UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

RONNIE MAURICE STEWART, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 1:18-cv-152 (JEB)
	)	
ALEX M. AZAR II, et al.,	)	
	)	
Defendants.	)	

PLAINTIFFS' MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

This case challenges the efforts of the Executive Branch to bypass the legislative process and act unilaterally to "comprehensively transform" Medicaid, a cornerstone of the social safety net. Purporting to invoke a narrow statutory waiver authority that allows "experimental, pilot, or demonstration" projects "likely to assist in promoting the objectives" of Medicaid, Defendants have instead effectively rewritten the Medicaid Act, bypassing congressional restrictions by regulatory fiat, overturning a half century of administrative practice, ignoring swaths of social science evidence and data, and threatening irreparable harm to the health and welfare of tens of thousands of people.

The Medicaid program provides health insurance to more than 75 million low-income individuals. The program offers a deal for states. If a state chooses to participate, the federal government will contribute the lion's share of the cost of providing care. In return, the state agrees to pay the remaining portion of those costs and follow all federal requirements, including those regarding the scope of coverage and eligibility for the program. The Social Security Act, of which Medicaid is a part, does permit the Secretary to "waive" certain Medicaid requirements, but only when likely to both promote the objectives of the Medicaid Act and serve an experimental purpose.

The far-reaching Kentucky HEALTH waiver application, granted by Defendants, meets neither of these requirements. The Kentucky HEALTH program imposes a work requirement on individuals to maintain their Medicaid benefits—the first time such a requirement has been permitted in the 50-year history of the Act—and it also (among other things) imposes premiums on very low-income people, imposes high cost sharing for non-emergency use of the emergency department, implements lockouts for failure to pay premiums, limits retroactive eligibility, and eliminates non-emergency medical transportation. All told, by the Commonwealth's own estimate, Kentucky HEALTH's punitive requirements and benefits cuts would *reduce* Medicaid

enrollment over a five-year period by over 95,000 adults and reduce payments for health care for low-income Kentuckians—like Plaintiffs—by approximately $2.4 billion. AR 5419-23. And that is just the start. The agency's letter to state Medicaid directors announcing its "new policy" on work requirements established guidelines for any State wishing to follow Kentucky's lead. The changes Defendants endorsed in the Kentucky waiver are thus effectively available nationwide.

The grant of the waiver here is notably at odds with the text and history of the Medicaid Act. The work requirements at the core of the Kentucky HEALTH scheme illustrate this point. The text of the Act sets forth eligibility requirements for covered populations, and work requirements are not among them. Over the years, Congress has repeatedly considered and rejected legislation that would impose work requirements on Medicaid recipients. When work requirements were added to the welfare program, it was Congress (not the agency) that accomplished the task. And for 50 years, no Administration has approved a work requirement as a condition of eligibility for health coverage. Congress does not hide elephants in mouseholes, and the limited authority to "waive" certain Medicaid requirements for the purposes of experimental or pilot projects does not permit the agency to broadly embrace the imposition of work requirements, in Kentucky or nationwide.

The Kentucky HEALTH waiver here is likewise at odds with Medicaid's purpose. That purpose—expressed in the text of the Act—is to enable states to "furnish medical assistance" and "rehabilitation and other services" to families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1. Defendants' embrace of objectives such as "strengthening workforce participation" and "lessening dependence on government assistance" and "familiarizing beneficiaries with . . . the commercial market" is thus beside the point: Those are not the purposes Congress set forth in the Act.

What is more, even if Defendants *had* the authority to grant the Kentucky HEALTH application, the administrative record in this case does not allow the Court to bless Defendants' paper-thin reasoning and decision making process. Defendants simply ignored the wealth of record evidence setting forth why the components of Kentucky HEALTH are ill-advised and counter-productive and therefore do not meet the Section 1115 requirements. This ostrich-like adjudication is the very definition of arbitrary and capricious decision making.

In the end, Defendants' actions here reflect not a reasoned agency effort to effectuate the text and purpose of the statute Congress enacted, but instead an effort by an Executive to take by regulatory fiat what it could not accomplish in Congress and to "fundamentally transform Medicaid." But transformation of the social safety net is manifestly a job for Congress, not the Executive. Because Defendants broadly overstepped their authority under the Social Security Act and failed to adequately support or explain their conclusions, summary judgment should be granted in Plaintiffs' favor as to Plaintiffs' Administrative Procedure Act ("APA") claims, and vacatur of the Dear State Medicaid Directors Letter and Defendants' grant of the Kentucky HEALTH Medicaid waiver is appropriate.[1]

STANDARD OF REVIEW

The APA is the principal safeguard against irrational, incoherent, or unexplained agency decision making. Under the familiar APA standard of review, *see* 5 U.S.C. § 706, the court must ensure that the agency "examine[d] all relevant factors," *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 923 (D.C. Cir. 2017) (internal quotation marks omitted), weighed "reasonably obvious alternative[s]" to its chosen course, *Walter O. Boswell Mem'l Hosp. v.*

[1] Plaintiffs do not seek summary judgment on their constitutional claim, which they believe is more than sufficient to overcome a motion to dismiss. In addition, because summary judgment on Plaintiffs' individual claims will provide complete relief—through vacatur—there is no need to consider the class allegations at this time.

Heckler, 749 F.2d 788, 797 (D.C. Cir. 1984), and furnished "a satisfactory explanation for its action"—one that draws a "rational connection between the facts found and the choice made," and that supplies "a reasoned analysis for [any] change," *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983) (internal quotation marks omitted).

Where "the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise," the agency's action is arbitrary and capricious, and the court must set it aside. *Id*.

STATEMENT OF FACTS

I. The Federal Medicaid Program

The Social Security Act establishes a number of public benefit programs to support low-income people in the United States. *See* 42 U.S.C. §§ 301-1397mm. The titles of the Act establish programs to address a range of needs, including cash assistance, nutritional assistance, housing, and health care. Title XIX of the Social Security Act addresses health care by establishing the medical assistance program known as Medicaid. *See id.* §§ 1396-1396w-5. Congress passed Medicaid "'[f]or the purpose of enabling each State, as far as practicable . . . to furnish (1) medical assistance on behalf of" families and 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." *Id*. § 1396-1.

States do not have to participate in Medicaid, but all do. The federal government reimburses states for a portion of "the total amount expended . . . as medical assistance under the State plan." *Id*. § 1396b(a)(1), (b) (establishing reimbursement formulas). To receive federal Medicaid funding, a state must operate its program according to a state plan that has been approved

by the Secretary of the Department of Health and Human Services ("Secretary" of "HHS"). *Id*. § 1396a. The state plan must describe the state's program and affirm its commitment to comply with the requirements imposed by the Medicaid Act and its associated regulations. *Id*.

The Medicaid Act describes the population groups that are eligible to receive coverage. *Id*. § 1396a(a)(10)(A), (C). States participating in Medicaid must provide medical assistance to individuals described in Section 1396a(a)(10)(A)(i) (the "mandatory categorically needy") and have the option to cover individuals described in Section 1396a(a)(10)(A)(ii) (the "optional categorically needy") and Section 1396a(a)(10)(C) (the "medically needy"). States must cover individuals who fall within a covered population group, meet the financial eligibility criteria applicable to that group, are residents of the state in which they apply, and are U.S. citizens or qualified immigrants. *Id*. § 1396a(a)(10)(A), (b)(2), (3); 8 U.S.C. §§ 1611, 1641.

Prior to the Affordable Care Act ("ACA"), the covered population groups included children, pregnant women, parents and other caretaker relatives, and individuals who were aged, blind, or disabled. The ACA added an additional mandatory group, as of January 1, 2014, requiring states to cover adults who are under age 65, not eligible for Medicare, do not fall within another Medicaid eligibility category, and have household income below 133% of the federal poverty level ("FPL") (the "expansion population"). Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 271 § 2001 (2010) (adding 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14)). By including this population group, Congress expanded Medicaid "into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level." *Nat'l Fed. of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575 (2012); *see also id*. at 583 ("It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance

coverage."). The Supreme Court's decision in *NFIB v. Sebelius* barred HHS from terminating federal funding to states that do not extend Medicaid coverage to the expansion population. 567 U.S. 519. However, this population group continues to be described in the Medicaid Act as a mandatory coverage group, and 31 states (and the District of Columbia) have implemented the Medicaid expansion to date. Kentucky is one of those states.

The Medicaid Act requires states to cover all members of a covered population group. A state cannot, therefore, decide to cover subsets of a population group described in the statute, *see* 42 U.S.C. § 1396a(a)(10)(B), and states cannot impose eligibility requirements that are not explicitly allowed, *id*. § 1396a(a)(10)(A); *see, e.g.*, *Jones v. T.H.*, 425 U.S. 986 (1976) (affirming a three-judge district court's holding that a Utah regulation was inconsistent with Title XIX because it added a requirement for obtaining medical assistance).

In addition, the Medicaid Act requires states to determine eligibility and provide medical assistance to eligible individuals with "reasonable promptness." 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906 (requiring states to allow individuals to apply without delay). The Medicaid Act requires states to provide retroactive eligibility for care provided in or after the third month before the month of application, as long as the enrollee would have been eligible for Medicaid at the time the services were received. 42 U.S.C. §§ 1396a(a)(34), 1396d(a). The enrollment process is to be streamlined, 42 U.S.C. § 18083, 42 C.F.R. § 435.907, and when re-determining the eligibility of enrollees, states must follow certain procedures to ensure continuity of coverage. 42 C.F.R. § 435.916(a)(3).

The Medicaid Act also includes protections designed to ensure that enrolled individuals receive a minimum level of coverage. States must cover certain basic health care and services, and can cover additional services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a). The statute also sets

forth the states' options for imposing premiums and cost sharing on enrollees. *Id.* §§ 1396o, 1396o-1. Finally, states must "provide such safeguards as may be necessary to assure" that eligibility and services "will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." *Id.* § 1396a(a)(19).

II. Section 1115 of the Social Security Act

Section 1115 of the Social Security Act authorizes the Secretary to "waive compliance" with certain requirements of the Medicaid Act in certain circumstances. *See id.* § 1315(a). Congress placed limits on this authority.

First, Section 1115 only allows the Secretary to grant a waiver for an "experimental, pilot, or demonstration" project. *Id.* § 1315(a). According to Congress, Section 1115 is to be used for "experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients" that are "to be selectively approved," and "designed to improve the techniques of administering assistance and . . . related rehabilitative services." 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); *see also* H.R. Rep. No. 97-3982, pt. 2 at 307-08 (1981).

Second, the Secretary may only grant a waiver that is "likely to assist in promoting the objectives" of the Medicaid Act. 42 U.S.C. §1315(a); *see, e.g.*, *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1098 (9th Cir. 2005) (Section 1115 "unambiguously requires the Secretary, as a condition of approval of a demonstration project, to find that the project 'is likely to assist in promoting the objectives of [Title] . . . XIX.'")). Medicaid's stated purpose is to enable states to "furnish medical assistance . . . and rehabilitation and other services" on behalf of low-income populations who cannot otherwise afford needed care and services. 42 U.S.C. § 1396-1.

Third, the Secretary may only waive compliance with the requirements of Section 1396a of the Medicaid Act. *Id.* § 1315(a)(1). Numerous Medicaid requirements are located outside of

that section. *See id.* §§ 1396-1, 1396b-1396w-5. Finally, the Secretary may only grant a waiver to the extent and for the period necessary to enable the state to carry out the experimental, pilot, or demonstration project. *Id.* § 1315(a)(1).

III. Kentucky Medicaid—From Medicaid Expansion to Kentucky HEALTH

A. Medicaid Expansion

Kentucky amended its state Medicaid plan to implement the Medicaid expansion, effective January 1, 2014. By the end of 2014, over 375,000 individuals had enrolled in Medicaid through the expansion. Administrative Record ("AR") 4979.[2] Over the course of the year, the proportion of uninsured low-income adults in Kentucky plummeted from 35% to under 11%. AR 4612-13. Enrollment has continued to grow, with over 428,000 individuals having access to medical assistance through the Medicaid expansion as of April 2016. AR 5437.

A substantial number of expansion enrollees have relied on Medicaid to receive critical preventive care and necessary services. In 2014 alone, over 232,000 enrollees in the expansion population had a non-annual office visit; almost 160,000 received medication monitoring; over 89,000 had their cholesterol tested; over 80,000 received preventive dental services; and 13,000 sought treatment for a substance use disorder. AR 5037. In addition, 26,000 women in the expansion population received breast cancer screenings, and 34,000 received cervical cancer screenings. AR 5037.

Not surprisingly, Medicaid expansion in Kentucky has been associated with a variety of positive health outcomes, including increased use of preventive services, decreased reliance on the emergency room, fewer skipped medications due to cost, lower out-of-pocket spending on medical

[2] The night before Plaintiffs' motion for summary judgment was due, Defendants served a supplement to the administrative record totaling nearly 1,200 documents, consisting mostly of comments submitted to the Secretary. Because Plaintiffs have not had a chance to review these documents, Plaintiffs were unable to rely on them here.

services, and improved self-reported health. AR 3876 (citing Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA Internal Med. 1501, 1505-06 (2016)). The Plaintiffs in this case illustrate the positive gains from Medicaid expansion. Through their Medicaid coverage, Plaintiffs have been able to access valuable and even lifesaving health care and have gained a measure of stability. *See generally* Plaintiffs' Decls., Exs. 1-16.

The Medicaid expansion has also provided a much-needed boost to both health care providers and job-seekers in the Commonwealth. Hospitals' uncompensated care costs were $1.15 billion lower in the first three quarters of 2014 than in the first three quarters of 2013. AR 5004. Providing Medicaid coverage to the expansion population created more than 12,000 jobs in health care and related fields in 2014 alone. AR 4996-97.

B. Kentucky HEALTH

Despite the success of the Medicaid expansion, Governor Bevin, after taking office in December 2015, set out to "comprehensively transform Medicaid" by requesting permission from the Secretary to implement a Section 1115 project called Kentucky HEALTH. AR 5447. The Governor asked to impose a number of burdensome requirements on enrollees and to both terminate Medicaid coverage and prohibit reenrollment for up to six months when enrollees cannot meet the requirements. He also requested permission to eliminate certain critical Medicaid services for individuals who remain enrolled. The Commonwealth estimated that Kentucky HEALTH would save approximately $2.4 billion over a five-year period, with the savings resulting largely from more than 95,000 adults losing Medicaid coverage. AR 5419-23.

Defendant Centers for Medicare and Medicaid Services ("CMS") provided two public comment periods on Kentucky HEALTH—one for the initial application in August 2016 and another after the Governor proposed modifications in July 2017. *See* Kentucky HEALTH,

Medicaid.Gov, https://public.medicaid.gov/connect.ti/public.comments/view?objectId=3242896 (last viewed Mar. 30, 2018). During the comment periods, CMS received over 3,000 comments through its website alone. *Id*.

With the Kentucky HEALTH application pending, the Trump administration began its efforts to transform Medicaid and "explode" the ACA, including the Medicaid expansion. *See* Amy Goldstein & Juliet Eilperin, *Affordable Care Act Remains "Law of the Land," but Trump Vows to Explode It*, Wash. Post (Mar. 24, 2017), https://www.washingtonpost.com/national/health-science/affordable-care-act-remains-law-of-the-land-but-trump-vows-to-explode-it/2017/03/24/4b7a2530-10c3-11e7-ab07-07d9f521f6b5_story.html. As soon as he took office, President Trump signed an Executive Order calling on federal agencies to unravel the ACA. Exec. Order No. 13765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal*, 82 Fed. Reg. 8351 (Jan. 20, 2017).

Shortly thereafter, the former HHS Secretary and Defendant Verma issued a letter to state Governors announcing CMS's disagreement with the purpose and objectives of the ACA, stating that "[t]he expansion of Medicaid through the Affordable Care Act ("ACA") to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program." *See* Sec'y of Health & Human Servs., Dear Governor Letter, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf. Subsequently, Defendant Verma repeatedly criticized the expansion of Medicaid to "able-bodied individual[s]," advocating for lower Medicaid enrollment and outlining plans to "reform" Medicaid through agency action.[3]

[3] *See* Casey Ross, *Trump health official Seema Verma has a plan to slash Medicaid rolls. Here's how*, Stat (Oct. 26, 2017), https://www.statnews.com/2017/10/26/seema-verma-medicaid-plan/; *see also, e.g.*, Remarks by Adm'r Seema Verma at the Nat'l Ass'n of Medicaid Dirs. (NAMD) 2017 Fall Conference, CMS.Gov (Nov. 7, 2017), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html (declaring that the

On January 11, 2018, well after the federal comment periods for the Kentucky HEALTH application had closed, CMS issued a Dear State Medicaid Director letter that announced a "new policy" to "Promote Work and Community Engagement Among Medicaid Beneficiaries." AR 0090-99. The policy includes new guidelines for states wanting to impose these requirements. *Id.*

The next day, the Secretary approved Kentucky HEALTH through September 30, 2023. AR 0002. As detailed below, the approval gave Kentucky permission to comprehensively restructure its Medicaid program. Effective July 1, 2018, Kentucky can require enrollees to work as a condition of Medicaid eligibility; to pay monthly premiums of up to 4% of household income (with punishment for non-payment, including termination of coverage and a six-month lockout penalty); and to pay heightened cost sharing for non-emergency use of the emergency room. AR 0087, 0144-45. Kentucky will no longer provide three-months' retroactive coverage or non-emergency medical transportation for certain enrollees. AR 0013-15.

This "restructuring" is of grave concern to the Plaintiffs, who are at risk of losing their Medicaid coverage when they cannot find or maintain work, submit a required monthly report on time, or pay the premium. Plaintiffs anticipate that, as before when they had no insurance coverage, they will incur medical bills they cannot afford to pay, they will have to depend on relatives and friends to help them with their health care, they will have to forego the care they need to stay healthy, their mental health or substance use disorders will again become problems, the cost of health care will leave them homeless, and their quality of life will diminish. *See* Stewart

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ACA's decision to "move[] millions of working-age, non-disabled adults into" Medicaid "does not make sense," and announcing that CMS would resist that change through approval of state waivers that contain work requirements); *The Future Of: Healthcare*, Wall St. J. (Nov. 10, 2017), http://www.wsj.com/ video/the-future-of-health-care/D5B767E4-B2F2-4394-90BB-37935CCD410C.html (declaring Medicaid expansion a "major, fundamental flaw[]" and announcing CMS's efforts to "restructure the Medicaid program").

Decl. ¶¶ 8-10; Kasey Decl. ¶¶ 10-12; Branham Decl. ¶¶ 7, 9-11; Ballinger Decl. ¶¶ 8, 9, 15-17; Kobersmith Decl. ¶ 9; Bennett Decl. ¶¶ 8-10; McComas Decl. ¶¶ 11-14; Hatcher Decl. ¶¶ 9-12; M. Woods Decl. ¶¶ 6, 8, 9, 11; S. Woods Decl. ¶¶ 6, 8, 9, 11; Withers Decl. ¶¶ 5, 7-10; Allen Decl. ¶¶ 6-10; Spears Decl. ¶¶ 8-11; Roode Decl. ¶¶ 6-9; Penney Decl. ¶¶ 11-15; Radford Decl. ¶¶ 8-11.

ARGUMENT

"[I]t is 'axiomatic' that 'administrative agencies may act only pursuant to authority delegated to them by Congress.'" *Clean Air Council v. Pruitt*, 862 F.3d 1, 9 (D.C. Cir. 2017). In approving the Kentucky HEALTH waivers, the Secretary far exceeded his authority under Section 1115. The Secretary lacks the authority to fundamentally restructure Medicaid through waiver grants or to rewrite the purposes of Medicaid—that is the job of Congress, not the Executive. But even if the Secretary had the authority necessary to grant the waiver requests—and he does not—the Secretary simply failed to adequately consider whether the conditions for waiver outlined in Section 1115 were met in this case. Indeed, given the evidence in the record, the Secretary could not have rationally concluded, as required by Section 1115, that the Kentucky HEALTH waiver proposals—individually or as a whole—were both of experimental value and likely to promote the objectives of the Medicaid Act. Thus, his approval was arbitrary and capricious. *See Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011); *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994).

I. The Secretary Lacks Authority to Fundamentally Restructure Medicaid Through the Approval of Kentucky HEALTH.

Before addressing the specific actions of the Secretary challenged here, it is important to set the stage. The Secretary of HHS, working hand-in-hand with a state, has sought to fundamentally alter the design and structure of Medicaid. Viewed in context, it is clear that these actions—as a whole—are arbitrary and capricious as fundamentally inconsistent with the statutory

scheme. CMS's approval letter waives compliance with numerous requirements of § 1396a, waives requirements *not* found in § 1396a, and adds brand new requirements untethered from the statute, all to implement the Kentucky HEALTH project, the express purpose of which, as the Commonwealth straightforwardly stated, is to "comprehensively transform" Congress's carefully crafted statutory program. AR 5447. Indeed, from the President on down through senior leadership at HHS, transforming Medicaid has been the Administration's goal. Defendant Verma, for example, repeatedly expressed her intent "to fundamentally transform Medicaid" through administrative action, and announced in November 2017—two months before Defendants granted Kentucky's waiver application—that CMS was "trying" to "restructure the Medicaid program."[4] That brazen effort to radically change Medicaid without action by Congress is at odds with the statutory text and expressed purpose of the Act.

A. The Secretary's Approval of Kentucky's Waiver Request Dramatically Expands His "Waiver" Authority.

First, the text. In Section 1115 of the Act, Congress authorized the Secretary to "waive compliance" with certain provisions of the Medicaid Act in the confines of an "experimental, pilot, or demonstration project." 42 U.S.C. § 1315(a).

The text of Section 1115 includes no authority to transform or restructure Medicaid. The Secretary has authority to "waive" certain requirements only to further an "experimental, pilot, or demonstration project." Even alone, the use of the word "waive" does not suggest broad authority to rewrite a statute. Waiver suggests authority to enforce or not to enforce a particular provision,

[4] Seema Verma, *Lawmakers have a rare chance to transform Medicaid. They should take it*, Wash. Post (June 27, 2017), https://www.washingtonpost.com/opinions/lawmakers-have-a-rare-chance-to-transform-medicaid-they-should-take-it/2017/06/27/f8e5408a-5b49-11e7-9b7d-14576dc0f39d_story.html?utm_term=.f1de699a4727; *The Future Of: Healthcare*, Wall St. J. (Nov. 10, 2017), http://www.wsj.com/video/the-future-of-health-care/D5B767E4-B2F2-4394-90BB-37935CCD410C.html.

see Black's Law Dictionary (10th ed. 2014) ("[t]o refrain from insisting on (a strict rule, formality, etc.); to forgo"), not the authority to fundamentally modify, amend, or change statutory provisions. And here the limited nature of the statutory authority is further constrained by the context in which it is exercised—waiver is permitted only for "experimental, pilot, or demonstration projects" that are likely to promote Medicaid objectives. Nothing in Section 1115 thus suggests the broad authority to "transform" or "restructure" the scheme Congress has enacted. "[H]ad Congress wished to assign that [authority] to an agency, it surely would have done so expressly." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (quoting *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2442 (2014)).

The idea that Congress does not implicitly or in ancillary provisions give agencies the authority to transform statutes is well-settled. Consider, for example, the Supreme Court's decision in *MCI Telecommunications Corp. v. American Telephone & Telephone Co.*, 512 U.S. 218 (1994). There, the Federal Communications Commission ("FCC") asserted that its statutory authority to "modify any requirement" in a section of the Communications Act gave the FCC broad authority to make "basic and fundamental changes in the scheme created by that section." *Id.* at 225. The Court rejected that interpretation. While acknowledging that the word "modify" grants authority to implement change, the Court emphasized that the provision the FCC sought to modify—a tariff-filing requirement—was "the heart of the common-carrier section of the Communications Act." *Id.* at 229. Therefore, the Court concluded, "[i]t is highly unlikely that Congress would leave the determination of whether an industry will be entirely, or even substantially, rate-regulated to agency discretion—and even more unlikely that it would achieve that through such a subtle device as permission to 'modify' rate-filing requirements." *Id.* at 231. Or, "to use the more general (and snappier) formulation of that rule, relevant to all 'ancillary

provisions,' Congress does not 'hide elephants in mouseholes.'" *Cyan, Inc. v. Beaver Cty. Emps. Ret. Fund*, No. 15-1439, __ U.S. __, 2018 WL 1384564, at *9 (U.S. Mar. 20, 2018) (citing *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001)). In so holding, the Court's decisions reflect the insight that, absent clear textual indication to the contrary, it is for Congress, not the Executive, to weigh the important public policy interests and adjust statutory programs accordingly. *See Chamber of Commerce of the U.S. v. U.S. Dep't of Labor*, No. 17-10238, __ F.3d __, 2018 WL 1325019, at *21 (5th Cir. Mar. 15, 2018) (summarizing cases and noting that "Congress enacts laws that define and, equally important, circumscribe the power of the Executive to control the lives of the citizens").[5]

So too here. When Congress granted the Secretary authority to "waive" the federal Medicaid requirements found in Section 1396a, it could not have intended to give the Secretary *carte blanche* to work a fundamental restructuring of the Medicaid program via a state demonstration project approval. Likewise, when Congress enacted the ACA expansion, it surely did not intend for an agency unhappy with that result to use waiver authority to wage a rear-guard action to try to "explode" the ACA. But, by Defendants' and the Commonwealth's own admissions, the waiver does just that. Accordingly, the Secretary's interpretation of his limited waiver authority "does not merit deference" because it is "inconsisten[t] with the design and structure of the statute as a whole." *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2442 (2014).

[5] *See also Nat'l Treasury Emps. Union v. Chertoff*, 385 F. Supp. 2d 1, 32 (D.D.C. 2005) (citing *MCI* and concluding that a provision in the Homeland Security Act prohibiting the Department of Homeland Security from "waiv[ing], modify[ing], or otherwise affect[ing]" any federal employment requirements except those establishing and defining the role of the Fair Labor Relations Authority did not grant DHS authority "to commandeer the resources of an independent agency and thereby fundamentally transform its functions, absent a clearer indication of congressional intent"), *aff'd in rel. part, rev'd in part*, 452 F. 3d 839 (D.C. Cir. 2006).

B. The Secretary's Approval of Kentucky's Waiver Request Attempts to Rewrite the Purposes of Medicaid.

Considerations of congressional purpose—as explicitly set out in the statute—dictate the same result. Defendants suggest to the contrary, arguing that approval of the Kentucky waiver advances the objectives of the Medicaid Act. But that is not so. Congress has expressly defined the objectives of the Act, and they do not include the purposes identified by Defendants.

Congress defined the objectives of Medicaid in Section 1396-1. That section appropriates funds for Medicaid "[f]or the purpose of enabling each State, as far as practicable . . . to furnish (1) medical assistance on behalf of [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. By its own terms, then, the purpose of the Act is to enable states to furnish medical, rehabilitative, and other health care services.

The Secretary sought to advance an entirely different set of objectives by granting the Kentucky HEALTH waivers. For example, the Secretary justified Kentucky's plan because it seeks to "familiarize beneficiaries with a benefit design that is typical of what they may encounter in the commercial market," AR 0004, "help individuals and families rise out of poverty and attain independence," AR 0090, "strengthen workforce participation and other forms of community engagement," and "lessen[] dependence on government assistance and promot[e] individual self-sufficiency," AR 1028-29; *see also* AR 0060-67, 1991-93. Defendants even assert that the waiver advances Medicaid's objectives by *withholding* health coverage and services from otherwise eligible individuals. *See* AR 0005.

None of these objectives are the ones identified by Congress. "[S]trengthening workforce participation" and "lessening dependence on government assistance" have little to do with

furnishing medical assistance to needy individuals, and preparing people to be off Medicaid is clearly not a purpose of Medicaid itself. The idea that *withholding* coverage and services is a means to promote the *furnishing* of coverage and services is an argument only Orwell could love. In short, the goals identified by Defendants are little more than euphemisms for the objectives that the Administration and the Governor of Kentucky have admitted—to knock people off Medicaid and undermine the Medicaid expansion enacted by Congress. Those are not (to say the least) the objectives Congress sought to achieve.

Nor can Defendants prevail by asserting that the waiver helps recipients to "attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1. The "independence" the Act seeks to advance is not (as Defendants would have it) "financial" independence. To the contrary, in the context of a clause that requires access to "rehabilitative services" as a means to attain a "capability for independence or self-care," it is clear that "independence" refers to *functional* (not financial) independence; that is, the capacity to accomplish the various activities of daily living, such as feeding, dressing, and bathing. Defendants' efforts to untether the term from the remainder of the passage and wring out meanings such as "upward mobility," "responsible decision making," and "economic self-sufficiency," cannot be squared with the sentence as a whole. *See Yates v. United States*, 135 S. Ct. 1074, 1082 (2015) (quoting *Deal v. United States*, 508 U.S. 129, 132 (1993) for proposition that it is a "fundamental principle of statutory construction (and, indeed, of language itself) that the meaning of a word cannot be determined in isolation, but must be drawn from the context in which it is used").

Defendants may disagree with Congress enacting the Medicaid Act to provide medical assistance and rehabilitation services to low-income individuals, *see, e.g.*, Part I.B. and note 3, *supra*, but Defendants must nevertheless abide by the choices Congress made. *See, e.g.*,

Waterkeeper Alliance v. EPA, 853 F.3d 527, 535 (D.C. Cir. 2017). Defendants' attempt to rewrite the objectives of the Medicaid Act to *reduce* medical assistance through Medicaid, rather than to help "furnish" it, usurps these legislative choices.

II. Approval of the Kentucky HEALTH Work Requirements Exceeds Statutory Authority and Is Arbitrary and Capricious.

In approving Kentucky HEALTH, the Secretary allowed the Commonwealth to require Medicaid enrollees to verify, as a condition of eligibility, completion of 80 hours per month of qualifying "community engagement" activities. AR 0002; 0042. Enrollees who are required but unable to meet these requirements will lose Medicaid coverage. AR 0043-44.

A. The Secretary Lacks the Authority to Approve the Kentucky HEALTH Work Requirements.

The imposition of work requirements exceeds the Secretary's authority under Section 1115. For the reasons stated above in Part I, Defendants' effort to fundamentally transform Medicaid from a program to ensure that the poorest Americans receive health insurance into a work program is inconsistent with the text and purposes of Medicaid and therefore outside of the Secretary's Section 1115 authority. The Medicaid Act carefully enumerates the detailed requirements that an individual must meet to receive Medicaid benefits; it does not require or give states the option of requiring individuals to work as a condition of Medicaid eligibility.

Congress has demonstrated time and again that Medicaid is a medical assistance program, not a work program. First, Congress has explicitly rejected efforts to add a work requirement to Medicaid. *See* American Health Care Act, H.R. 1628, 115th Cong., § 117 (2017) (proposing to amend § 1396a by adding the following: "a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement . . ."); Medicaid Reform and Personal Responsibility Act of 2017, S. 1150, 115th Cong. (2017) (bill proposing to amend § 1396a to require states to "condition

medical assistance . . . upon . . . an individual's satisfaction of a work requirement."). The "negative implications raised by disparate provisions are strongest in those instances," as here, "in which the relevant statutory provisions were considered simultaneously when the language raising the implication was inserted." *Gomez-Perez v. Potter*, 553 U.S. 474, 486 (2008) (internal quotation and alteration omitted).

Second, the statutory provisions governing Temporary Assistance for Needy Families ("TANF") and Supplemental Nutritional Assistance Program ("SNAP") both specifically reference work requirements in their statutory texts. *See* 42 U.S.C. § 607 (requiring states to ensure that most TANF recipients engage in "work activities," and that TANF payments will be reduced or terminated if an individual does not engage in the work activities); 7 U.S.C. § 2029(a)(1) (allowing states "to operate a workfare program").

There is no equivalent for the Medicaid program. This difference is a strong indication that Congress intended for Medicaid's eligibility requirements to differ from TANF and SNAP. *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (amending eligibility criteria for SNAP, TANF, and Medicaid, but including work requirements only in SNAP and TANF); *Digital Realty Tr., Inc. v. Somers*, 138 S. Ct. 767, 777 (2018) ("[W]hen Congress includes particular language in one section of a statute but omits it in another[,] . . . this Court presumes that Congress intended a difference in meaning.") (alterations in original, internal quotation omitted); *Jama v. Immigration & Customs Enf't*, 543 U.S. 335, 341 (2005) (same). It also shows that Congress knows how to include work requirements in a safety net program when it wants to.

Furthermore, Congress has had several opportunities to import the work requirements from Aid to Families with Dependent Children ("AFDC") and TANF into the Medicaid program on

wholesale basis, but has not done so. When Congress repealed AFDC in favor of TANF in 1996, it also amended Medicaid's Section 1396u to maintain consistency for certain joint TANF/Medicaid recipients. The statute granted narrow authority to states to terminate the Medicaid benefits of those individuals—and only those individuals—who were enrolled in TANF and had their TANF benefits terminated for failure to comply with TANF's work requirements. 42 U.S.C. § 1396u-1(b)(3)(A). But Congress did not amend the Medicaid Act to permit work requirements for any other individuals.

Third, Congress did not just permit work requirements in SNAP and TANF, but prescribed detailed regimes outlining the scope and nature of the work requirements, including how those work requirements would balance against other Congressional policy priorities—such as worker minimum wage protections and nondiscrimination statutes. *See, e.g.*, *id.* § 607 (detailing TANF work requirements, exemptions, and penalties for beneficiaries, and creating non-displacement protections for other workers); *id.* § 604a (addressing role of religious organizations and establishing nondiscrimination protections for contracting organizations and beneficiaries); 7 U.S.C. § 2029(a)(1) (directing SNAP benefit amounts to account for minimum wage laws). These are the types of policy judgments that must be left to Congress in the first instance.

Nor can the Secretary salvage his actions here by an appeal to "deference." As Defendants noted in their approval letter, in the 50-plus years of Medicaid, CMS has not previously approved a work requirement as a condition of Medicaid eligibility. AR 0004. Instead, HHS has consistently *denied* these requests, acknowledging that work requirements "could undermine access to care" and are therefore not consistent with the purposes of Medicaid.[6] The agency's

[6] Letter from Andrew M. Slavitt, Acting Administrator, Ctrs. For Medicare & Medicaid Servs., HHS to Thomas Betlach, Dir. Az. Health Care Cost Containment Sys. (Sept. 30, 2016), at https://www.azahcccs.gov/Resources/Downloads/1115Waiver/LetterToState09302016.pdf

prior interpretation of work requirements as *outside* its own Section 1115 waiver authority undermines any plea for deference here. *See United States v. Nat'l Ass'n of Sec. Dealers, Inc.*, 422 U.S. 694, 717 (1975).

CMS's responsibility to explain its reversal is even higher here because Congress "effectively ratified" the agency's "position that it lacks" authority under Section 1115 to impose mandatory work requirements; Congress has amended the Medicaid Act numerous times, but has never expanded the Secretary's authority in this way. *FDA v. Brown & Williamson*, 529 U.S. 120, 144 (2000); *see also Saxbe v. Bustos*, 419 U.S. 65, 74 (1974) ("[A]dministrative construction is entitled to great weight, particularly when, as here, [C]ongress has revisited the Act and left the practice untouched."). Accordingly, the Secretary lacks statutory authority to create new work requirements in the Medicaid program.

B. The Secretary Failed to Adequately Examine If the Kentucky HEALTH Work Requirements Met the Section 1115 Conditions.

Even if the Secretary had authority to introduce work requirements, to avoid vacatur the administrative record must demonstrate that, in approving Kentucky HEALTH, the Secretary reasonably concluded that the community engagement and work requirements proposed by Kentucky were a valid experiment and likely to assist in promoting the objectives of the Medicaid

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(hereinafter "Letter to Thomas Betlach"); *see also* Letter from Vikki Wachino, Dir., CMS, to Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Human Servs. at 1 (Nov. 1, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf (hereinafter "Letter to Jeffrey A. Meyers"). HHS has previously denied work requirement requests from Arkansas and Indiana. *See* Letter to Thomas Betlach; CMS.Gov, *CMS and Indiana Agree on Medicaid Expansion* (Jan. 27, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html (not approving work requirements). Other states withdrew requests to include a work requirement in a Section 1115 demonstration project after HHS indicated that it would not grant such requests. *See* Kaiser Fam. Found., Medicaid Expansion in Pennsylvania: Transition from Waiver to Traditional Coverage (Aug. 3, 2015), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/#footnote-159781-6.

Act. 42 U.S.C. § 1315(a); *Beno*, 30 F.3d at 1069; *Newton-Nations*, 660 F.3d at 380. Comments and research in the record focused extensively on the likelihood that work requirements will remove individuals from health care coverage, reduce access to medical care, and result in poorer health outcomes for individuals.[7] Comments and research in the record also noted the role of Medicaid coverage in helping individuals find and maintain employment and offered evidence that removing people from coverage will hinder their ability to work.[8]

Comments and research showed that work requirements are ineffective and even detrimental in other public assistance programs, and do not result in stable jobs that offer employer-provided coverage or wages sufficient to buy private insurance.[9] Defendants appeared to ignore this evidence, instead emphasizing the need to align Medicaid with these programs' work

[7] *See, e.g.*, AR 3310, 3317, 3683, 3773, 3793, 3796, 3803, 3808, 3826, 3830, 3838, 3851, 3862, 3875, 3900, 3927. These comments are supported with citations to research. *See, e.g.*, Hannah Katch, Center on Budget and Policy Priorities, *Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment* (July 2016), http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-withoutsignificantly (work requirements will lead to significant reductions in Medicaid coverage and negative health outcomes).

[8] *See, e.g.*, AR 3310, 3756, 3758, 3862, 3927, 4704. These comments are supported by citations to research, including: U.S. Dep't of Health & Human Servs. & U.S. Dep't of Educ., *National Evaluation of Welfare-to-Work Strategies: Evaluating Alternative Welfare-to-Work Approaches: Two-Year Impacts for Eleven Programs* (June 2000) (concluding that Medicaid coverage cannot be replaced through the limited-wage jobs that low-income people often work); Ohio Dep't of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (Jan. 2017) (finding 55% of respondents reporting that coverage and access to care made it easier to seek employment).

[9] *See, e.g.*, AR 3317, 3851, 3875, 3890, 3900, 3927, 4704, 4764-66. These comments are supported by citations to research, including: Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. Pol'y Analysis & Mgmt. 231 (2016) (analyzing 20 years of work requirements in TANF and concluding that adding work requirements to Medicaid without providing work opportunities would increase the "extent of extreme poverty"); LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (June 7, 2016), http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows (analyzing literature on TANF work requirements and finding that "deep poverty increased significantly in six of the 11 sites").

requirements. *See, e.g.*, AR 0093, 1160, 0008.

Comments showed that the vast majority of Medicaid enrollees are already working or are part of a working household, but they rely on Medicaid for health insurance because the available employment does not provide insurance or they cannot afford to purchase insurance. *See, e.g.*, AR 3796, 3773, 3875, 3941, 4646 (most of Kentucky's Medicaid expansion population are low-wage workers, but only 56% of employed people in Kentucky have employer-provided health care coverage). Commenters cited evidence demonstrating that significant percentages of Medicaid enrollees who are not working face market and structural barriers to employment, not lack of motivation.[10] Evidence from SNAP and TANF shows that these individuals will disproportionately lose coverage as a result of the work requirements.[11]

Relatedly, comments and evidence noted that work requirements are likely to be administratively complex and expensive to implement, and to strain the capacity of the agencies expected to implement them.[12] These comments and associated research were not addressed in

[10] *See, e.g.*, AR 3779, 3875, 3927. These comments are supported by citation to research, including: Bill Estep, *In Eastern Kentucky, "there's so many people unemployed fighting over so few jobs*," Lexington Herald Leader (Mar. 1, 2014), http://www.kentucky.com/news/hot-topics/article44474187.html (discussing reasons for high unemployment rates in Eastern Kentucky); John Cheves, *Bevin's proposed Medicaid changes could give nonprofits unwanted "volunteers*," Lexington Herald Leader (Aug. 17, 2016), http://www.kentucky.com/news/ politics-government/article96232057.html (reporting on inability of Kentucky nonprofits to take on increase in volunteers hoping to satisfy work requirements); Jason Bailey, Kentucky Center for Economic Policy, *Job Recovery for Some Kentucky Counties, Second Recession for Others* (May 15, 2017), http://kypolicy.org/job-recovery-kentucky-counties-second-recession-others/ (discussing job losses and lack of economic recovery in Kentucky).

[11] *See, e.g.*, AR 3310, 3683, 3793, 3838, 3862, 3890, 3927, 3976. These comments are supported by citations to research, including: Yeheskel Hasenfeld, et al., Univ. of Penn., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004), at https://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers (noting studies finding that those with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirements).

[12] *See, e.g.*, AR 3310, 3830, 3838, 3890, 3900, 3927. These comments included citations to research. *See, e.g.*, Julia B. Isaacs, et al., Urban Inst., *Changing Policies to Streamline Access to*

Defendants' approval of the Kentucky HEALTH waiver or elsewhere in the record.

Other criticisms and alternatives were similarly ignored by the Secretary. *See, e.g.*, AR 3759 (requirements may violate Fair Labor Standards Act, which federal agencies have stated applies to recipients of TANF and SNAP), 3830-31 (requirements "could displace paying jobs and weaken labor markets in economically depressed areas of Kentucky"), 3322 (suggesting alternative of voluntary work training programs "structured to address the actual barriers to work that individuals are confronting"), 3855 (skills training would be more effective alternative).

Rather than address or engage with these comments and research findings, CMS simply implied in a conclusory manner that the requirements would lead to positive outcomes in furtherance of its newly crafted interpretation of the objectives of the Medicaid program. *See, e.g.*, AR 0004, 0005, 0008. Evidence cited favorably by CMS does not support its position that work requirements will improve health outcomes among enrollees. That evidence suggests a positive correlation between volunteering and health, and it indicates that certain gainful employment and increased earnings can improve health. AR 4824-25, 4840-43, 5074-83, 5392-408.[13] From that starting point, Defendants take a leap that defies logic: They assume that *requiring* individuals to work to get health care coverage will yield the same benefits. None of the evidence cited by CMS backs that contention. Nor does CMS offer any evidence for how terminating insurance coverage

Medicaid, SNAP, and Child Care Assistance (Mar. 2016) (implementing work requirements in other program increased administrative costs and required shifting significant state agency staff).

[13] CMS's new policy announcing work requirements, cited in the approval letter, AR 0009, and discussed in Part VIII, *infra*, also refers to a handful of studies. However, the studies do not support CMS's conclusion that work requirements are likely to improve health outcomes. Among other things, CMS failed to discuss the applicability of basing its policy decisions on studies from the United Kingdom and other European countries that offer universal health coverage. And, none of the articles suggest that *requiring* work as a condition of eligibility is likely to promote health outcomes. In fact, the 2006 literature review from the article by Waddell and Burton reports that interventions that force individuals off benefits are more likely to harm health and well-being.

for failure to comply will improve health outcomes. Finally, CMS provides no evidence that work requirements actually improve income or long-term employment, much less that they do so in a manner that leads to improved health outcomes for people with low income.

This is plainly insufficient under the APA. "At the very least, the agency must have reviewed relevant data and articulated a satisfactory explanation [for its action that] establish[es] a 'rational connection between the facts found and the choice made.'" *Foster v. Mabus*, 103 F. Supp. 3d 95, 109 (D.D.C. 2015) (citation omitted). The agency also must have "examine[d] all relevant factors," *Am. Wild Horse Pres. Campaign*, 873 F.3d at 923, and weighed "reasonably obvious alternative[s]" to its chosen course, *Walter O. Boswell Mem'l Hosp.*, 749 F.2d at 797. CMS failed to do that here.

III. Approval of the Kentucky HEALTH Premiums Exceeds Statutory Authority and Is Arbitrary and Capricious.

In approving Kentucky HEALTH, the Secretary allowed the Commonwealth to require Medicaid enrollees with household income from 0% to 133% of FPL to pay monthly premiums of up to 4% of household income, but no less than $1. AR 0038. Individuals who are unable to pay the premiums face a range of consequences, including loss of Medicaid coverage, being locked out of the program for up to six months, and having money deducted from their *My Rewards* account. AR 0026, 0040-41.

The result of this combination of provisions is clear—individuals will have to pay a significant monthly premium to retain their Medicaid eligibility, despite the fact that Congress explicitly prohibited states from imposing any premiums on this population. For example, under the Kentucky HEALTH program, an individual earning $1,067 per month (about $12,800 per year, or 105% of FPL) will face a monthly premium of $43. Through this "waiver," Medicaid will simply become too costly for many individuals, resulting in people having their Medicaid coverage

terminated. As discussed below, the Secretary does not have authority to impose such fees on enrollees, nothing about these conditions can be squared with the purposes of Medicaid, and they are not supported by the record before the agency.

A. The Secretary Lacks the Authority to Waive the Medicaid Act's Limits on Premiums.

The Medicaid Act contains two provisions that prohibit states from charging premiums to most enrollees with incomes below 150% of FPL, Section 1396o and Section 1396o-1. The first, Section 1396o, prohibits states from charging enrollees an "enrollment fee, premium, or similar charge," except as permitted under Section 1396o(c). 42 U.S.C. § 1396o(a)(1). Subsection (c), in turn, allows states to impose premiums on certain specific categories of enrollees, but only if their household income is above 150% of FPL. *Id.* § 1396o(c). The second provision, Section 1396o-1, also prohibits states from imposing premiums on enrollees with income below 150% of FPL. *Id*. § 1396o-1(b)(1)(A), (a)(2)(A). The Section 1115 waiver authority, which the Secretary purports to have exercised here, extends only to waivers of Section 1396a, not Sections 1396o or 1396o-1. *See id.* § 1315(a)(1). As such, Section 1115 does not authorize the Secretary to waive the premium and cost sharing limits. *See Pharm. Research & Mfrs. of Am. v. Thompson*, 251 F.3d 219, 222 (D.C. Cir. 2001) (Section 1115 "does not authorize [the Secretary] to waive . . . [§ 1396o's] requirement that Medicaid beneficiaries contribute no more than a 'nominal' amount to the cost of medical benefits they receive.").

The Secretary *acknowledges* that his Section 1115 authority is limited to waiving Section 1396a requirements—a provision that contains no substantive premium requirement. Nonetheless, he claims the authority to ignore Congress's carefully crafted scheme for premiums and cost sharing by arguing that 42 U.S.C. § 1396a(a)(14) "incorporates Sections 1916 [1396o] and 1916A [1396o-1]." AR 0014. That is both textually wrong and wholly inconsistent with Congress's

enactment of Sections 1396o and 1396o-1.

To begin with, Section 1396(a)(14) does not even reference Section 1396o-1, so it clearly cannot incorporate it. While Section 1396a(a)(14) does refer to Section 1396o, the text, structure and history of the Medicaid Act show that this reference does not incorporate Section 1396o into Section 1396a(a)(14) such that it can be waived pursuant to Section 1115. Rather, Congress intended the premium and cost sharing requirements in Section 1396o to fall beyond the reach of the Secretary's waiver authority.

Section 1396o has its own separate demonstration waiver provision, Section 1396o(f), which is even more restrictive than Section 1115. *See* 42 U.S.C. § 1396o(f) (permitting waiver of cost sharing requirements only if, after public notice and comment, the Secretary finds that the proposed project will meet five tightly circumscribed criteria). What is more, Section 1396o(f) *explicitly provides* that "[n]o deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary," except as provided in Section 1396o and Section 1396o-1. *Id.*

Congress did not include a provision in Section 1396o allowing the Secretary to waive the premium requirements. Thus, under the well-established interpretive canon, *expressio unius est exclusio alterius*, they are not waivable. *Sebelius v. Cloer*, 569 U.S. 369, 378 (2013) (explaining and applying canon). Further, if the Secretary could use Section 1115 to waive the requirements in Section 1396o, then Section 1396o(f) would be superfluous. *See, e.g.*, *Laurel Baye Healthcare of Lake Lanier, Inc. v. NLRB*, 564 F.3d 469, 472 (D.C. Cir. 2009) (noting that interpretations creating superfluity are disfavored).

Moreover, Section 1396a(a)(14) states that premiums and cost sharing may be imposed "only as provided in section 1396o." 42 U.S.C. § 1396a(a)(14). This is the only place in Section 1396a where Congress uses the phrase "only as provided in." The new language, combined with

the more precise waiver authority of 1396o, indicates that Congress intended to place premiums and cost sharing outside the Secretary's Section 1115 authority.

The history and structure of Sections 1396a(a)(14) and 1396o make this intention clear. When Congress passed Medicaid in 1965, it allowed states to impose premiums and cost sharing on enrollees, as long as the amount was "reasonably related" to their financial situation. Social Security Act Amendments of 1965, Pub. L. No. 89-97, § 1902(a)(14), 79 Stat. 286, 346. In 1972, Congress amended Section 1396a(a)(14) to curb states' ability to charge premiums and cost sharing. States could only impose premiums on enrollees who qualified through the optional "medically needy" category. Cost sharing was prohibited for mandatory services provided to the categorically needy and limited to "nominal" amounts for optional services. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1381, § 208(a)(14)(A) (1973) (codified at 42 U.S.C. § 1396a(a)(14) (1974)).

During the 1970s, two courts upheld the Secretary's Section 1115 authority to waive Section 1396a(a)(14) to allow states to impose heightened cost sharing on Medicaid enrollees. *See Crane v. Mathews*, 417 F. Supp. 532, 538-40, 543 (N.D. Ga. 1976); *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491 (N.D. Cal. 1972). Congress responded in 1982 by removing the substantive provisions on premiums and cost sharing from Section 1396a(a)(14) and creating a new Section 1396o—outside of Section 1396a—to address premiums and cost sharing. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367. Congress also created a new and freestanding requirement in Section 1396o that independently requires states to impose premiums and cost sharing as set forth in the Section. *See* 42 U.S.C. § 1396o(a), (b) (stating "the State plan shall provide . . . ."). These changes in the structure of the Medicaid Act reflect Congress's intent to insulate the premiums and cost sharing provisions from the

Secretary's waiver authority under Section 1115.

The legislative history of Section 1396o confirms that Congress did not intend to incorporate Section 1396o into Section 1396a(a)(14); rather, Congress expressly intended for Section 1396o to insulate premiums and cost sharing from Section 1115 waivers. *See* H.R. Rep. No. 97-757, pt. 1, at 6 (1982) (noting that States have sought Section 1115 waivers for cost sharing and finding that this bill and its more restrictive waiver provision "make[s] further exercise of the Secretary's demonstration authority unnecessary").

Finally, reading the statute to allow the Secretary to waive the requirements of Section 1396o would not only eviscerate Section 1396o(f)'s specific limits on demonstration waivers, but also would produce an absurd result. The Secretary could conceivably permit states to impose premiums on individuals with household income below 100% of FPL (through a waiver of Section 1396o), but not on individuals between 100 and 150% of FPL (as independently prohibited by Section 1396o-1, which is not referenced in Section 1396a). Congress could not have intended such a bizarre and unjust outcome.

B. The Secretary Failed to Adequately Examine If the Kentucky HEALTH Premiums Met the Section 1115 Conditions for Waiver.

Section 1115 requires the Secretary to reasonably conclude that the premiums and associated penalties for inability to pay are experimental and likely to assist in promoting the objectives of the Medicaid Act. In particular, the Secretary was obligated to make "some judgment" that the premiums, delay in coverage, and lockout penalty have a research or demonstration value. *Beno*, 30 F.3d at 1069. In addition, in determining that the premiums are likely to promote the objectives of the Medicaid Act, the Secretary needed to consider their impact on the individuals that the Medicaid program was enacted to protect. *Newton-Nations*, 660 F.3d at 381 (citing *Beno*, 30 F.3d at 1070). The Secretary did none of that here.

Commenters identified serious, fundamental problems regarding the Kentucky HEALTH premiums and associated consequences. Numerous comments in the administrative record indicate that the premiums and punishments for inability to pay will deter and reduce enrollment in Kentucky HEALTH. More than a dozen of these comments cite the substantial research that, over nearly two decades, has examined the effects of imposing premiums on low-income individuals enrolled in Medicaid, the Children's Health Insurance Program, and similar state-funded insurance programs. *See, e.g.*, AR 3846-50, 3826-29, 3890-92, 3735-50, 3796-800, 4324-39, 3851-61, 3862-72, 3875-89, 3808-16, 3830-32, 3691-98, 3927-55, 3900-03, 3833-37, 4360-63. The cited research establishes that even very low premiums deter and reduce coverage.[14]

Commenters also highlighted data from several states with Section 1115 waivers to charge monthly premiums on the very populations that will be subject to premiums under Kentucky HEALTH.[15] *See, e.g.*, AR 3735-50, 3796-800, 3875-89, 3830-32, 3833-37, 3808-16. The data

[14] *See, e.g.*, Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, 43 Inquiry 378, 380 (2006) (imposing premiums on CHIP enrollees in Kentucky reduced initial enrollment, led to substantial disenrollment, and disproportionately affected non-white individuals); Leighton Ku & Teresa Coughlin, *Sliding Scale Premium Health Insurance Programs: Four States' Experiences*, 36 Inquiry 471 (1999/2000) (finding among low-income enrollees, premiums as low as 1% of household income reduce enrollment by 15%, and premiums of 3% of household income reduce enrollment by 50%); Bill J. Wright et al., *The impact of increased cost sharing on Medicaid enrollees*, 24 Health Affairs 1106 (2005) (finding after Oregon imposed premiums ranging from $6 to $20 and a lockout penalty on Medicaid enrollees below 100% of FPL, nearly half of affected enrollees lost coverage within first six months; of those who lost coverage, 40% (68% for individuals below 25% of FPL) identified premiums as main reason for disenrollment); Bill J. Wright et al., *Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out*, 29 Health Affairs 2311 (2010); Leighton Ku & Victoria Wachino, Ctr. On Budget & Policy Priorities, *The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings* 7 (2005) ("Evidence indicates that premiums reduce Medicaid participation and make it harder for individuals to maintain stable and continuous enrollment."); Abdus et al., *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 Health Affairs 8 (2014).

[15] The premium requirements were not challenged in those cases, so the Secretary's ability to increase premiums on the ACA's Medicaid expansion population through his Section 1115 waiver authority is a novel question of law.

show that a significant portion of Medicaid enrollees who are subject to monthly premiums do not pay them, and in states that terminate enrollees who do not pay premiums, a significant number of Medicaid enrollees have lost coverage. *See id.*

Notably, the administrative record includes a recent evaluation of the Indiana Section 1115 project's premiums and associated consequences for inability to pay, which are similar to those in Kentucky HEALTH. AR 4962-69 (citing The Lewin Group, *HIP 2.0: Power Account Contribution Assessment* (2017)). The evaluation found that the premiums created substantial barriers to both enrollment and continued coverage. Of individuals who were found eligible for the program and required to pay premiums to fully enroll and maintain eligibility, 23% never paid the initial premium and as a result, did not receive coverage. The Lewin Group, *HIP 2.0: Power Account Contribution Assessment* 12 (2017). Another 6% were terminated for nonpayment. *Id*. at 10-11. Overall, 55% of individuals who were found eligible for the program did not pay at least one monthly premium, meaning they never received coverage, were terminated from the program, or were shifted to a plan with fewer benefits and higher cost sharing. *Id*. at 8-11.

Comments from Medicaid enrollees, their families, and their health care providers stated that the premiums would represent a large financial burden and could cause them to lose coverage. *See, e.g.*, AR 2984 (comment 229673), 2998 (comment 229833), 3390 (comment 218385), 3447 (comment 219417), 3462 (comment 219705), 3544 (comment 222277), 3557 (comment 222701), 3687-88, 4315-19, 3873-74, 3729-30, 4517; *see also* AR 3735-50, 3713 (citing HHS Office of the Assistant Secretary for Planning and Evaluation 2015 report concluding that individuals below 100% of FPL are sensitive to even nominal increases in out-of-pocket medical costs and must choose between health care and other basic needs like child care and transportation). Commenters also noted that the nonpayment penalty imposed on enrollees with household income below 100%

of FPL will reduce access to medically necessary services, such as HIV treatment and mental health services.[16]

There is no evidence that CMS considered any of these specific issues, research findings, or comments before approving the Kentucky HEALTH premiums and associated consequences. *See* AR 0001-10. In announcing its approval, CMS made no effort to determine whether the premiums have experimental value. *See* AR 0001-10; *Beno*, 30 F.3d at 1074 ("[W]e cannot infer an agency's reasoning from mere silence or where the agency failed to address significant objections and alternative proposals.").

CMS approved the waiver, noting the need to maintain the "fiscal sustainability" of the Medicaid program. AR 0005. However, the desire to save money is not a valid experiment. *See Newton-Nations*, 660 F.3d at 381. Moreover, while Kentucky provided no estimate of the administrative costs associated with implementing the premiums, AR 0052, the record shows that the Commonwealth may well spend more on administration than it will receive in premium payments from enrollees. *See* AR 4324-31, 3851-61, 3875-89, 3773-77, 3735-50. Thus, the only logical conclusion is that Kentucky expects the premiums and associated consequences will save money by reducing overall enrollment in the program—an outcome inconsistent with the objectives of the Medicaid Act.

As for whether the Kentucky HEALTH premiums and associated consequences are likely

[16] *See, e.g.*, AR 3891, 3707-09, 3692-95, 3846-47, 3891, 3782-83, 3796-98, 3835-36, 4361, 3864-68. These comments included citations to research reviewing numerous studies concluding that premiums and cost sharing prevent low-income individuals from seeking care. *See, e.g.*, Kaiser Comm'n on Medicaid & the Uninsured, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (2013), https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf; Jane Perkins & David Machledt, *Nat'l Health Law Program, Medicaid Premiums and Cost Sharing* (2014), https://nationaldisabilitynavigator.org/wp-content/uploads/resources-links/NHeLP_IssueBriefMedicaidCostSharing_03262014.pdf.

to promote the objectives of the Medicaid Act, CMS simply stated that it had reviewed all of the comments received when making its determination. AR 0004, 0007-08. But, "[s]tating that a factor was considered . . . is not a substitute for considering it." *Beno*, 30 F.3d at 1075 (citing *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986)).

CMS's rationale for concluding that the premium requirements are likely to promote the objectives of the Medicaid Act (to furnish medical assistance) does not withstand even minimal scrutiny. CMS found that the premiums will "ensure continuity of care" by "provid[ing] beneficiaries [with] the tools to successfully utilize commercial market insurance, thereby removing potential obstacles to a successful transition from Medicaid to commercial coverage." AR 0006. CMS cites no evidence from the administrative record to support this reasoning.

Of course, contrary to CMS's contention, AR 0007, private insurance does not operate like the Kentucky HEALTH project. People with commercial insurance have their premiums automatically deducted from their paychecks (Medicare beneficiaries, from their Social Security checks), the amounts do not vary over the course of the year, and insureds are not subjected to monthly notices and payment requirements. AR 3310, 4025. Similarly, CMS recognized the relationship between continuous coverage and better health outcomes but then proceeded to ignore the substantial, uncontroverted evidence in the record indicating that the premiums and lockout penalty will reduce the number of individuals with continuous coverage.

In addition, CMS's approval relied on the Commonwealth's contention that the premiums and lockout penalty are likely to further the objectives of the Medicaid Act because they "will result in more efficient use of health care services." AR 0019, 1998. However, CMS made this declaration without coherent explanation or evidentiary support. By contrast, the record contains substantial research, conducted over almost two decades, consistently demonstrating that imposing

premiums on low-income Medicaid enrollees reduces enrollment and reduces coverage.

Based on the administrative record before him, the Secretary could not rationally conclude that the Kentucky HEALTH premiums are likely to promote the objectives of the Medicaid Act or have any demonstration value. As a result, his approval was arbitrary and capricious. *See Motor Vehicle*, 463 U.S. at 43.

IV. Approval of the Kentucky HEALTH Waiver to Lock Individuals Out of Medicaid Coverage Exceeds Statutory Authority and Is Arbitrary and Capricious.

Federal law already requires states to re-determine eligibility for most Medicaid enrollees every 12 months and to terminate coverage for enrollees who do not complete the re-determination process by the end of their eligibility period. 42 C.F.R. §§ 435.916(a), 435.930(b). In addition, outside of the re-determination process, Medicaid enrollees in Kentucky must promptly report changes in circumstances that affect their eligibility for Medicaid. 907 Ky. Admin. Regs. 20:010. Federal law also includes a comprehensive process for states to handle fraud among Medicaid enrollees. *See* 42 C.F.R. §§ 455.12-455.17 (requiring states to, among other things, refer cases of possible enrollee fraud to an appropriate law enforcement agency); *id.* § 431.214 (reducing prior notice of action from ten to five days when state is taking action to terminate coverage in cases of probable fraud); 42 U.S.C. § 1320a-7b(a) (providing for criminal penalties and lockout (at state option) from the program for individuals convicted of fraud).

The Secretary gave Kentucky permission to impose a six-month lockout on enrollees who do not complete the re-determination process in a timely way or report changes in household circumstances that affect their eligibility (the "redetermination lockout" and the "reporting lockout"). AR 0027-28, 0030. Kentucky designed the lockouts to "encourage" enrollees to comply with existing administrative requirements. *See* AR 1992-93.

Not surprisingly, commenters noted that the lockouts will reduce coverage and access to

health services, resulting in worse health outcomes among low-income individuals in Kentucky. *See, e.g.*, AR 3968 (citing research on the association between coverage and positive health outcomes), 3783, 3799, 3811, 3836, 3866, 3891, 1798-99, 3756-57, 3153 (comment 266941), 3165 (comment 269005), 3700, 4062. Nothing in the record indicates that CMS adequately considered these comments before concluding that the lockouts are likely to assist in promoting Medicaid's objectives. *See* AR 0007.

Notably, in 2016 CMS rejected a request from Indiana to implement a re-determination lockout, finding that the penalty "is not consistent with the objectives of the Medicaid program," because completing re-determination could be "challenging" for low-income individuals. AR 0239-40. CMS cited language access issues, frequent moves, and other barriers to receiving mail, as well as disabling health conditions, including mental illness, as particular challenges, and CMS expressed concerns that the lockout could impair access to treatment and medication that could prevent existing conditions from worsening. AR 0239-40.

In approving Kentucky HEALTH, CMS acknowledged its prior position, but did not explain the shift. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016). Instead, CMS made a conclusory statement that "it believes that this policy should be evaluated and is likely to support the objectives of Medicaid to the extent that it prepares individuals for a smooth transition to commercial health insurance coverage and ensures that resources are preserved for individuals who meet eligibility requirements." AR 0007. CMS appeared to use the same reasoning in approving the reporting lockout—it will prepare Medicaid enrolls for private market insurance. AR 0007.

In taking this new position on lockouts, CMS made several logical leaps that lack support in the administrative record. First, as noted above, preparing Medicaid enrollees for private market

insurance is not an objective of the Medicaid program. Also, Kentucky HEALTH does not resemble private insurance, as many of the administrative requirements are unique to Medicaid. For example, private insurance plans do not require enrollees to report changes in income or household characteristics. AR 3310. Thus, even assuming that Medicaid enrollees do need help preparing for commercial insurance, the lockouts would not provide that preparation.

The only other thin reeds on which CMS appears to rely are not supported in the record: (a) a bare statement that forcing individuals who are otherwise eligible for Medicaid to go without insurance for six months will promote continuous coverage and positive health outcomes among low-income individuals, AR 0006-07, an idea that strains all logic, and (b) the general notion that lockouts protect both "program integrity" and "the fiscal sustainability of the program." AR 0006-07. Nothing suggests that Kentucky has a particular problem with program integrity or that the lockouts would remedy such a problem.

Moreover, CMS did not even attempt to articulate how the lockouts are experimental or likely to yield useful information. *See Beno*, 30 F.3d at 1069. While both Kentucky and CMS expect the lockouts to save money by reducing enrollment in Medicaid, AR 0006-07, saving money by cutting benefits does not constitute an experiment. *See Newton-Nations*, 660 F.3d at 381. Because the record does not indicate that the Secretary rationally concluded that the lockouts meet the Section 1115 criteria, the approval must be vacated as arbitrary and capricious.

V. Approval of the Kentucky HEALTH Waiver of Retroactive Eligibility Exceeds Statutory Authority and Is Arbitrary and Capricious.

The Medicaid Act requires states to extend coverage up to three months prior to the person's application, provided that the individual was otherwise eligible. *See* 42 U.S.C. §§ 1396a(a)(34), 1396d(a). The three-month retroactive period is meant to "protect[] persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either

because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying." *Cohen ex rel. Cohen v. Quern*, 608 F. Supp. 1324, 1332 (N.D. Ill. 1984) (quoting H.R. Rep. No. 92-231 (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5099)); *see also* S. Rep. No. 92-1230 at 209 (1972) (same). Congress also wanted to encourage providers to "furnish necessary medical assistance and ensure financial protection to otherwise eligible persons during the retroactive period." *Amends. to the Soc. Sec. Act 1969-1972: Hearing. on H.R. 17550 Before the S. Comm. on Fin.*, 91st Cong. 1262 (1970) (statement of Elliot L. Richardson, Sec'y, Dep't of Health, Edu., & Welfare).

The Secretary approved a waiver to end retroactive coverage for certain Kentucky HEALTH enrollees. *See* AR 0014 ¶ 4. As discussed below, this action was improper.

A. The Secretary Lacks Authority to Waive Retroactive Coverage.

The Secretary's waiver authority is limited to provisions of the Medicaid Act in Section 1396a. That section includes a retroactivity requirement in subparagraph (a)(34), which the Secretary waived. *See* AR 0004. The Medicaid Act, however, separately mandates retroactive coverage both by obligating the Commonwealth to "provide – for making *medical assistance* available" to individuals who meet the federal eligibility requirements, 42 U.S.C. § 1396a(a)(10), and by defining "medical assistance" to be "payment of part or all of the cost of the following care and services or the care and services themselves, or both (*if provided in or after the third month before the month in which the recipient makes application for assistance. . . .*"), *id.* § 1396d(a) (emphasis added). The Secretary did not waive Section 1396a(a)(10) to allow the Commonwealth to eliminate retroactive coverage and could not waive Section 1396d(a). Regardless of the waiver of Section 1396a(a)(34), the retroactive coverage requirement still protects Kentucky enrollees by virtue of the separate and independent Medicaid provisions that were not, and could not be, waived.

B. The Secretary Failed to Adequately Examine If the Kentucky Waiver Met the Section 1115 Conditions for Approval.

The record does not show that the Secretary could have reasonably concluded that the waiver was likely to promote the objectives of the Medicaid Act and was experimental in nature. Providing retroactive coverage is a key component of Medicaid's overall goal of furnishing medical assistance to low-income individuals, including ensuring against gaps in their coverage. Defendants' waiver of retroactive coverage squarely contradicts this core feature. In every instance where the waiver has effect, it will *eliminate* medical assistance and *create* gaps in coverage—precisely what Medicaid is designed to prevent.

Defendants offered only general, conclusory statements to support the approval. CMS says that Kentucky HEALTH is likely to assist in improving health outcomes by promoting preventive care and increased upward mobility, AR 0004, and specifically says the waiver of retroactive coverage "encourages beneficiaries to obtain and maintain health coverage, even when healthy," with the intent "to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick," AR 0006. But CMS fails to explain how this could be so, particularly since one of the original congressional justifications of retroactive coverage is to help those who did not know they were eligible for coverage in the first place. *See Cohen*, 608 F. Supp. at 1332. What is more, CMS points to no evidence in the record indicating that low-income individuals decline to enroll in Medicaid because they are healthy. The agency also fails to address substantial evidence in the record which indicates the removal of retroactive coverage will interrupt continuity of medical care, leading to worse overall health outcomes. *See, e.g.*, AR 3917, 3701, 3684; 3464, 3643.

Comments make clear that removal of retroactive coverage will increase medical debt and bankruptcy and damage the credit of low-income individuals. *See, e.g.*, AR 3703, 3806, 3742;

3360, 3709, 3791, 3873, 3880, 3931, 4637. The administrative record also repeatedly states that this waiver will increase financial losses for those who provide Medicaid-covered services to eligible persons and could weaken the provider network serving the Medicaid population. *See* AR 3703, 3731, 3869, 3806, 3873. The record also reflects concern, based on experience, that clerical and tracking errors and delays currently affecting the Kentucky Medicaid system will cause inadvertent terminations and denials of enrollment that will be exacerbated by this waiver. *See, e.g.*, AR 3931, 3791, 3486, 3497, 3499, 3643, 3652, 3659, 3661.

Despite the overwhelming evidence in the record, CMS failed to acknowledge, much less respond to, these critical concerns. Its actions are thus arbitrary and capricious.

VI. Approval of the Kentucky HEALTH Waiver to Eliminate Non-Emergency Medical Transportation Is Arbitrary and Capricious.

Medicaid requires states to ensure that enrollees have necessary transportation, often referred to as non-emergency medical transportation ("NEMT") to and from Medicaid services. *See* 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.53. Both the federal government and the courts have recognized the importance of NEMT in the Medicaid program. *See, e.g.*, *Smith v. Vowell*, 379 F. Supp. 139, 145 (W.D. Tex.), *aff'd*, 504 F.2d 759 (5th Cir. 1974) (citing amicus brief of the Department of Health, Education, and Welfare). Yet the Secretary gave Kentucky permission to ignore the NEMT requirement for the expansion population. AR 0015.

Again, nothing in the record indicates that the Secretary adequately considered the impact of this benefits cut on Kentucky HEALTH enrollees. *See Beno*, 30 F.3d at 1070. Data from Kentucky reveal that a substantial number of Medicaid enrollees rely on NEMT to access covered health services. AR 5478 (from June 2014 through June 2015, enrollees in the expansion population used around 140,000 NEMT trips). In addition, a number of commenters, including

Kentucky Medicaid providers, highlighted the need for NEMT among Medicaid enrollees.[17] Similarly, commenters cited evidence showing that eliminating NEMT will reduce access to preventive, mental health, and substance use disorder services, leading to worse health outcomes.[18]

Significantly, the record incorporates data from two states—Indiana and Iowa—that received waivers to NEMT for the expansion population. *See* AR 4850-69. Regardless of the questionable legality of those waivers, these data show that a substantial number of enrollees in Indiana and Iowa reported not receiving medically necessary services due to lack of transportation. In addition, the data from Iowa show that eliminating NEMT disproportionately affects women, people of color, and enrollees with significant health needs, likely perpetuating or exacerbating existing health disparities. *See* AR 3870.

Several commenters noted that the removal of NEMT is likely to increase emergency department use, contrary to one of CMS's stated goals. *See, e.g.*, AR 4029-30, 3799 (citing Suzanne Bentler et al. (finding that enrollees with an unmet transportation need had 45% greater odds of visiting the emergency department than those without such a need)), 4280, 4702. The administrative record also includes evidence regarding the long-term cost ineffectiveness of

[17] *See, e.g.*, AR 3748, 3697, 4361, 3442 (comment 219297), 2966 (comment 229477), 3071 (comment 231101), 4140, 4639-40 (describing the lack of public transportation in the Commonwealth), 4084. These comments are supported by citation to research. *See, e.g.*, Paul T. Cheung et al., *National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries*, 60 Ann. Emerg. Med. 4 (2012) (finding 0.6% of individuals with private insurance report lack of transportation is a barrier to accessing timely primary care treatment, compared with 7% of Medicaid enrollees).

[18] *See, e.g.*, AR 3697, 3799, 3892, 3757, 3673 (comment 225701), 4135-36, 4285. These comments are supported by citation to research. *See, e.g.*, Jinkyung Kim et al. *Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care* 44 Health Serv. Res 145 (2009) ("The literature shows two distinct health effects of poor transportation: less use of preventive and primary care, and more use of the emergency department. These associations are particularly significant for those people who live in rural areas, and are also found for medical care services such as prescription drugs . . . Overall, these studies suggest that provision of reliable transportation services is important to enable patients to have access to regular and preventive care.").

eliminating NEMT. *See, e.g.*, AR 4361, 3748.

The record does not demonstrate that the Secretary considered any of these issues before allowing Kentucky to eliminate NEMT for the expansion population. Moreover, the approval documents contain no explanation as to how the Secretary determined that eliminating NEMT is experimental, as opposed to a "simple benefits cut," *Beno*, 30 F.3d at 1069, and no explanation as to how cutting these benefits is likely to promote the objectives of the Medicaid Act.

In its application, Kentucky indicated that the waiver is "consistent with the goal of offering a commercial market experience." AR 5454, 5513, 5525. CMS appears to have adopted that rationale, suggesting that eliminating NEMT would create "greater alignment" between Medicaid and commercial insurance. AR 0116. However, as noted above, that is not an objective of Medicaid. In addition, CMS's rationale ignores the fact, as demonstrated in the record, that Medicaid enrollees have different needs than commercial market enrollees, including a greater need for NEMT. AR 4029. Because the agency failed to engage in reasoned decision making, its approval of the NEMT waiver was arbitrary and capricious.

VII. Approval of the Heightened Cost Sharing for Non-Emergency Use of the Emergency Department Exceeds Statutory Authority and Is Arbitrary and Capricious.

The Medicaid Act defines cost sharing to include a deduction, copayment, or similar charge. States may impose cost sharing on enrollees, but there are clear limitations. *See* 42 U.S.C. §§ 1396o, 1396o-1; *see also Neb. Pharmacists Ass'n v. Neb. Dep't of Soc. Servs.*, 863 F. Supp. 1037, 1046 (D. Neb. 1994) (noting that "the difference between a one dollar or two dollar copayment . . . is significant (and not nominal) to those who are poor and in need of prescription drug services"). Thus, for non-emergency use of the emergency room, states can charge individuals with household income below 150% of FPL twice the "nominal" amount, as set by regulation. 42 U.S.C. §§ 1396o-1(e), 1396o(a)(3), (b)(3); *see id.* § 1396o-1(e)(4)(A) (defining

non-emergency services). The Secretary has set this amount at $8, subject to increases for inflation. 42 C.F.R. § 447.54(b).

The Kentucky HEALTH charge for non-emergency services violates these limits. The amounts Kentucky proposed—$20 for the first visit, $50 for the second, and $75 for subsequent visits—range from over two times to over nine times the amount allowed by law. AR 5463. Kentucky will assess the charge by deducting money from enrollees' *My Rewards* accounts. The Secretary allowed the Commonwealth to go forward without a waiver, simply stating that "the My Rewards account deduction is not a copayment." AR 0034. But that is wrong.

As noted, the Medicaid Act limits apply not only to copayments but also "any deduction . . . or similar charge" for non-emergency use of the emergency room. 42 U.S.C. § 1396o-1(a)(3)(B), (e); *see also id.* § 1396o(a)(3). The deduction from the *My Rewards* account clearly constitutes a "deduction, copayment, or similar charge." Indeed, the Secretary referred to it as a "deduction." AR 0034. And, this deduction will have real, financial consequences for Kentucky HEALTH enrollees. The Commonwealth will no longer cover vision services, dental services, or over-the-counter medications for enrollees in the expansion population; rather, it expects enrollees to use money in their *My Rewards* account to pay for these services. AR 0033-34. Enrollees who do not have enough money in their accounts to cover the costs of the services will have to pay out-of-pocket or forego those services entirely. Any deduction from the *My Rewards* account reduces the funds the enrollee has available to pay for medically necessary vision services, dental services, or over-the-counter medications. Consequently, while the Kentucky HEALTH charge is different from a traditional copayment (a direct payment to the health care provider that leaves the payer with less money available to him), the effect of the charge is nearly identical. The Kentucky HEALTH charge unquestionably constitutes a "deduction, copayment, or similar charge" under

the Medicaid Act. *See* 42 U.S.C. §§1396o, 1396o-1. The Secretary exceeded his authority in approving the charge.[19]

VIII. The Dear State Medicaid Director Letter Violates the APA.

When Kentucky's approval package was ready, Defendants issued a 9-page letter, without notice and comment, reversing the agency's stance against work requirements. AR 0090-99. The Letter established criteria portrayed as "considerations for states" in formulating applications. AR 00090. Defendants tailored those criteria to match Kentucky's proposed program and others the agency was already working toward approving. Then, instead of meeting their obligation to address the robust public criticism of Kentucky's proposal, Defendants fell back on the "new policy" and "parameters" in the Letter—issued just one day before the approval package—to justify their about-face. AR 0007-08. This Court should reject Defendants' defective attempt to bolster their fatally flawed endorsement of work requirements.[20]

A. The Letter Announces an Agency Decision Authorizing Work Requirements That is Arbitrary and Capricious.

Quite apart from the merits of the agency's decision, which separately warrant vacatur, *see* Parts I-II, *supra*, the Letter violates the APA's bar on arbitrary and capricious action. Defendants offered no logical reasoning for concluding that work requirements advance the Medicaid Act's

[19] As discussed above, the Secretary could only waive the copayment requirements by complying with the detailed provisions in Section 1396o(f)(1)-(5). Even if the Secretary had attempted to do so, he could not have approved the request under the first factor (requiring a unique and previously untested use of copayments) or the third factor (requiring a benefit to recipients that is reasonably expected to be equivalent to the risks to the recipients). *See, e.g.*, AR 3735-50, 3830-32, 3862-72, 3851-61 (citing multiple studies that cost sharing for non-emergency use of the emergency department does not reduce non-emergency visits among Medicaid enrollees).

[20] Counsel for Plaintiffs in this action, the National Health Law Program, raised these issues to CMS in a letter and statement of review sent the same day CMS issued its flawed letter. *See* Jane Perkins, NHeLP, *NHeLP Letter to CMS Regarding Work Requirements* (Jan. 11, 2018), http://www.healthlaw.org/issues/medicaid/nhelp-letter-to-cms-regarding-work-requirements. These materials are not in the administrative record, despite the fact that NHeLP requested that they be included.

objectives and neglected to discuss any alternatives they considered to this drastic approach with life-altering consequences for Medicaid beneficiaries.

For example, Defendants failed to articulate their reasons and ignored the obvious distinction between choice and mandate. None of the "authorities" cited in the Letter (many of them of questionable value) address work requirements or come close to supporting them. For example, two of the "authorities" focus on benefits of volunteering—i.e., something done *voluntarily*. AR 0091 & nn.8-9. As discussed above, *see* Part II.B, *supra*, these studies plainly cannot provide reasons why requirements (which by definition are not voluntary) capture equivalent benefits. Likewise, the fact that CMS "has long assisted state efforts to promote work and community engagement and provide incentives" for individuals to work does not rationalize a decision to authorize penalties for failure to do so. AR 0091. In short, nothing in the Letter addresses why work *requirements*, as opposed to voluntary labor market participation or community service, are likely to promote any objective of the Medicaid Act.

Defendants compounded this failure by neglecting to mention a single alternative course of action that the agency considered. *See Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 817 (D.C. Cir. 1983) (explaining that an agency decision must be vacated when "the agency's explanation could not justify its drastic decision" over a more modest approach). The Letter nowhere weighs any number of obvious and compelling alternatives to Defendants' chosen intervention. The Letter acknowledges that, in the past, the agency sought to capture any salutary effects from work and community engagement by supporting state programs like "job training and work referral," but does not explain why that approach was ineffective or insufficient. AR 0091. The Letter's myopic focus on requirements and penalties, rather than options and incentives, reveals Defendants' true aim: to justify waiver applications it already planned to grant. "[S]uch

an artificial narrowing of options is antithetical to reasoned decisionmaking and cannot be upheld." *Donovan*, 722 F.2d at 817 (internal quotation marks omitted).

Moreover, Defendants failed to discharge their "duty to explain why [they] deemed it necessary to overrule [their] previous position" on work requirements—either in the Letter itself or in its decision granting the Kentucky HEALTH application. *Encino Motorcars*, 136 S. Ct. at 2126. Although the APA does not bar an agency from reversing course, *Nat'l Ass'n of Home Builders v. EPA*, 682 F.3d 1032, 1043 (D.C. Cir. 2012), the agency must candidly weigh the relevant factors, including the "facts and circumstances that underlay or were engendered by the prior policy," *FCC v. Fox Television Studios, Inc.*, 556 U.S. 502, 515-16 (2009). It must also "set forth with such clarity as to be understandable" why it is changing course. *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947). That is true even when the White House changes hands. *See, e.g.*, *Clean Air Council*, 862 F.3d at 8-9; *Envtl. Def. Fund, Inc. v. Gorsuch*, 713 F.2d 802, 817 (D.C. Cir. 1983).

Rather than squarely confront the scope of their actions as the APA requires, Defendants instead seek to downplay the Letter as a mere "shift from prior agency policy" on work requirements. AR 0092. In fact, the Letter is a complete repudiation of the agency's longstanding position. Until they granted the waiver application for Kentucky HEALTH, Defendants had *never* approved a Medicaid waiver application containing a mandatory work requirement. The agency's reason was simple: Work requirements jeopardize access to care and thereby impede, rather than promote, the objectives of the Medicaid Act—meaning that "the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work." Sec'y of Health & Human Servs. Sylvia Burwell, Hearing on The President's Fiscal Year 2017 Budget, Responses to Additional Questions for the Record, U.S. House of Rep. Energy & Commerce Health

Subcommittee at 13 (Feb. 24, 2016), http://docs.house.gov/meetings/IF/IF14/20160224/104521/HHRG-114-IF14-Wstate-BurwellS-20160224-SD002.pdf.[21]

Defendants simply failed to explain their about-face. They offered only the vague and unsupported claim that imposing work requirements "is anchored in historic CMS principles that emphasize work to promote health and well-being." AR 0092. Yet Defendants do not identify those principles or explain why they support conditioning healthcare on satisfaction of work requirements. Moreover, the "studies" they cite in the Letter all predate agency decisions to reject work requirements as fundamentally incompatible with the Medicaid Act, so they cannot contend that new information supported the shift. *Compare* AR 0091 nn.3-9, *with* note 21, *infra*. Their decision to "simply disregard" the agency's earlier rationale confirms that they did not undertake a reasoned analysis of the complex issues at stake and their vital importance for millions of Americans. *Fox*, 556 U.S. at 515.

Finally, Defendants adopted their position after they had decided to grant Kentucky's waiver application—they tailored the policy to fit the waiver. The Letter came after the agency had decided to grant Kentucky's application. Defendants cannot credibly dispute that fact. They admitted to working toward approval for a year prior to granting it. AR 0001. And as if more were needed, the face of the approval letter confirms that Defendants worked backwards: When they wrote the approval letter, they left a blank for the date of the "new policy" announcement—but they forgot to fill it in before they issued it. AR 0008 (invoking "the parameters set out in the January X state Medicaid directors letter"). The "new policy" was not a factor that Defendants

[21] *See, e.g.*, Letter to Thomas Betlach (explaining that work requirements in Arizona application "could undermine access to care and do not support the objectives of the program"); Letter to Jeffrey A. Meyers (explaining that work requirements in New Hampshire application "could undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program").

took into account; it was a justification they invented after the fact.

B. The Letter Imposes a Substantive Rule Without The Requisite Notice-and-Comment Procedures.

The Letter also violates the APA's procedural requirements of notice and comment. The APA mandates notice-and-comment rulemaking before any substantive rule (also known as a legislative rule) can take effect. *See* 5 U.S.C. § 553(b), (c); *Chamber of Commerce of U.S. v. OSHA*, 636 F.2d 464, 470-71 (D.C. Cir. 1980). There is no dispute Defendants failed to comply with notice-and-comment procedures. Because the Letter announces a rule that cabins the agency's discretion, drives its outcomes, and alters the regulatory framework, the lack of notice and comment provides an independently sufficient reason to invalidate the Letter.

Agency action qualifies as a substantive rule, and thereby requires notice-and-comment rulemaking, if it (a) alters the rights or interests of parties; (b) makes a substantive change to the statutory or regulatory framework, and (c) has a present binding effect. *See Cmty. Nutrition Inst. v. Young*, 818 F.2d 943 (D.C. Cir. 1987). The D.C. Circuit has emphasized that the key inquiry is "whether the substantive effect is sufficiently grave so that notice and comment are needed to safeguard the policies underlying the APA." *Elec. Privacy Info. Ctr. v. U.S. Dep't of Homeland Sec. (EPIC)*, 653 F.3d 1, 5-6 (D.C. Cir. 2011).

The Letter clearly meets that test. Under the guise of "guidance," the Secretary has upended a 50-year-old interpretation of his waiver authority and the very purposes of the Medicaid program, immediately affecting hundreds of thousands of Kentuckians and almost immediately affecting millions of Medicaid recipients across the nation. Through this Letter, the Secretary "comprehensively transforms" Medicaid from medical care for the poorest Americans to a work program with health benefits on the side—all without Congressional action or authorization.

In a very real sense, the Secretary has sought to make law, under the cover of the waiver

authority. The Letter does more than "clarify a statutory or regulatory term, remind parties of existing statutory or regulatory duties, or 'merely track[]' preexisting requirements and explain something the statute or regulation already required." *Mendoza v. Perez*, 754 F.3d 1002, 1021 (D.C. Cir. 2014) (quoting *Nat'l Family Planning & Reprod. Health Ass'n v. Sullivan*, 979 F.2d 227, 236-37 (D.C. Cir. 1992)). It "effects a substantive regulatory change to the statutory or regulatory regime." *EPIC*, 653 F.3d at 6-7; *see also Time Warner Cable Inc. v. FCC*, 729 F.3d 137 (2d Cir. 2013) (where agency decision results in "substantive burden," is issued contrary to "established [agency] practice," and is of questionable authority, notice and comment is required).

That the Letter purports to leave the agency with discretion to make case-by-case determinations does not make it any less substantive or binding. First, the Letter "constrains the agency's discretion." *McLouth Steel Prods. Corp. v. Thomas*, 838 F.2d 1317, 1320 (D.C. Cir. 1988). The Letter introduces a new policy and sets out several criteria guiding implementation. *See Cmty. Nutrition Inst.*, 818 F.2d at 948; *Pickus v. U.S. Bd. of Parole*, 507 F.2d 1107, 1112-13 (D.C. Cir. 1974); *Mendoza*, 754 F. 3d at 1023 (agency action telling applicants what is required for certification supplements the statute and is a substantive rule). It speaks of those criteria in binding terms, stating that state applicants "will be required" to make various showings to win agency approval, and "will not be permitted" approval unless they meet certain standards. AR 0093, 0096-98. Individuals who comply with a TANF or SNAP work requirement "must automatically be considered to be complying with the Medicaid work requirements," and "States must also create exemptions for individuals determined to be medically frail." AR 0094. This kind of "'mandatory, definitive language'" is a "'powerful, even potentially dispositive, factor'" in identifying a substantive rule. *McLouth*, 838 F.2d at 1321; *see id.* ("The use of the word 'will' suggests the rigor of a rule, not the pliancy of a policy."); *Gen. Elec. Co. v. EPA*, 290 F.3d 377,

383 (D.C. Cir. 2002) ("[A]n agency pronouncement will be considered binding . . . [if it] appears on its face to be binding.").

Second, the agency has confirmed in its application of the Letter that it binds. *See Gen. Elec. Co. v. EPA*, 290 F.3d at 384-85; *see also Texas v. United States*, 809 F.3d 134, 173 (5th Cir. 2015), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016) ("a rule can be binding if it is 'applied by the agency in a way that indicates it is binding'"). The Kentucky HEALTH decision itself conceded that many comments on Kentucky's waiver application "opposed the community engagement requirement" and "emphasized that CMS has rejected similar proposals in the past." AR 0008. In particular, Defendants noted, "some commenters questioned the efficacy of work requirements." *Id*. Rather than addressing that critique in any meaningful way, as was their obligation, Defendants instead hid behind their "deci[sion] to allow states to test the implementation of community engagement requirements in Medicaid, subject to the parameters set out in the January X state Medicaid directors letter." AR 0008-09. Put another way, Defendants deemed the Letter controlling, by invoking that rule to avoid engagement with comments it was required to address.

Subsequent waiver decisions underscore the Letter's binding effect. In approving an Arkansas program with work requirements, the agency explained, "CMS is approving the community engagement program based on our determination that it is likely to assist in promoting the objectives of the Medicaid program" because its terms and conditions "are consistent with the guidance provided to states through [the Letter]." *See* Letter from Seema Verma, Dir. of HHS, to Asa Hutchinson, Governor of Arkansas (Mar. 5, 2018), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf. The agency's Indiana approval was even more explicit. It justified approval of work requirements

based on the fact that the "terms and conditions of Indiana's community engagement requirement that accompany this approval are aligned with the guidance provided to states through [the Letter]." *See* Letter from Demetrios Kouzoukas, Principal Dep. Admin., Ctrs. For Medicare & Medicaid Servs., HHS to Allison Taylor, Medicaid Dir., Ind. Family & Soc. Servs. Admin. (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-support-20-ca.pdf.

The Letter has driven each outcome the agency has reached since issuing it. "A policy initially classed as a general statement is not immunized from subsequent judicial review for conformity with the APA if later developments show the agency to be using it as binding policy." *Am. Hosp. Ass'n v. Bowen*, 834 F.2d 1037, 1057 n.4 (D.C. Cir. 1987). The Letter replaces a policy against work requirements with a command to support state efforts and apply enumerated criteria to reach that result. It substantively changed the regulatory regime, and it required notice and comment. *See Cmty. Nutrition Inst.*, 818 F.2d at 949.

CONCLUSION

For the reasons above, Plaintiffs respectfully ask the Court to vacate the approval or, in the alternative, sever and vacate the aspects of the waiver approval that exceeded the Secretary's authority and/or vacate and remand the aspects of the waiver approval that lacked evidentiary support. The Plaintiffs also ask the Court to vacate the Letter as a rule that was not properly promulgated under the APA.

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CERTIFICATE OF SERVICE

I hereby certify that on March 30, 2018, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send an electronic notice to the authorized CM/ECF filer listed below:

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