DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

The General Counsel
Washington, D.C. 20201

ADVISORY OPINION 24-01 ON MEDICAID SECTION 1115 DEMONSTRATIONS IMPOSING WORK REQUIREMENTS

December 11, 2024

This Advisory Opinion explains that the Secretary lacks authority to approve Medicaid demonstration projects that impose requirements to work, look for work, study, volunteer, or undertake related activities for a minimum number of hours per month as a condition of Medicaid eligibility or continued enrollment. (These sorts of conditions are sometimes called "community engagement" or work requirements.) Section 1115(a) of the Social Security Act ("the Act") authorizes the Secretary of Health and Human Services ("the Secretary") to approve experimental, pilot, or demonstration projects in Medicaid that are, in the Secretary's judgment, "likely to assist in promoting the objectives of … [title] XIX" of the Act. 42 U.S.C. § 1315(a). The structure and purpose of Title XIX make clear, and federal courts have confirmed, that the core objective of that Title is furnishing medical assistance, rehabilitation, and other services to eligible people (*i.e.*, furnishing Medicaid coverage). It would exceed the Secretary's statutory authority to approve Section 1115 demonstrations that impose work requirements as a condition of Medicaid eligibility or continued enrollment, because they conflict with that core objective.

I. BACKGROUND

A. *Statutory Background*

Section 1115(a) of the Act provides:

> [i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of … [title] XIX, … in a State or States … (1) the Secretary may waive compliance with any of the requirements of section … [1902], … to the extent and for the period he finds necessary to enable such State or States to carry out such project, and (2)(A) costs of such project which would not otherwise be included as expenditures under section . . . [1903], … shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such [title], or for administration of such State plan or plans, as may be appropriate.

42 U.S.C. § 1315(a). Under this authority, the Secretary may waive otherwise applicable requirements imposed by Section 1902 of the Act for groups of people covered under the Medicaid state plan (*i.e.*, the regular Medicaid program governed by title XIX of the Act). See *id.* § 1315(a)(1). The Secretary may also provide federal matching funds for state expenditures that would not otherwise be federally matched under section 1903 of the Act, including state expenditures on services and populations that are not otherwise part of the Medicaid program described in title XIX. See *id.* § 1315(a)(2)(A).

Whether the Secretary may approve a Medicaid action under Section 1115(a) depends on whether that action "is likely to assist in promoting the objectives" of Title XIX. 42 U.S.C. § 1315(a). Several federal courts have turned to Sections 1901 and 1905(a) of the Act to discern the objectives of title XIX.[1] Section 1901 authorizes a federal appropriation of funds "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care[.]" 42 U.S.C. § 1396-1. Section 1905(a) defines "medical assistance" as "payment of part or all of the cost of [listed] care and services or the care and services themselves, or both" for eligible individuals. 42 U.S.C. § 1396d(a). In 2010, Congress expanded the purpose of the Medicaid program to include furnishing medical assistance to a group of low-income individuals between the ages of 19 and 64 who would not otherwise qualify for the program (the "new adult group").[2]

Title XIX refers only once to work requirements. Section 1931(b)(3)(A) of the Act grants states the "[o]ption" to terminate Medicaid benefits when a beneficiary who receives both Medicaid and Temporary Assistance for Needy Families (TANF) fails to comply with *TANF's* work requirements. 42 U.S.C. § 1396u-1(b)(3)(A). As the D.C. Circuit has found, this provision enables states to coordinate benefits for recipients receiving both TANF and Medicaid, but it does not incorporate TANF work requirements and additional objectives into Medicaid.[3] Notably, in 2017, Congress rejected proposed legislation that would have given states authority

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[1] See *Stewart v. Azar*, 313 F. Supp. 3d 237, 260 (D.D.C. 2018) ("courts have traditionally looked to 42 U.S.C. § 1396-1, which provides standing appropriation authority for federal support of 'State plans for medical assistance,' to discern those objectives."); *Stewart v. Azar*, 366 F. Supp. 3d 125, 139 (D.D.C. 2019) ("The Court concludes, therefore, as it did previously, that § 1396-1 provides a central objective of the Medicaid Act: to furnish medical assistance to the populations covered by the Act."); *Gresham v. Azar*, 363 F. Supp. 3d 165, 176 (D.D.C. 2019), *aff'd*, 950 F.3d 93, 101 (D.C. Cir. 2020) ("the text specifically addresses only coverage. 42 U.S.C. § 1396-1."), *vacated and remanded as moot sub nom.*, *Becerra v. Gresham*, 142 S. Ct. 1665 (2022); *Rose v. Becerra*, 2024 WL 3202342, at *16 (D.D.C. June 27, 2024) (directing readers to discussions of Medicaid objectives in *Stewart*, 313 F. Supp. 3d at 260-62, *Stewart*, 366 F. Supp. 3d at 138, *Gresham*, 363 F. Supp. 3d at 176, and *Gresham*, 950 F.3d at 99); *Georgia v. Brooks-LaSure*, 2022 WL 3581859, at *16 (S.D. Ga. Aug. 19, 2022) ("'[c]ourts often look to the appropriations section as a source [of] statutory purposes'"); see also, *e.g., Harris v. McRae*, 448 U.S. 297, 301 (1980) ("[the] Medicaid program was created . . . for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons"); *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) ("The primary purpose of Medicaid is to enable states to provide medical services to those whose 'income and resources are insufficient to meet the costs of necessary medical services[.]'") (quoting section 1901 of the Act); *W. Va. Univ. Hosps. Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989) ("[T]he primary purpose of [M]edicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it.").

[2] Section 1902(a)(10)(A)(i)(VIII) of the Act (42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)); 42 C.F.R. § 435.119. See also *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012) ("*NFIB*").

[3] *Gresham*, 950 F.3d at 102.

to impose work requirements as a condition of Medicaid eligibility.[4]

B. *Procedural Background*

The Secretary's determination whether to approve a Section 1115 demonstration must not be arbitrary or capricious. Agency action is arbitrary and capricious if, for example, the agency "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." *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 43 (1983). An agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Id*. at 43 (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)) (cleaned up). In the context of Section 1115 demonstration approvals this means that the Secretary must consider any relevant evidence, including evidence regarding the impact of similar demonstration projects in other states. He may not ignore evidence indicating that the demonstration is likely to conflict with Title XIX's objectives. He must adequately explain his decision in the approval documents (including by addressing contrary evidence).

Federal regulations help to ensure that the Secretary's Section 1115 demonstration approvals avoid these legal pitfalls. Section 1115(d) directs the Secretary to promulgate regulations related to applications for and renewals of Section 1115(a) demonstration projects, and to follow those regulations when considering an application for or renewal of such a project. These regulations, at 42 C.F.R. Part 431, Subpart G, require public notice and comment at the state level before an application is submitted to the Secretary; they also require a federal public notice and comment process after the application is received by the Secretary.[5] The regulations require the state's application to include information related to the goals of the program to be implemented or renewed under the demonstration project, the expected state and federal costs and coverage projections of the demonstration project, and the specific plans of the state to ensure that the project will be in compliance with Title XIX.[6] They also require the state to submit periodic reports to the Secretary concerning implementation of the demonstration project, and they require the state and the Secretary to engage in periodic evaluation of the demonstration project.[7] Taken together, these regulations help ensure that the Secretary makes a non-arbitrary decision on the record of the application and public comments before him, and that he identifies and considers the demonstration's experimental purpose.[8]

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[4] H.R. 1628, 115th Cong., § 117 (2017), at https://www.congress.gov/115/bills/hr1628/BILLS-115hr1628pcs.pdf.

[5] Section 1115(d)(2)(A) and (C) of the Act; 42 C.F.R. §§ 431.408 and 431.416.

[6] Section 1115(d)(2)(B) of the Act; see also 42 C.F.R. §§ 431.400, 431.412, and 431.420(a).

[7] Section 1115(d)(2)(D) and (E) of the Act; 42 C.F.R. §§ 431.420, 431.424, and 431.428.

[8] See *Beno v. Shalala*, 30 F.3d 1057, 1069-1076 (9th Cir. 1994) (finding arbitrary and capricious the Secretary's approval of a section 1115 demonstration approval cutting benefits when the record contained "a stunning lack of" evidence that the Secretary had considered the relevant statutory factors, identified the experimental goals of the project, or considered commenters' objections).

C. *History of Work Requirements*

In 2018-2020, the Secretary approved several Section 1115 demonstrations permitting states to impose work requirements as a condition of accessing or maintaining Medicaid coverage. Under some of these approvals, states imposed work requirements through waivers under section 1115(a)(1) on individuals whose eligibility is established under the Medicaid state plan. Under others, states imposed the requirements on individuals eligible only under section 1115(a)(2) demonstration expenditure authority.[9] The implementation history of these demonstrations demonstrates that work requirements impede access to Medicaid coverage.

For example, the Centers for Medicare & Medicaid Services in 2018 approved an amendment to a Section 1115 demonstration project for the state of Arkansas. The state called the amended project "Arkansas Works." Through Section 1115(a)(1) waivers of Section 1902(a)(8) and (a)(10) of the Act, the demonstration required non-exempt beneficiaries ages 19 to 49 who were eligible under the state plan to participate for a minimum of 80 hours per month in work or work-related activities, such as employment, education, job skills training, or community service. The demonstration described this requirement as a "community engagement" requirement. The state required beneficiaries to report monthly on their compliance with, or exemption from, the community engagement requirement. Three months of non-compliance in a calendar year could result in the beneficiary being disenrolled and locked out of coverage until the next plan year. The amendment exempted certain beneficiaries from being required to engage in the "community engagement" activities (but not from having to report that they were exempt). These individuals included beneficiaries who were medically frail or temporarily incapacitated, beneficiaries who were pregnant or within the 60-day postpartum period, full-time students, beneficiaries caring for an incapacitated person or living in a home with a dependent child age 17 or younger, beneficiaries exempt from Supplemental Nutrition Assistance Program (SNAP) or Transitional Employment Assistance Cash Assistance work requirements, beneficiaries receiving unemployment benefits, and beneficiaries participating in a treatment program for alcohol or substance use disorders.[10]

Arkansas began implementing its "community engagement" requirement on June 1, 2018, for demonstration beneficiaries ages 30 to 49 and on January 1, 2019, for demonstration beneficiaries ages 19 to 29.[11] The requirement remained in effect until March 27, 2019, when a federal district court vacated the Secretary's approval of the demonstration amendment.[12] Before the court acted, the state reported that from August 2018 through December 2018 a total

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[9] See *infra* notes 46 and 51 and accompanying discussions.
[10] Arkansas Works (Mar. 5, 2018), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf. *See* section X of the demonstration special terms and conditions for more details on Arkansas's work requirement.
[11] Letter from Elizabeth Richter, Acting Admin'r, CMS, to Dawn Stehle, Deputy Dir. for Health & Medicaid, Ark. Dep't of Human Services at 4 (Mar. 17, 2021), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-ca2.pdf ("CMS Letter to Arkansas").
[12] *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019), *aff'd*, 950 F.3d 93 (D.C. Cir. 2020), *vacated and remanded as moot sub nom., Becerra v. Gresham*, 142 S. Ct. 1665 (2022).

of 18,164 individuals had been disenrolled for "noncompliance with the work requirement."[13] Most of these individuals had never submitted any reports to the state.[14] During the same period, the monthly rate of coverage loss as a percentage of those who were required to report work and community engagement activities fluctuated between 20 and 47 percent.[15]

The uninsured rate among low-income Arkansans ages 30 to 49 rose from 10.5 percent in 2016 to 14.5 percent in 2018, after the "community engagement" requirement took effect.[16] The policy led to a drop in Medicaid or Marketplace coverage by 13.2 percentage points as well as an increase in the uninsured rate of 7.1 percentage points among Arkansans ages 30 to 49, relative to other age groups and states.[17]

Arkansans ages 30 to 49 reporting disenrollment from Medicaid or Marketplace coverage at any point in the prior year experienced significantly higher medical debt and financial barriers to care, compared to Arkansans ages 30 to 49 who maintained that coverage. Specifically, 50 percent reported serious problems paying off medical bills; 56 percent delayed seeking health care because of cost; and 64 percent delayed taking medications because of cost.[18]

There was no associated increase in employment or other community engagement activities among low-income individuals subject to the Arkansas requirement either in the first year when the policy was still in effect or nine months after the policy was blocked.[19] Instead, nearly everyone who was targeted by the Arkansas Works "community engagement" requirement either had already met the requirement or was exempt from it, so there was little margin for the program to increase work or community engagement—in one study, 97 percent of survey respondents aged 30 to 49 had already met the requirement or were exempt.[20] Those outcomes are consistent with research indicating more generally that most Medicaid beneficiaries are already working or are likely to be exempt from a potential "community engagement" requirement.[21] It thus appears that barriers to reporting data to the state, rather than a failure to meet the underlying "community engagement" requirement, were the main cause for coverage losses for Arkansas during the period while the requirement was in effect in 2018.[22] Not only do these results demonstrate that the work requirement in Arkansas's demonstration conflicted with the objectives of Medicaid, they also show that the requirement

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[13] CMS Letter to Arkansas at 4.
[14] Benjamin D. Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 Health Affairs 1522, 1522 (Sept. 2020).
[15] CMS Letter to Arkansas at 4.
[16] *Id.*
[17] *Id.* (citing Sommers et al., Health Affairs).
[18] CMS Letter to Arkansas at 5 (citing Sommers et al., Health Affairs).
[19] CMS Letter to Arkansas at 6 (citing Sommers et al., Health Affairs, and Benjamin D. Sommers et al., *Medicaid Work Requirements—Results from the First Year in Arkansas*, 381 N. Eng. J. Med. 1073 (2019)).
[20] *Id.* at 6-7 (citing Sommers et al., N. Eng. J. Med.).
[21] *Id.* at 7 (citing, e.g., Nicole Huberfeld, *Can Work Be Required in the Medicaid Program?*, 378 N. Eng. J. Med. 788 (2018)).
[22] Sommers et al., Health Affairs at 1529.

failed to achieve the state's intended goals.[23]

The experience of New Hampshire and Michigan with work requirements in Section 1115 demonstration projects provides similar evidence of the effect of such projects on coverage. As in Arkansas, both states began projects that imposed work requirements on state-plan-eligible beneficiaries under the waiver authority in Section 1115(a)(1) of the Act. However, unlike in Arkansas, in each of these states the projects were set aside by courts before beneficiaries were disenrolled from Medicaid coverage.[24] In New Hampshire, within the period of just over a month when the "community engagement" requirement was in effect, almost 17,000 beneficiaries—about 40 percent of those subject to the requirement, representing one-third of the demonstration's total enrollment—were set to be suspended for non-compliance and lose Medicaid coverage.[25] In Michigan, before the policy was vacated by a court, 80,000 beneficiaries—representing nearly 33 percent of individuals subject to the requirement—were at risk of suspension, if not loss of coverage, for failing to report compliance with the "community engagement" requirement; the state projected that 100,000 beneficiaries subject to the requirement would have been disenrolled within the first year of implementation.[26] As in Arkansas, the evidence suggests that even individuals who were working or who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at

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[23] Arkansas had hypothesized that "individuals enrolled in Arkansas Works [would] sufficiently value health insurance coverage to comply with the work and community engagement activities which, over time, will lead to increased earnings and transition to other health insurance coverage." Ark. Dep't of Human Servs., *Arkansas Works Work and Community Engagement Requirements: Medicaid Section 1115 Demonstration Project Work Requirement Evaluation Design & Strategy* at 6, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-cmmnty-engagement-draft-eval-dsgn-20180813.pdf.

[24] New Hampshire Granite Advantage Health Care Program (Nov. 30, 2018), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-granite-advantage-health-care-program-cms-ext-appvl-11302018.pdf; Healthy Michigan (Dec. 21, 2018), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-healthy-michigan-cms-ext-appvl-12212018.pdf; *Philbrick v. Azar*, 397 F. Supp. 3d 11 (D.D.C. 2019), *aff'd* 2020 WL 2621222 (D.C. Cir. May 20, 2020), *vacated and remanded as moot sub nom., Becerra v. Gresham*, 142 S. Ct. 1665 (2022); *Young v. Azar*, No. 1:19-CV-03526 (D.D.C. Mar. 4, 2020) (minute order vacating the Dec. 21, 2018 approval of the work and community-engagement requirements in the Healthy Michigan Plan in light of the D.C. Circuit's decision in *Gresham v. Azar*, which has since been vacated; this case was dismissed without prejudice on April 15, 2024).

[25] CMS Letter to Arkansas at 8; Letter from Elizabeth Richter, Acting Admin'r, CMS, to Lori Shibinette, Comm'r, N.H. Dep't of Health and Human Servs. (Mar. 17, 2021) at 4, at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-granite-advantage-health-care-program-ca2.pdf.

[26] CMS Letter to Arkansas at 8; Letter from Elizabeth Richter, Acting Admin'r, CMS, to Kate Massey, Dir., Mich. Med. Servs. Admin. (Apr. 6, 2021) at 4, at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-healthy-michigan-ca2.pdf.

risk of losing coverage because of complicated administrative and paperwork requirements.[27]

Georgia—which is the only state that has a Section 1115 demonstration project with a work requirement that is still in effect—has had a similar experience that illustrates how work requirements conflict with Medicaid's core objective. In October 2020, CMS approved Georgia's application for a project known as "Georgia Pathways to Coverage," under which the agency had permitted the state to implement a work requirement as a condition of initial and continued Medicaid eligibility for individuals ages 19 through 64 who would become eligible for coverage under a Medicaid demonstration pursuant to Section 1115(a)(2) of the Act, but whom the state could instead have covered under its Medicaid state plan.[28] Georgia delayed its implementation of the work requirement element of the demonstration in light of the COVID-19 pandemic and concerns raised by CMS in a February 2021 letter, but planned to begin implementation starting in January 2022. Before the requirement went into effect, CMS revoked its approval of that element of the demonstration.[29] CMS relied on the experience of Arkansas, Michigan, and New Hampshire with similar projects to predict that, if the Georgia demonstration were to go into effect with a work requirement, the likely result would be to create a barrier to enrollment in health coverage with little ascertainable effect on employment levels.[30] In August 2022, however, a federal district court set aside CMS's decision, and the work requirement element of Georgia's demonstration has been in effect since that date.[31]

The implementation of Georgia's work requirement has resulted in coverage for far fewer people than the state had hoped, and for only a small fraction of the individuals who might otherwise have accessed Medicaid coverage if Georgia had opted to provide this coverage without a work requirement or by fully implementing the "new adult group" under the Medicaid state plan. Georgia initially estimated that approximately 31,093 individuals would receive coverage under the demonstration during its first year, and that approximately 64,336 individuals would enroll in coverage under the demonstration or subsidized employer-sponsored coverage over the five-year demonstration approval period.[32] In contrast, independent research showed that at least 269,000 Georgians would have received coverage in the first year if the state had

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[27] CMS Letter to Arkansas at 8 (citing Jennifer Wagner & Jessica Schubel, *States' Experiences Confirm Harmful Effects of Medicaid Work Requirements*, Center on Budget and Policy Priorities (2020)).

[28] Georgia Pathways to Coverage (Oct. 15, 2020), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf. Under this demonstration, the state opted to cover only a subset of the "new adult group" that it otherwise could have covered under the Medicaid state plan.

[29] Letter from Chiquita Brooks-LaSure, Admin'r, CMS, to Caylee Noggle, Comm'r, Ga. Dep't of Comm. Health at 1 (Dec. 23, 2021), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-12-23-2021-ca.pdf ("CMS Letter to Georgia"); see also Letter from Elizabeth Richter, Acting Admin'r, CMS to Frank W. Berry, Comm'r, Ga. Dep't of Comm. Health (Feb. 12, 2021), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathways-to-coverage-cms-ltr-state-demo-02122021.pdf.

[30] CMS Letter to Georgia at 18-19.

[31] *Georgia*, 2022 WL 3581859 at *23.

[32] CMS Letter to Georgia at 12.

implemented the demonstration project without a work requirement.[33] And if Georgia had instead implemented the expansion of Medicaid coverage to the full "new adult group" under its Medicaid state plan, an estimated 445,000 individuals would have gained Medicaid eligibility in Georgia.[34] Although people in that group with household incomes over 100% of the federal poverty limit would be eligible for coverage with premium tax credits through the Health Insurance Marketplace®[35] if the state did not implement Medicaid coverage for the "new adult group," that Marketplace coverage option is generally not available to those with household incomes under 100% of the federal poverty level. As of June 2024, however—the most recent month for which data is publicly available—Georgia had reported to CMS that only a total of 4,231 Georgians were enrolled in the demonstration project, falling far short of even the limited goals for enrollment that it had set for itself in its initial application.[36]

II. ANALYSIS

A. *Title XIX's Core Objective is Enabling States to Furnish Medicaid Coverage*

The constitutional foundation of Title XIX is the Spending Clause.[37] Thus, the federal Medicaid requirements in title XIX and HHS's implementing regulations are enforceable because they are conditions on a state's receipt of federal Medicaid matching funds.[38] Because Section 1901 of the Act specifies the "purpose" for which federal Medicaid matching funds are appropriated, and because Medicaid is constitutionally grounded on the availability of that federal funding, Section 1901 describes the Medicaid program's core objective. Section 1901

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[33] *Id.* (citing, e.g., Laura Harker, *Expand Medicaid Fully: Reject Risky and Expensive State Plan*, Ga. Budget & Policy Inst. (Feb. 17, 2021)).

[34] D. Keith Branham et al., *Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining Non-Expansion States Expand* at 2, U.S. Dep't of Health & Human Servs., Ass't Sec'y for Planning & Res., Office of Health Policy (May 28, 2021), at https://aspe.hhs.gov/sites/default/files/documents/c84adec46ff3a9fc253a9f7505a5b325/aspe-data-point-medicaid-expansion-new-eligible.pdf.

[35] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

[36] CMS, *Georgia Pathways to Coverage Section 1115 Demonstration: Monthly Monitoring Report* (June 2024), available at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81441.

[37] U.S. Const., Art. I, § 8, cl. 1.

[38] See *NFIB*, 567 U.S. at 576 ("We have long recognized that Congress may use [Spending Clause] power to grant federal funds to the States, and may condition such a grant upon the States' taking certain actions that Congress could not require them to take.") (quoting *College Savings Bank v. Florida Prepaid Postsecondary Ed. Expense Bd*., 527 U.S. 666, 686 (1999), cleaned up); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 ("legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions"); *see also Harris v. McRae*, 448 U.S. at 308 ("The cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State."); *W. Va. Univ. Hosps*., 885 F.2d at 19 ("[State] participation in the [Medicaid] program is voluntary, but once a state chooses to participate it is obligated to devise a [M]edicaid plan that complies with the federal statutory and regulatory conditions of funding.").

establishes that the core objective of Medicaid is to enable states, as far as is practicable under the conditions in the state, (1) to furnish medical assistance to people unable to pay for medical services themselves, and (2) to enable states to furnish rehabilitation and other services to such people to help them attain or retain independence.

The structure and content of title XIX confirm that the core objective of Medicaid is furnishing medical assistance, rehabilitation, and other services to eligible people. Section 1902 of the Act outlines the contents of a state's Medicaid plan, which documents and governs how Medicaid will be implemented in a state. See 42 U.S.C. § 1396a. That statutory provision includes requirements relating to eligibility, beneficiary protections, benefits, services, and premiums. See *id.* Section 1903 generally describes expenditures that may be matched with federal title XIX funding, allowable sources of the non-federal share of Medicaid expenditures, and managed care requirements. See 42 U.S.C. § 1396b. Section 1905 defines various terms used throughout the rest of title XIX, including, critically for Section 1901, "medical assistance." 42 U.S.C. § 1396d. Other sections of Title XIX define additional Medicaid benefits and coverage (*e.g*., Sections 1906, 1906A, 1915, 1934, 1945, and 1945A), establish additional parameters on and processes for determining eligibility (*e.g*., Sections 1917, 1920, 1920A, 1920B, 1924, 1925, 1931, and 1943), establish parameters for participation of certain health care providers in Medicaid (*e.g*., Sections 1910, 1911, and 1919), establish a rebate program for certain Medicaid-covered drugs (Section 1927), outline additional requirements for state plan managed care (Section 1932), support the fiscal integrity of the program (*e.g*., Sections 1908A, 1909, 1914, and 1936), and establish federal parameters on states' ability to charge beneficiaries premiums and cost-sharing (Sections 1916 and 1916A).[39] Simply put, the rest of Title XIX details *how* states are to satisfy Medicaid's core objective of furnishing medical assistance, rehabilitation, and other services.[40]

Section 1901 indicates that states furnish Medicaid coverage "as far as practicable under the conditions in such [s]tate." In the past, HHS and some states have argued that this phrase creates an independent "fiscal sustainability" objective of Medicaid; one court has said that "practicability is at least a qualifier of the extent to which states must furnish medical assistance."[41] However, the phrase "as far as practicable" is best read as simply referring to the structure of Title XIX, under which state participation is voluntary but if a state participates, coverage of some eligibility groups and benefits is mandatory, and other such coverage optional. In other words, a state may choose to offer optional coverage if it determines that doing so is practicable for that state. The statute has as objectives allowing states to, "as far as practicable," furnish medical assistance and rehabilitation and other services. The statute certainly does not grant participating states the authority to avoid providing mandatory coverage

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[39] See 42 U.S.C. §§ 1396e, 1396e-1, 1396n, 1396u-4, 1396w-4, 1396w-4a; 42 U.S.C. §§ 1396p, 1396r-1, 1396r-1a, 1396r-1b, 1396r-5, 1396r-6, 1396u-1, 1396w-3; 42 U.S.C. §§ 1396i, 1396j, 1396r; 42 U.S.C. § 1396r-8; 42 U.S.C. § 1396u-2; 42 U.S.C. §§ 1396g-1, 1396h, 1396m, 1396u-6; 42 U.S.C. §§1396o, 1396o-1.

[40] See, *e.g., W. Va. Univ. Hosps*., 885 F.2d at 19 ("Generally, the Medicaid Act consists of numerous sections and subsections that together form a cooperative mosaic through which the federal government reimburses a portion of the payments made by participating states to hospitals and other providers furnishing care to eligible needy persons.").

[41] *Stewart*, 366 F. Supp. 3d at 149.

on the basis that the state or the Secretary determines such coverage is not "practicable" for it. Furthermore, the phrase "as far as practicable" must be read together with Section 1904 of the Act, which directs the Secretary to withhold federal Medicaid funding when a state fails to meet the requirements of Section 1902 (at least with respect to parts of the Medicaid program affected by that failure).[42] This means that, notwithstanding Section 1901's authorization of appropriations, HHS is generally[43] not permitted to pay federal Medicaid matching funds to a state that fails to meet the requirements of Section 1902—including providing the full scope of mandatory coverage and, if the state has chosen to provide optional coverage, providing that optional coverage consistent with the parameters established under title XIX and implementing federal regulations. Even though Section 1115(a)(1) gives the Secretary the authority to waive Section 1902 requirements and continue to pay the state federal Medicaid matching funds, the Secretary is statutorily authorized to do this only in connection with a demonstration project he has determined will be likely to assist in promoting the objectives of Title XIX. And the core objective of Title XIX is furnishing Medicaid coverage.

Independence from receiving health coverage through the Medicaid program is not an objective of the Medicaid program. As used in Section 1901, the word "independence" does not mean "financial independence" or "independence from publicly funded health coverage." To read the word that way wrenches it out of its statutory context: "[f]or the purpose of enabling each State . . . to furnish . . . (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care[.]" As is indicated by the reference to "self-care" and the reference to "rehabilitation," "independence" as used in Section 1901 means *functional*, not *financial* independence.[44] And, the word is used in Section 1901 in connection with providing coverage for rehabilitation and other services, not in connection with taking that coverage away.

Given the length and breadth of Title XIX, the statute arguably has other, secondary objectives. However, furnishing Medicaid coverage is Title XIX's core objective. Accordingly, if a Section 1115 Medicaid demonstration project frustrates this core objective, the Secretary lacks authority to approve it. The federal courts that have examined this question are in accord with this conclusion.[45]

B. *Medicaid Objectives and Section 1115 Demonstrations Imposing Work Requirements*

As outlined in more detail below, the Secretary's authority to waive provisions of Section 1902 under Section 1115(a)(1), or to make non-applicable other provisions of the Act pursuant to Section 1115(a)(2)(A), is not unlimited. The Secretary may take these actions only in connection with a demonstration project that he has determined is likely to assist in promoting

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[42] 42 U.S.C. § 1396c.
[43] See *NFIB*, 567 U.S. at 585 (precluding the Secretary from withholding federal Medicaid funding unrelated to the "new adult group" from a state that failed to cover the "new adult group").
[44] The D.C. Circuit reached the same conclusion, although the decision was later vacated as moot. *Gresham*, 950 F.3d at 102.
[45] See, *e.g., Stewart*, 366 F. Supp. 3d at 137-55; *Gresham*, 950 F.3d at 99-102; *Philbrick*, 397 F. Supp. 3d at 23-31; *Rose*, 2024 WL 3202342 at *16-*26.

the objectives of Medicaid. He is not authorized to approve a demonstration project that conflicts with Title XIX's core objective of furnishing Medicaid coverage. Because Medicaid demonstration projects that impose work requirements conflict with that core objective, they exceed the Secretary's statutory authority.

1. *Medicaid Objectives and Section 1115(a)(1) Waivers*

Section 1115(a)(1) authorizes the Secretary to waive the provisions of Section 1902 only with respect to demonstration projects that he determines are "likely to assist in promoting the objectives of" Title XIX. HHS typically approves Section 1115(a)(1) waivers with respect to people or services that a state already covers under its Medicaid state plan. If a state does not already cover an optional eligibility group or benefit under the Medicaid state plan, then it can opt to cover that group or benefit through expenditure authority under Section 1115(a)(2) rather than covering it under the state plan. Section 1115(a)(1) waivers give the state the flexibility to provide coverage for people and services even if the state fails to meet certain requirements in Section 1902 of the Act. For example, a common Section 1115(a)(1) approval, especially prior to enactment of Section 1932 of the Act (which outlines requirements for state plan managed care), was a waiver of section 1902(a)(23). Section 1902(a)(23) guarantees Medicaid beneficiaries a free choice among qualified and willing providers of covered services, and waivers of that provision permit states to operate their Medicaid programs as managed care delivery systems, with limited networks of providers. See 42 U.S.C. § 1396a(a)(23).

As noted above, in a few instances in the past, HHS waived certain requirements of Section 1902(a) to permit states to impose work requirements on access to coverage for individuals whose eligibility had been established under the state plan. Specifically, HHS waived Sections 1902(a)(8) and 1902(a)(10) to permit states to take Medicaid eligibility, coverage, or continued enrollment away from people who were otherwise eligible under the state plan but who did not report compliance with or exemption from a "community engagement" requirement.[46] Because these approvals enabled states to restrict access to medical assistance,

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[46] *See* Arizona Health Care Cost Containment System ("AHCCCS") (Jan. 18, 2019), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-appvd-demo-01182019.pdf; Arkansas Works (Mar. 5, 2018), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf; Healthy Indiana Plan (Feb. 1, 2018), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-cms-amend-appvl-02012018.pdf; KY Health (Jan. 12, 2018), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/health/ky-health-cms-appvl-011218.pdf; KY Health (Nov. 20, 2018), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ky-health-demo-appvl-20181120.pdf; MaineCare (Dec. 21, 2018), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/mainecare/me-mainecare-request-approval-12212018.pdf; Healthy Michigan (Dec. 21, 2018), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-healthy-michigan-cms-ext-appvl-12212018.pdf; New Hampshire

rather than enabling them to furnish it, they conflicted with Section 1901's description of Medicaid's core objective and thus exceeded the Secretary's Section 1115 authority.

Unsurprisingly, federal courts reversed many of these approvals. HHS and states were unable to establish to these courts' satisfaction that the waivers were needed to enable the state to furnish medical assistance "as far as is practicable under the conditions in the state."[47] And, as I explained above, even that showing would not be enough to justify the waivers. Courts found these demonstration approvals impermissible for a simple reason—their purpose was inconsistent with the primary objective of the Medicaid program.

In some of these cases, states argued that if they could not obtain approval of Medicaid work requirements, they would be unable to continue coverage for the "new adult group."[48] But states could make the same argument about almost any Medicaid requirement in Title XIX, or about their participation in Medicaid generally. Crediting this argument would transform Section 1115 into a means for evading every requirement Congress imposed on the Medicaid program. Surely all states would prefer to receive federal Medicaid funds without complying with each and every requirement imposed by Congress. If all they had to do was threaten to leave unless the Secretary waived the requirements to which they objected, Congress's decision to make certain aspects of Medicaid mandatory on participating states would be rendered a nullity. It would be implausible to read Section 1115, which is designed to promote experimentation in achieving the objectives of the Medicaid program, as creating a free-floating license to eviscerate any requirement Congress imposed on participating states to which those states object.

As a Spending Clause program, Medicaid is voluntary. States may opt against participating in Medicaid—and they may opt against participating in certain aspects of the program, whether the ACA's Medicaid expansion or other aspects Congress itself made voluntary. But once they choose to participate in the program in general, or in these voluntary aspects of the program, Congress required that they meet certain requirements. Section 1115 does not authorize the Secretary to permit them to restructure the program if doing so would conflict with the objectives of Title XIX. Section 1115 grants the Secretary authority to approve a demonstration project only if he determines—after observing the procedural requirements described above, including the requirement that he address the evidence developed from other similar projects—that it is likely to assist in promoting Title XIX's objectives.[49]

Granite Advantage Health Care Program (Nov. 30, 2018), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-granite-advantage-health-care-program-cms-ext-appvl-11302018.pdf.

[47] See, *e.g., Rose*, 2024 WL 3202342 at *24-*26 (finding arbitrary and capricious the Secretary's determination that the challenged demonstration would improve the fiscal sustainability of Indiana's Medicaid program); *Philbrick*, 397 F. Supp. 3d at 29-31 (same, re: New Hampshire's demonstration); *Stewart*, 366 F. Supp. 3d at 148-55 (same, re: Kentucky's demonstration).

[48] See *Stewart*, 366 F. Supp. 3d at 153-55; *Philbrick*, 397 F. Supp. 3d at 25-27; *Rose*, 2024 WL 3202342 at *20-*22.

[49] See *Beno v. Shalala*, 30 F.3d at 1069 ("On its face, the statute allows waivers only (1) for experimental, demonstration or pilot projects, which (2) in the judgment of the Secretary are

Recent case law confirms this limitation on the Secretary's authority. An agency may not rely on a statutory power to "waive" certain provisions in a statute that it administers to justify the "addition of … new and substantially different provisions" to the statutory text. *Biden v. Nebraska*, 143 S. Ct. 2355, 2370 (2023). For the reasons noted above, a waiver under Section 1115(a)(1) that would permit states to condition Medicaid eligibility or continued enrollment on complying with a work requirement would establish a program with new conditions that are substantially different from the statute that Congress enacted. Likewise, a demonstration project that would provide expenditure authority under Section 1115(a)(2) for a state to impose similar terms would result in "basic and fundamental changes in the [statutory] scheme" reaching beyond the Secretary's authority under that provision. *Nebraska*, 143 S. Ct. at 2368. Congress has certainly been aware of the possibility of imposing work requirements as a condition of Medicaid eligibility. But it has declined to do so, with the limited exception described above concerning TANF eligibility. The choice to permit a broader range of work requirements under the Medicaid program is therefore likely "one[] that … Congress intended for itself," and advocates of work requirements cannot "point to clear congressional authorization" for such a program. *Nebraska*, 143 S. Ct. at 2375.

2. *Medicaid Objectives and Section 1115(a)(2)(A) Expenditure Authority*

Under Section 1115(a)(2)(A), the Secretary is authorized to match state expenditures that would not otherwise be federally matched under Section 1903 of the Act, as long as he determines that doing so would be likely to assist in promoting the objectives of Title XIX. Historically, the Department has used this authority to federally match state expenditures on services and populations that states cannot otherwise cover as part of the Medicaid program. In other words, these expenditures have expanded coverage beyond what Title XIX authorizes. For example, under Section 1115(a)(2)(A) of the Act, CMS approved state coverage for certain groups of childless adults before the Affordable Care Act made it possible to cover the "new adult group" under Title XIX.[50]

Section 1115(a)(2)(A) "expenditure authority" has become especially relevant to certain states in the wake of the Supreme Court's holding in *NFIB* that the Secretary lacks authority to withhold traditional Medicaid funding from states that fail to cover the "new adult group" described in Section 1902(a)(10)(A)(i)(VIII). After *NFIB*, some states, with HHS approval, opted against covering that group under their state plans, and instead chose to cover the group under Section 1115(a)(2)(A). Some of these states covered the entire "new adult group" under Section 1115(a)(2)(A) authority, while others opted to cover only part of it under that authority. At the same time, these states, with HHS approval, sought to impose work requirements on the

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likely to assist in promoting the objectives of the Social Security Act and only (3) for the extent and period she finds necessary. Thus, while the Secretary has considerable discretion to decide which projects meet these criteria, she must, at a minimum, examine each of these issues.")

[50] See, *e.g.,* the Maine Childless Adults demonstration, at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81871 (expired demonstration covering a group of childless adults by redirecting a portion of the state's disproportionate share hospital funding allocation).

population covered by the demonstration.[51] These states contended that the imposition of work requirements in such a demonstration project would comport with the purposes of the Medicaid statute; they reasoned that, by opting to cover any part of the "new adult group" under Section 1115(a)(2)(A) demonstration authority, they would be furnishing more medical assistance than they otherwise would have absent the demonstration, given their decision not to cover that group at all under the state plan.

One federal court reviewing CMS's withdrawal of authority for Georgia's work requirement accepted that logic and reversed CMS's decision.[52] It may be true that a state's decision to use expenditure authority to cover a group of people or a set of services that the state could not otherwise cover under Title XIX would promote the statute's objective of furnishing medical assistance, even if the state were to subject eligibility for that coverage to certain conditions. However, where Title XIX already provides a coverage pathway for people or services, it would be inconsistent with the statute's objective for a state to use Section 1115(a)(2) demonstration authority to cover the same people or services (or a subset of these people or services) while imposing conditions on coverage for those people or services that serve as a barrier to the furnishing of medical assistance. If Title XIX creates authority for a state to cover a service or a group of people, the coverage established for that group or service is already defined in the statute as medical assistance. Whether the state purports to provide coverage through its Title XIX plan or through Section 1115(a)(2) demonstration authority, it may not impose conditions on that coverage that hinder the statutory objective of furnishing medical assistance. And, indeed, the experience with Georgia's demonstration project shows how far short the state has fallen from Title XIX's objective; the state is covering only about 4,200 people under its demonstration project with work requirements, as compared to the estimated 445,000 people who would be eligible for Medicaid if the state had included the ACA's expansion population in its state plan, or the estimated 269,000 people who would have gained coverage if the state had implemented its demonstration project without a work requirement.[53]

In sum, it would conflict with the objective of the Medicaid program to impose work requirements as a condition of coverage for persons who would be eligible for coverage under a

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[51] See Georgia Pathways to Coverage (Oct. 15, 2020), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf; Utah Primary Care Network (Dec. 23, 2019), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-care-network-amendment-appvl-12232019.pdf; Wisconsin BadgerCare Reform (Oct. 31, 2018), at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wi-badgercare-reform-cms-ext-appvl-10312018.pdf.

[52] *Georgia*, 2022 WL 3581859 at *12-*16.

[53] Notably, HHS has historically determined demonstration coverage under expenditure authority to be "budget neutral" to the federal government if that coverage could otherwise have been provided under Title XIX. *See* Centers for Medicare & Medicaid Services, State Medicaid Director letter # 24-003, "RE: Budget Neutrality for Section 1115(a) Demonstration Projects" 3-4, at https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf; Centers for Medicare & Medicaid Services, State Medicaid Director letter #18-009, "RE: Budget Neutrality for Section 1115(a) Demonstration Projects" 3, at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf.

state plan, including the "new adult group" made eligible for coverage under the Affordable Care Act, no matter whether a state attempts to imposes those requirements under a section 1115(a)(1) or a section 1115(a)(2)(A) demonstration project.

III. Limitations

This Advisory Opinion sets forth the current views of the Office of the General Counsel. It is not a final agency action or a final order.

Samuel R. Bagenstos -S

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