and transportation assistance.[14]

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Not a single one of these waivers helps furnish any health service. In fact, all of them directly *reduce* the furnishing of health services — by directly reducing services, reducing the duration of coverage, terminating individuals who are eligible under the law, or preventing them from re-enrolling. By Kentucky's own estimate, the equivalent of 100,000 enrollees would have lost coverage under these waivers.[15] These waivers were a not-even-thinly veiled attempt to simply cut Medicaid — not promote the program's objective of furnishing health services.

As HHS flouts the clearly stated statutory requirements for an experimental project that promotes the objectives of Medicaid, it raises a deeply troubling legal question: If the statute does not constrain the authority of the Secretary to grant waivers, what limit is there on the use of this authority? Consider for a moment that some of the waivers (e.g., work requirements), do not even involve the waiver of an applicable Medicaid provision — they are effectively the quasi-legislative *creation* of a new eligibility requirement. It is a basic pillar of Constitutional law that an agency — the Executive Branch — cannot usurp Congress's exclusive authority to legislate.[16] In fact, even if it *wanted* to, Congress could not delegate such legislative power to an agency, and can only allocate regulatory power with an "intelligible principle" limiting the authority.[17] By disregarding the statutory criteria guiding or limiting its discretion, HHS is operating outside of its Constitutional power.

HHS's Position

HHS has defended the waivers in Kentucky — and suggested the Secretary's approvals are a proper exercise of authority — using several lines of argument. First, HHS argues that the Secretary is not limited to the purposes of the Medicaid statute described in the Medicaid Act. The Secretary makes this argument by piggy-backing on the logic of the 2012 *NFIB* case, which found that the Medicaid expansion category was distinct from traditional Medicaid such that HHS could not withhold funding for noncompliance with the new category in the same way that HHS does for traditional categories.[18] Thus, HHS argues, so too the traditional purpose of Medicaid does not apply to the Medicaid expansion population, and consequently HHS has more discretion in using the authority towards a broader range of purposes. However, there is no statutory support for the argument that the Medicaid expansion is somehow different from other categories; the expansion group is described in the same part of the statute as other groups, including both original 1965 Medicaid categories and ones added subsequently.[19]

A second line of legal argument HHS makes is to seize upon words in the statutory description of Medicaid's purpose that includes helping individuals "retain capability for independence," and using that as a basis to justify reducing the scope of public assistance and, among other things, promoting work.

However, in making this argument HHS is taking words out of the written and programmatic context. The full phrase in the statute is "furnish ... rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."[20] Independence only modifies the rehabilitation and other services, and is not an end in itself. More importantly, the meaning of the entire phrase — and the misinterpretation by HHS — is remarkably clear in the context of the exactly two things the Medicaid program does. The statutory purpose of Medicaid includes two clauses, the first referring to medical services ("medical assistance") and the sec-

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ond referring to long-term care ("rehabilitation and other services"). Independence, therefore, modifies the *long-term care* function, and refers to increasing the function of individuals with functional limitations that make them eligible for long-term care. Ironically, the cite HHS justifies to impose work requirements on "able-bodied" adults in fact describes providing supports to individuals with disabling conditions.

Court Review of Agency Action

As mentioned earlier, HHS's waiver activity raises serious Separation of Powers problems. In addition to crossing stark Constitutional lines, however, HHS is also operating outside of its authority under federal law. The Administrative Procedures Act (APA) sets outer limits on federal agency actions and HHS's use of waiver authority goes well beyond those limits.[21] Many legal commentators misunderstand this area of the law because it is often reduced to the pithy precept that "agency interpretations are given deference." Under the law, however, deference is not automatic and there are important limits even when deference is granted. This issue is critical because APA claims are likely to be at the center of litigation around Kentucky's (on-going) and other states' waiver programs. Looking at the body of law carefully, it is not surprising that one court has already found that Kentucky's 1115 approvals were impermissible under the APA.

Summaries of the law sometimes vary, but there are generally three steps an agency being reviewed by a court must surpass to have its action given deference and upheld as consistent with the APA.[22] First, the decision must be one for which deference is relevant — in other words, deference is wholly inapplicable to certain types of decisions.[23] One such type of decision is one which is an "enormous and transformative" interpretation of authority or of deep "political significance."[24] Kentucky and the Trump administration have both stated that their purpose in adding work requirements is to *transform* Medicaid.[25] In 2017, Congress tried and failed, on entirely partisan lines, to legislate work requirements — making approving them through an administrative process enormously significant *politically*.[26] Given the scope of the decision, a court should not find that broad deference is applicable, especially where, as here, Congress has consistently *chosen* not to do so itself.[27]

Second, even assuming it is a decision to which deference *could* apply, the court will then review whether deference should be accorded. A court will not grant deference if Congress's statute is unambiguous.[28] If a court focuses on the text of the Social Security Act, it cannot conclude that work requirements are within the scope of Medicaid. If the court focuses on the intent or context of the statute, it will see that Congress explicitly added work promotion to the cash assistance program statute at the same time it definitively separated Medicaid and cash assistance eligibility processes from each other.[29] Under either theory of statutory construction, a court should find that work requirements are unambiguously impermissible under Congress's statute — and thus there should be no broad deference.

Third, even if the court finds that deference *should* be accorded, it will still review whether, with that due deference, the agency's decision is valid. There are numerous standards for evaluating an agency's actions with deference, and a court should not find HHS's waiver approvals lawful under those standards.[30] Given the limits in the Social Security and Medicaid Acts, HHS's expansive waivers are "not in accordance with law."[31] HHS's approvals "rel[y] on factors which Congress has not intended it to consider," such as preparing enrollees for commercial insurance, and ignore "relevant factors" Congress clearly intended HHS to consider, such as losing and even being barred from coverage.[32] In the Kentucky case, HHS's decision was specifically found "arbitrary and capricious"[33] given the administrative record before the agency containing evidence overwhelmingly supporting *denial* of the waivers.[34]

Ultimately, HHS's approval of Kentucky's waivers fails on *each* step of this legal sequence, and thus should not survive *all three* steps of analysis and be found a proper exercise of authority under the APA in future cases and appeals. Under the law, the courts must uphold Congress's primacy over legislative action.

Note

The author has no conflicts to declare.

References

1. Social Security Act §§ 1902(a)(10)(A)(ii), 1905(a), 1932, 1915(i), 1902(a)(5), and 1930(a)(10)(A).
2. Social Security Act §§ 1115(a).
3. S. Rep. No. 87-1589, at 19-20, as reprinted in 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (1962).
4. Omnibus Reconciliation Act of 1981, Report of the Committee on the Budget House of Representatives to Accompany H.R. 3982, Rept. 97-158, 97th Cong. (1981).
5. *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).
6. Social Security Act § 1115(a).
7. Social Security Act § 1901.
8. S. Artiga, "The Role of Section 1115 Waivers in Medicaid and CHIP: Looking Back and Looking Forward," Kaiser Family Foundation (2009).
9. S. Rep. No. 87-1589, *supra* note 3.
10. Arizona's entire Medicaid program has been run through Section 1115 authority since 1982.
11. S. Rosenbaum et al., "How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy," Commonwealth Fund (2006).
12. *See* Social Security Act §§ 1932 and 1902(a)(10)(A)(i)(VIII).

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13. *Stewart v. Azar*, 1:18-CV-00152 JEB (D.D.C. June 29, 2018).
14. Centers for Medicare and Medicaid Services, Kentucky HEALTH Approval Letter and Special Terms and Conditions (Jan. 12, 2018).
15. *See* Kentucky HEALTH §1115 Demonstration Modification Request application, 11 (July 3, 2017).
16. U.S. Constitution, Article I, Section 1.
17. *Whitman v. American Trucking Associations, Inc.*, 531 U.S. 457 (2001).
18. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).
19. See Social Security Act § 1902(a)(10)(A)(i).
20. Social Security Act § 1901.
21. 5 U.S.C. § 706.
22. Traditional *Chevron* deference is a two-step process. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Court decisions have added a third step, sometimes referred to as "Step Zero," prior to the two *Chevron* steps. *See* C. Sunstein, "Chevron Step Zero," *Virginia Law Review* 92, no. 2 (2006): 187-249.
23. *Id.*
24. *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427 (2014).
25. S. Verma, "Lawmakers Have a Rare Chance to Transform Medicaid. They Should Take It." *Washington Post*, June 27, 2017; Kentucky HEALTH §1115 Demonstration Modification Request application 3 (July 3, 2017).
26. *See e.g.*, American Health Care Act, H.R. 1628, 115th Cong. (2017).
27. *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 122 (2000). Courts might still confer a lower level of deference, sometimes known as *Mead* deference. *United States v. Mead Corp.*, 533 U.S. 218 (2001).
28. *Chevron v. Natural Resources Defense Council*, 467 U.S. 837 (1984).
29. W. Chavkin and P. H. Wise, "The Data Are In: Health Matters in Welfare Policy," *American Journal of Public Health* 92, no. 9 (2002): 1392-1395.
30. 5 U.S.C. § 706.
31. *Id.*
32. *See Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 923 (D.C. Cir. 2017); *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983).
33. *Id.*
34. *Stewart v. Azar*, 1:18-CV-00152 JEB, 37 (D.D.C. June 29, 2018).

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