



PROPOSED ACTION
MEMORANDUM

Rescinding Medicaid Block Grant Guidance

Department of Health and Human Services
December 2020

I. Summary

Medicaid is a bedrock safety net program that can expand to cover more people or benefits, increase payment rates, or absorb higher costs as needed. Despite the importance of this aspect of Medicaid funding, the Department of Health and Human Services (HHS) issued sweeping Healthy Adult Opportunity (HAO) guidance to encourage states to apply for waivers that would cap federal Medicaid financing. In exchange for capped federal contributions, states could limit eligibility and reduce access to services. States could thus redesign their Medicaid programs using block grants or per capita caps while taking advantage of programmatic flexibility, diverting Medicaid funds to other programs, and relying on limited federal oversight.

This memorandum proposes that HHS rescind the current HAO guidance. In doing so, HHS would cite the administration's changed legal and policy position and research showing that capped federal Medicaid funding could reduce access to care and increase out-of-pocket costs for beneficiaries. These impacts would undermine Medicaid's core objectives, and such proposals should not be approved under HHS's experimental authority. This memorandum also identifies procedures that could be used to address pending or approved waivers for block grants or per capita caps.

II. Justification

Block grants or per capita caps would dramatically alter the way that Medicaid is financed. These policies cite savings as their goal but, in reality, shift more of the burden of Medicaid financing from the federal government to states.¹ Because Medicaid per capita spending is already low,² there is little room to cut costs. As Medicaid costs rose (due to, say, an economic recession or a breakthrough medical treatment), states with a block grant could no longer rely on increased federal funds. Instead, states would be forced to increase state spending—or reduce enrollment and benefits for beneficiaries.³ Block grants or per capita caps also limit the ability of states to leverage federal Medicaid matching funds to finance new initiatives, such as expanding behavioral health services or access to opioid treatment.

Recognizing that states would have to make difficult choices about financing their Medicaid program in the face of higher costs, block grant and per capita cap proposals typically provide increased “flexibility” for states in managing their programs. This “flexibility” would enable states to waive core Medicaid protections for beneficiaries and restrict eligibility and benefits, likely leading to coverage losses, capped enrollment, higher out-of-pocket costs, and provider reimbursement cuts.⁴ These changes would disproportionately impact communities and providers that rely on Medicaid, including low-income children, people of color, people with disabilities, nursing home and community-based long-term care providers, and safety-net hospitals and clinics.⁵

¹ See, e.g., Cindy Mann et al., The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative, The Commonwealth Fund (Mar. 6, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/mar/fiscal-impact-trump-administration-medicaid-block-grant-initiative> (finding that states that take up the block grant waiver option would see substantial reductions in Medicaid funding).

² See Medicaid and CHIP Payment and Access Commission, Medicaid Per Person Spending: Historical and Projected Trends Compared to Growth Factors in Per Capita Cap Proposals (Jun. 2017), <https://www.macpac.gov/wp-content/uploads/2017/07/Medicaid-per-Person-Spending-Historical-and-Projected-Trends-Compared-to-Growth-Factors-in-Per-Capita-Cap-Proposals.pdf>.

³ See Jeanne M. Lambrew, “Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals,” *Milbank Q.* 83(1): 41-63 (2005); See also Congressional Budget Office, Establish Caps on Federal Spending for Medicaid (2018), <https://www.cbo.gov/budget-options/2018/54726>.

⁴ See, e.g., Jacob Leibenluft et al., Like Other ACA Repeal Bills, Cassidy-Graham Plan Would Add Millions to Uninsured, Destabilize Individual Market, Center on Budget and Policy Priorities (Sep. 20, 2017), <https://www.cbpp.org/research/health/like-other-aca-repeal-bills-cassidy-graham-plan-would-add-millions-to-uninsured>.

⁵ E.g., Robin Rudowitz, 5 Key Questions: Medicaid Block Grants & Per Capita Caps, Kaiser Family Foundation (Jan. 31, 2017),

Policymakers need look no further than Puerto Rico, which receives federal Medicaid funding in the form of a block grant, to understand how such a policy limits access to benefits and provider reimbursement rates.⁶ Capped federal Medicaid funding would also affect other sectors, such as education.⁷ Overall, block grants and per capita caps—and the state flexibilities that accompany these policies—would significantly erode Medicaid’s ability to serve as a true safety net program for millions of vulnerable and low-income Americans.

III. Current State

The Medicaid program is a jointly financed, means-tested entitlement program. The federal government covers at least half of all Medicaid costs, but the federal medical assistance percentage varies by state and ranges from 50% to 78%.⁸ Currently, Medicaid expenditures are shared by the federal government and the state government without a cap. As a result, when Medicaid spending increases (due to, say, higher enrollment or rising health care costs), so does federal Medicaid funding. This enables state Medicaid programs to expand in response to economic downturns, or other public emergencies or disasters.⁹

Despite the importance of Medicaid, some policymakers have long tried to adopt block grants and per capita caps. Most recently, these policies featured prominently in debates over repealing and replacing the Affordable Care Act throughout 2017 and have been included in the Trump administration’s budget proposals ever since.¹⁰ With Congress unwilling to enact these policies, the Trump administration has tried to advance such changes under its Medicaid waiver authority.

Under Section 1115 of the Social Security Act, the Secretary of HHS can approve experimental, pilot, or demonstration projects that waive certain federal requirements and are, in the judgment of the Secretary, “likely to assist in promoting the objectives” of the Medicaid program.¹¹ HHS has exercised this discretionary authority over time,¹² typically to enhance or strengthen Medicaid coverage.¹³ No prior administration had allowed states to cap federal Medicaid spending, or otherwise entertain a block grant or per capita cap.¹⁴

<https://www.kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/>.

⁶ Judith Solomon, Puerto Rico’s Medicaid Program Needs an Ongoing Commitment of Federal Funds, Center on Budget and Policy Priorities (Apr. 22, 2019),

<https://www.cbpp.org/research/health/puerto-ricos-medicaid-program-needs-an-ongoing-commitment-of-federal-funds> (“[Puerto Rico] receives only a fixed block grant funding amount each year that does not come close to covering the costs of health care for its Medicaid enrollees.”).

⁷ Edwin Park, Illustrating the Harmful Impact of Medicaid Block Grants and Per Capita Caps on State Funding of K-12 Education, Georgetown University Center for Children and Families (Jul. 9, 2020), <https://ccf.georgetown.edu/2020/07/09/illustrating-the-harmful-impact-of-medicaid-block-grants-and-per-capita-caps-on-state-funding-of-k-12-education/>.

⁸ Congressional Research Service, Medicaid’s Federal Medical Assistance Percentage (FMAP) (Jul. 29, 2020), <https://fas.org/sfp/crs/misc/R43847.pdf>. Congress increased the FMAP rate for all states by 6.2 percentage points during the COVID-19 public health emergency so long as states and the territories comply with certain conditions. Families First Coronavirus Response Act, Pub. L. No. 116-127 § 6008, 134 Stat. 178, 208-09 (2020) (as amended by the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136).

⁹ See, e.g., Laura Snyder & Robin Rudowitz, Trends in State Medicaid Programs: Looking Back and Looking Ahead, Kaiser Family Foundation (Jun. 21, 2016), <https://www.kff.org/medicaid/issue-brief/trends-in-state-medicaid-programs-looking-back-and-looking-ahead/view/print/>.

¹⁰ See Tarun Ramesh, Undermining Medicaid: How Block Grants Would Hurt Beneficiaries, Center for American Progress (Aug. 7, 2019), <https://www.americanprogress.org/issues/healthcare/reports/2019/08/07/472879/undermining-medicaid-block-grants-hurt-beneficiaries/>.

¹¹ 42 U.S.C. § 1315(a).

¹² See Anthony Albanese, “The Past, Present, and Future of Section 1115: Learning from History to Improve the Medicaid-Waiver Regime Today,” 128 *Yale L.J.* F. 827, 833 (2019).

¹³ Jane Perkins, “The Administration’s Medicaid Waivers: Exploding in the Guise of Experimenting,” 13 *St. Louis Univ. J. Health L. & Pol.* 53, 58-61 (2019).

¹⁴ Although the Bush administration approved waivers in Rhode Island and Vermont that were referred to as “block grant waivers” the structure, funding levels, and programmatic flexibility provided to those states differentiates them from the waivers contemplated under the 2020 SMDL. See Judith Solomon & Jessica Schubel, “Block Grant” Guidance Will Likely Invite Medicaid Waivers That Pose Serious Risks to Beneficiaries, Providers, and States, Center on Budget and Policy Priorities (Jun. 27, 2019),

<https://www.cbpp.org/research/health/block-grant-guidance-will-likely-invite-medicaid-waivers-that-pose-serious-risks-to> (“[T]here’s no precedent for a block grant waiver. Proponents of block grants and per capita caps often cite Medicaid waivers in Rhode Island and Vermont as precedents for Medicaid block grants that saved both the state and the federal government money without hurting beneficiaries. But these claims are misguided. While

In January 2020, HHS issued a letter to state Medicaid directors (SMDL) that encouraged states to request Section 1115 waivers for capped federal funding for low-income adults, primarily in the Medicaid expansion population (2020 SMDL).¹⁵ Under the 2020 SMDL, states would receive a set amount of federal Medicaid funding in exchange for more flexibility and less federal oversight.¹⁶ States could, for instance, require Medicaid beneficiaries to pay premiums and higher out-of-pocket costs, impose work and community engagement requirements, end retroactive coverage, delay coverage for new enrollees, and narrow benefits for prescription drugs, among other flexibilities. The 2020 SMDL would also allow states that opt for a block grant to be eligible for “shared savings,” providing the option to divert unused federal Medicaid funds to non-health services (such as infrastructure) that are unrelated to the Medicaid program or its goals.

To date, there has been limited interest in pursuing these types of waivers.¹⁷ Only three states—Oklahoma, Tennessee, and Utah—applied for demonstration projects with block grant or per capita cap proposals.¹⁸ Tennessee and Utah submitted their waiver requests before the 2020 SMDL was issued.¹⁹ Oklahoma’s application referenced the 2020 SMDL but has since been withdrawn.²⁰ Although Utah’s proposal remains formally pending before HHS, the state has since proceeded with full Medicaid expansion. Tennessee has not expanded its Medicaid program under the ACA, and its block grant proposal would be an amendment to its existing TennCare demonstration project, which will be considered for extension in 2021.

IV. Proposed Action

This memorandum proposes that HHS: (i) rescind the 2020 SMDL, and (ii) deny any pending waivers that would cap federal Medicaid spending. If the Trump administration decides to approve such a waiver before the end of the term, this memorandum identifies ways to address those approvals. Though not discussed here, HHS should begin to develop its priorities for Section 1115 waivers and issue new guidance to encourage state proposals that are aligned with its coverage goals.

these waivers used varying approaches to lower state Medicaid spending, *neither* waiver (1) created a block grant; (2) included a reduction or rigid constraint on federal funding; or (3) gave the state new authority to cut eligibility or benefits.”).

¹⁵ See CMS, Healthy Adult Opportunity, SMD #20-001 (Jan. 30, 2020), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd20001.pdf> [hereinafter 2020 SMDL].

¹⁶ See Cindy Mann, What Does New Block Grant Guidance Mean for the Medicaid Program? The Commonwealth Fund (Jan. 31, 2020), <https://www.commonwealthfund.org/blog/2020/what-does-new-block-grant-guidance-mean-medicaid-program>. Under the per capita cap, federal funding would be capped per enrollee and could still be adjusted to account for changes in enrollment (but not health care costs). Under the block grant, total federal funding would be capped, putting states at risk for higher costs and higher enrollment.

¹⁷ This is unsurprising. See Sara Rosenbaum et al., The Medicaid Block Grant (Experiment) Cometh, Health Affairs Blog (Feb. 7, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200207.495036/full/> (“The number of states that convert to HAO status is likely to be extremely limited, since the initiative is exceptionally complicated.”).

¹⁸ Kaiser Family Foundation, Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State (Nov. 13, 2020) <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>.

¹⁹ Tennessee’s block grant proposal was submitted on November 20, 2019, and Utah’s per capita cap proposal was submitted on August 1, 2019. Division of TennCare, TennCare II Demonstration (No. 11-W-00151/4), Amendment 42 (Nov. 20, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa10.pdf>; Utah Department of Health, Utah 1115 Demonstration Waiver Application (Jul. 31, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-per-capita-cap-pa.pdf>.

²⁰ See Melody Anthony, Letter to James Scott Re: SoonerCare 1115(a) Research and Demonstration Waiver Application HAO (Aug. 11, 2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-soonercare-2-withdraw-ltr-hoa.pdf>; see also Carmen Forman, “Oklahoma Withdraws Block Grant Proposal Following Medicaid Expansion Vote,” *The Oklahoman* (Aug. 18, 2020) (quoting a state official noting that “[d]ue to the passage of State Question 802, the waiver application is no longer applicable to the Oklahoma Medicaid program”).

Process to Revoke the 2020 SMDL

HHS should rescind the 2020 SMDL and inform stakeholders of this change in policy. There is precedent for doing so. In 2014, HHS issued an SMDL to withdraw “free care” guidance issued in 1997.²¹ The 1997 guidance had been challenged and set aside by the HHS Departmental Appeals Board (DAB), which had concluded that the “free care” policy was not an interpretation of either the Medicaid statute or existing regulations.²² In rescinding the 1997 guidance, HHS cited the DAB ruling and issued replacement guidance to “facilitate and improve access to quality healthcare services and improve the health of communities.”²³ HHS has revoked other SMDLs as well.²⁴

Here, HHS should put forth a rationale, including consideration of reliance interests, in rescinding the 2020 SMDL. HHS could do so in a new SMDL, or in a press release or memorandum that announces the decision to rescind the 2020 SMDL.²⁵ HHS should also remove the 2020 SMDL from the HHS Guidance Portal. If HHS chooses to maintain all or parts of the Trump administration’s recent “good guidance” rule (which has been heavily criticized and may itself be pulled back or amended), an interested party could petition HHS to withdraw or modify the 2020 SMDL.²⁶

HHS is not required to use notice-and-comment procedures to rescind the 2020 SMDL. Historically, HHS has not used such procedures when issuing or revoking SMDLs and may not want to set the precedent for doing so. In general, HHS must provide a public notice-and-comment period of at least thirty days prior to issuing a “significant guidance document.”²⁷ But rescission of the 2020 SMDL should not be considered a “significant guidance document,”²⁸ and notice-and-comment procedures are not required for *rescinding* guidance.²⁹ HHS can rescind a guidance document, such as the 2020 SMDL, by not maintaining its posting on the HHS guidance repository.³⁰ So long as HHS does not issue a *replacement* policy, it should be able to rescind the 2020 SMDL without having to offer a notice-and-comment period. To avoid implicating the “good guidance” rule, HHS should explicitly state that it is only rescinding the 2020 SMDL.

Justifications to Cite When Revoking the 2020 SMDL

In rescinding the 2020 SMDL, HHS should briefly cite legal and policy justifications for doing so and consider relevant reliance interests. The revocation statement should be as straightforward as possible, while acknowledging a change in position, and offering a reasoned explanation that addresses why it is changing its

²¹ CMS, Medicaid Payment for Services Provided Without Charge (Free Care), SMD #14-006 (Dec. 15, 2014), <https://www.medicare.gov/federal-policy-guidance/downloads/smd-medicare-payment-for-services-provided-without-charge-free-care.pdf>.

²² HHS, DAB Decision No. 1924 (2005), on recon. Ruling 2005-1 (2005).

²³ CMS, *supra* note 21 at 1.

²⁴ See CMS, Rescinding SMD #16-005 Clarifying “Free Choice of Provider” Requirement, SMD #18-003 (Jan. 19, 2018), <https://www.medicare.gov/federal-policy-guidance/downloads/smd18003.pdf> (citing concern that SMD #16-005 “raises legal issues under the Administrative Procedure Act, and limited states’ flexibility with regard to establishing reasonable Medicaid provider qualification standards”).

²⁵ 85 Fed. Reg. 78770-87 (Dec. 7, 2020) (“[C]urrently, the public has no way to know that HHS has decided to withdraw a guidance document, unless HHS chooses to make a specific announcement. Operating divisions remain free to announce when they are rescinding or replacing a guidance document, and we encourage operating divisions to do so.”).

²⁶ See 45 C.F.R. § 1.5.

²⁷ HHS recently reaffirmed notice-and-comment procedures for guidance documents in a new rule on “good guidance” practices (which has been heavily criticized and may itself be rescinded or amended). 85 Fed. Reg. at 78770-87; see also Exec. Order No. 13891 of October 9, 2019, 84 Fed. Reg. 55235-38 (Oct. 15, 2019).

²⁸ 45 C.F.R. § 1.2 (defining a “significant guidance document” as a document “that may reasonably be anticipated to lead to an annual effect on the economy of \$100 million or more, or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights or obligations of recipients thereof; or raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles of Executive Order 12866.”).

²⁹ 85 Fed. Reg. at 78781 (“HHS is free to elect to stop relying on or using a guidance document, including without soliciting public feedback.”).

³⁰ 45 C.F.R. § 1.4(a)(2), (3)(ii). The HAO guidance is currently listed on the HHS Guidance Portal. HHS, HHS Guidance Portal Submissions, HHS-0938-1970-F-3797 (pub. on Jun. 19, 2020), <https://www.hhs.gov/guidance/document/opportunities-promote-work-and-community-engagement-among-medicare-beneficiaries>.

interpretation. HHS should emphasize its experience since the 2020 SMDL was issued and need not include a full legal analysis of why the 2020 SMDL is inconsistent with the Medicaid statute.

First, HHS should state its view that the types of policies outlined in the HAO initiative fail to satisfy the overall requirements of Section 1115. Under Section 1115, a demonstration project must still further the core objective of Medicaid, which is to furnish medical assistance to low-income individuals.³¹ Research shows the opposite—that capped federal Medicaid funding would leave states unable to maintain the same scope of Medicaid coverage—which suggests that the use of experimental authority to adopt a block grant or per capita cap is too risky to allow.

As discussed above, block grants, per capita caps, and many of the other flexibilities in the 2020 SMDL would likely hinder, rather than promote, the program's core objectives. The 2020 SMDL also invites states to pursue waivers—such as a demonstration project with a closed prescription drug formulary but continued access to the Medicaid drug rebate program—that HHS has denied in the recent past.³² The HAO policies would lead to decreased enrollment and limited care—the opposite of the program's explicit statutory purpose. HHS should also acknowledge that HAO caps on federal Medicaid spending could threaten, rather than promote, the fiscal sustainability of the Medicaid program.

For all of these reasons, waivers with many of the features highlighted in the HAO initiative should not be approvable under the Secretary's experimental authority. HHS should reiterate that its authority under Section 1115 is limited to proposals that are consistent with the core objectives of the Medicaid program. While acknowledging that the HAO initiative may not meet this standard, HHS should indicate that it will continue to work with state officials to review and approve Section 1115 waivers that satisfy this statutory standard.

Second, as an additional explanation for rescinding the 2020 SMDL, HHS should reference its experience considering HAO and related waiver proposals, and communicating with states considering such applications. Based on this experience, HHS could state that the 2020 SMDL was too complex and did not provide sufficient guidance for states. For instance, HHS could conclude that the shared savings mechanism in the HAO initiative is no longer an appropriate use of Medicaid funds, and acknowledge concerns about the complexity of calculating and showing shared savings.

Further discussions with states may have led HHS to conclude that, even by the end of a demonstration, states would not have sufficient data to inform a decision on renewal or adjustment, and that the delays associated with the data collection would further negate the demonstration's experimental value. These experiences and discussions with states, HHS could conclude, helped lead it to review and ultimately revoke the 2020 SMDL.

Third, HHS must acknowledge the reliance interests of states that will be affected by its change in position, even though consideration of these interests should not change the policy. HHS should acknowledge that (i) it has not approved any HAO initiative or related waivers and, even if it had, continuation of any waiver is not guaranteed, and (ii) HHS is preserving case-by-case review of state waiver proposals. If HHS approves an HAO or related waiver before the end of the Trump administration's term, HHS should additionally note that no waiver has yet been implemented, and HHS reserves the right to withdraw waivers that it determines are not in the public interest or do not promote the objectives of the Medicaid program.

³¹ See 42 U.S.C. § 1396-1.

³² See Virgil Dickson, "CMS Denies Massachusetts' Request to Choose Which Drugs Medicaid Covers," *Modern Healthcare* (Jun. 27, 2018).

Addressing Pending or Approved Waivers

HHS should consider similar factors when addressing Tennessee's pending block grant waiver (which is even broader than the waiver envisioned by the 2020 SMDL³³) and Utah's pending per capita cap waiver. The Secretary is authorized to deny a waiver request that, in her judgment, will not assist in promoting the objectives of the Medicaid program.³⁴ Indeed, the Secretary has regularly denied Section 1115 waiver requests under her discretionary authority.³⁵

First, HHS could try to encourage these states to withdraw their proposals. States have often withdrawn proposals in the face of difficult negotiations or reconsideration.³⁶ To this end, HHS should inform state officials that the 2020 SMDL has been withdrawn and that similar proposals do not, in its view, promote the purposes of the Medicaid program. Assuming HHS also rescinds its separate SMDL on work and community engagement requirements, federal officials may already be engaged in significant negotiations with states over the scope of proposed Section 1115 waivers.

HHS could also deny or simply not act on pending waiver requests. Although past denial letters have been relatively simple,³⁷ HHS should fully justify any denial and emphasize the discretionary nature of its decision. The Department of Justice (DOJ) has taken the position that denial of a Section 1115 waiver application is not subject to judicial review. Even assuming that a denial is subject to review, a state's challenge to a waiver denial is unlikely to succeed if HHS fully justifies its determination.

Second, Tennessee's proposal is an amendment to its existing TennCare demonstration project, which will be considered for extension in 2021. Even if HHS approves Tennessee's block grant proposal before Inauguration Day, this approval can be revisited when reviewing the broader TennCare project. In general, HHS should follow Section 1115's waiver transparency requirements in revoking approval of a waiver.³⁸ Approved waivers would also be subject to Special Terms and Conditions (STCs). Under these STCs, HHS generally reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Medicaid. HHS would need to follow STC procedures when revoking the approvals, including providing an opportunity for the state to request a hearing; it cannot simply withdraw waiver approval in an immediate, *ex parte* fashion.

³³ See Brett Kelman & Joel Ebert, "TennCare and the Trump Administration Have Drastically Different Block Grant Plans," *The Tennessean* (Jan. 30, 2020).

³⁴ 42 U.S.C. § 1315(a).

³⁵ See, e.g., Frank J. Thompson & Courtney Burke, "Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process," 32 *J. Health Pol., Pol'y & L.* 971, 978 (2007) (noting that a total of only nine waivers requests were explicitly disapproved under the Clinton and Bush administrations).

³⁶ *Id.* (noting that states commonly withdrew Section 1115 waiver proposals or let their requests lapse).

³⁷ See, e.g., CMS, Letter to Donna Frescatore re: Delivery System Reform Incentive Payment Program (Feb. 21, 2020); CMS, Letter to Jeffrey A. Myers re: Health Protection Program Premium Assistance (Nov. 1, 2016); CMS, Letter to Billy Millwee re: Women's Health Program Renewal (Dec. 12, 2011).

³⁸ The Affordable Care Act amended Section 1115 to establish state and federal public notice-and-comment requirements. It follows by implication that action to revoke a waiver would need to comply with notice-and-comment procedures as well.

