UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

COMMONWEALTH OF KENTUCKY'S REPLY MEMORANDUM IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Plaintiffs' response largely ignores the Commonwealth of Kentucky's and the federal government's arguments in support of Kentucky HEALTH. Where Plaintiffs do respond, they show how wrong they are. This is perhaps most true for Article III standing. Under no circumstances can Plaintiffs establish that their injury is redressable by this Court. If they prevail here and the Court's decision is upheld, Plaintiffs will lose their Medicaid coverage by operation of Governor Bevin's January 12, 2018 executive order. Rather than address this dispositive issue, Plaintiffs primarily respond with over-the-top language, accusing the Commonwealth of "bullying" and "browbeating," which ignores that Kentucky HEALTH is the Commonwealth's only way to preserve Plaintiffs' Medicaid coverage. Plaintiffs' strong language aside, they cannot overcome the well-established rule that redressability does not exist where a plaintiff's ability to secure his or her desired relief is left to a state government. Nor can Plaintiffs establish an injury-in-fact from most, if not all, of Kentucky HEALTH.

On the merits, Plaintiffs do everything they can to undermine the deference due to the Secretary as well as his latitude to act. In a single footnote, they ask the Court to reject the Second and Third Circuits' appropriately deferential approach to Section 1115 waivers. They next make the long-shot argument that *Chevron* deference somehow does not apply here. They also try to tie the Secretary's hands by arguing that he can only consider the purposes of traditional Medicaid in considering a Section 1115 waiver for participants in expanded Medicaid. And they argue at length about what, in their biased views, the research and studies in the administrative record show, forgetting that it is the Secretary's judgment, not theirs or the Court's, that determines whether a Section 1115 waiver is justified. Plaintiffs' arguments should be rejected as an attempt to invalidate a program merely because they dislike it.

ARGUMENT[1]

I. Plaintiffs lack standing.

A. Plaintiffs' alleged injuries are not redressable by the Court.

Plaintiffs' rationale for why the Court can redress their alleged injuries is non-responsive to the Commonwealth's arguments. In its opening brief, the Commonwealth explained that Governor Bevin's January 12, 2018 executive order made this case an instance where another party exercises "broad and legitimate discretion the courts cannot presume either to control or to predict" over whether Plaintiffs continue to receive expanded Medicaid. *See Nyambal v. Mnuchin*, 245 F. Supp. 3d 217, 224 (D.D.C. 2017) (citation omitted). The Commonwealth cited binding case law in which courts have found redressability lacking because a state government possesses ultimate discretion over whether a plaintiff secures his or her desired relief. *See, e.g., Klamath Water Users Ass'n v. F.E.R.C.*, 534 F.3d 735, 740 (D.C. Cir. 2008).

Rather than try to distinguish this case law, Plaintiffs ignore it completely and posit that "injuries are redressable even if there is no guarantee that the plaintiff will ultimately receive the benefit in question due to a party's subsequent actions." (Pls.' Resp. at 8.) Plaintiffs' lead citation for this point, however, does not get them anywhere. In *Village of Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252 (1977), a developer wanted to develop multi-family housing, but the local government denied its zoning application. The Supreme Court determined that the developer had standing to challenge the denial, which was an "absolute barrier" to the housing project, even though the lawsuit would not "guarantee that [the housing project]

[1] The Commonwealth incorporates by reference the federal government's arguments regarding Counts 1 and 9 of Plaintiffs' complaint. Count 1, in any event, has no bearing on the legality of Kentucky HEALTH. In addition, the Commonwealth incorporates by reference the federal government's arguments against Plaintiffs' requested relief (ECF No. 51-1 at 50) while noting the effect of Governor Bevin's January 12 executive order on this issue.

will be built." *Id.* at 261. The developer, the Court explained, "would still have to secure financing, qualify for federal subsidies, and carry through with construction" before the housing would be built. *Id.* (footnote omitted). The Court concluded that these further steps did not render redressability too speculative given how "detailed and specific" the housing project was. *Id.* at 261–62.

Arlington Heights should not be applied here for at least three reasons. *First*, and most importantly, if the *Arlington Heights* developer secured its building permit, all further steps to completing the housing project were largely in the hands of the developer, who had demonstrated to the Court through its "detailed and specific" plan that it would do everything it could to complete the project. *See id.* That is to say, unlike here, if the developer succeeded in its lawsuit, it did not have to depend entirely on the discretion of a third party to secure its ultimate relief. Here, by contrast, whether or not Plaintiffs can keep their expanded Medicaid if they succeed depends entirely on the Commonwealth's decision about continuing to participate in expanded Medicaid. More to the point, no matter how much Plaintiffs want expanded Medicaid and no matter how hard they work to keep it, that ultimate decision is not up to them. That decision is Kentucky's to make. This simple point distinguishes *Arlington Heights* and brings this case within the rule applied in *Klamath Water Users Association*.

Second, Plaintiffs cannot establish that Kentucky HEALTH operates as an "absolute barrier" to their participation in expanded Medicaid. Whereas the plaintiff in *Arlington Heights* could not build the housing project without the Court's intervention, Plaintiffs here can receive Medicaid if they follow Kentucky HEALTH's applicable requirements. *See id.* at 261 ("If MHDC secures the relief it seeks, that barrier will be removed."). This simple fact, which demonstrates that Plaintiffs can get Medicaid without the Court's intervention, diminishes this lawsuit's

likelihood of redressing Plaintiffs' claimed injuries. *Arlington Heights*, then, was about the developer's lack of an opportunity to pursue a housing project, whereas at present Plaintiffs have the opportunity to secure Medicaid.

Third, and finally, *Arlington Heights*'s rationale turned in large part on the peculiarities of the housing market. In holding that it could not "guarantee" that the housing project would be completed, the Court observed that "all housing developments are subject to some extent to similar uncertainties." *Id.* This reasoning, which is specific to being a developer, has no equivalent here. Plaintiffs' ability to secure Medicaid is a function of Kentucky's Medicaid plan, not a series of uncertainties.

Plaintiffs' redressability theory also relies on *Teton Historic Aviation Foundation v. U.S. Department of Defense*, 785 F.3d 719 (D.C. Cir. 2015) (per curiam). There, a purchaser of aircraft parts sought to challenge agency decisions that made it "effectively impossible" to purchase surplus aircraft parts. *Id.* at 721. In arguing that the purchaser lacked standing, the federal government argued that another party had ultimate discretion over whether to sell the aircraft parts. *Id.* at 725. The Court nonetheless found that the plaintiff's injuries were redressable because "[t]he Department has routinely sold its surplus property to the public in the past and has a continued, substantial interest in the income such sales can generate." *Id.* Past practices, the D.C. Circuit held, demonstrated the requisite likelihood of future conduct. The same cannot be said here. Governor Bevin has made it unmistakably clear that Kentucky will withdraw from expanded Medicaid if this case ultimately succeeds in invaliding Kentucky HEALTH. In fact, he has given that conclusion the force of law. *See Klamath Water Users Ass'n*, 534 F.3d at 736 (finding no redressability where a state has "independent authority" over a matter and "has already held that it will not be bound by [the issue under consideration before the court]").

Plaintiffs imply that Governor Bevin cannot withdraw Kentucky from expanded Medicaid.[2] (Pls.' Resp. at 9–10.) Plaintiffs promise that if Governor Bevin's executive order takes effect, he "would certainly face a challenge that he cannot lawfully rescind Medicaid coverage for the mandatory expansion population." (*Id.* at 9.) This, in their view, makes it sufficiently likely that this lawsuit will redress their alleged injuries. But the possibility that Governor Bevin's executive order could be challenged and even invalidated in future litigation is far too speculative to confer standing to challenge Kentucky HEALTH in this lawsuit, as the Supreme Court has held in analogous contexts. *See Whitmore v. Arkansas*, 495 U.S. 149, 159–60 (1990) ("It is just not possible for a litigant to prove in advance that the judicial system will lead to any particular result in his case."); *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 413 (2013) ("In the past, we have been reluctant to endorse standing theories that require guesswork as to how independent decisionmakers will exercise their judgment"). In short, Plaintiffs cannot base redressability on the potential success of a yet-to-be-filed legal challenge to Governor Bevin's January 12 executive order.

[2] In pressing this position, Plaintiffs' only argument is that the ACA describes the expansion population as "mandatory," their implication being that expanded Medicaid somehow becomes forever mandatory once a state opts in. This is so, apparently, even for a state like Kentucky that expressly noted that its decision to participate in expanded Medicaid could be revoked. (ECF No. 50-3 at 2.) Under Plaintiffs' theory, however, a state that desires to leave expanded Medicaid faces the same unconstitutional choice invalidated in *NFIB*: "They must either accept a basic change in the nature of Medicaid, or risk losing all Medicaid funding." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012) (plurality opinion) ("States may choose to reject the expansion; that is the whole point . . . . Some States may indeed decline to participate . . . because they are unsure they will be able to afford their share of the new funding obligations . . . ."). The federal government cannot put Kentucky to that choice; nor does it appear that the federal government will do so. (*See* ECF No. 51-1 at 31 n.11.)

B. Plaintiffs have not established an injury-in-fact.

Plaintiffs' response does nothing to establish that they face an injury-in-fact that is "certainly impending and immediate" as opposed to "remote, speculative, conjectural, or hypothetical." *Food & Water Watch, Inc. v. Vilsack*, 808 F.3d 905, 914 (D.C. Cir. 2015) (citation omitted).

Redetermination and reporting requirements. Plaintiffs base their claimed injury from the redetermination and reporting requirements on the possibility that they could lose Medicaid coverage if they do not abide by these requirements. Virtually all of their worries center around the consequences of failing to report a change in income. (Pls.' Resp. at 7–8.) Plaintiffs act as if every time their paycheck goes up or down by a dollar, they have to report it. However, under Kentucky HEALTH, the only changes in income that must be reported are those that affect eligibility. (AR at 30 (stating that disenrollment will only occur if the failure to report "led to additional month(s) of Medicaid eligibility during which the member was not otherwise eligible").) For this reason, failing to report a fluctuation in income will only affect those who are no longer eligible for Medicaid coverage. It follows that the income-reporting requirements cannot injure Plaintiffs. Any Plaintiff who loses Medicaid coverage for failing to report a change in income will already be ineligible for Medicaid on account of his or her income.

Plaintiffs dismiss the Commonwealth's commonsense point that Plaintiffs' ability to comply with the redetermination and reporting requirements—something that was required of Plaintiffs *before* Kentucky HEALTH—undercuts their claim of an imminent injury. Plaintiffs fail to acknowledge the on-point case law that the Commonwealth cited for this proposition. In *Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992), the Supreme Court held that the concept of an imminent injury "has been stretched beyond the breaking point when, as here, the plaintiff alleges

only an injury at some indefinite future time, and *the acts necessary to make the injury happen are at least partly within the plaintiff's own control.*" *Id.* at 564 n.2 (emphasis added). The D.C. Circuit has twice applied this aspect of *Lujan*'s holding to find no standing where the likelihood of an injury turned at least in part on the plaintiff's own conduct. *See Animal Legal Def. Fund, Inc. v. Espy*, 29 F.3d 720, 725–26 (D.C. Cir. 1994) ("[T]he alleged injury is in large part contingent on the conduct of Fouts and his employing facility—if they design an adequate 'plan' that satisfies the USDA, no injury will ever come to pass."); *Animal Legal Def. Fund, Inc. v. Espy*, 23 F.3d 496, 500–01 (D.C. Cir. 1994) ("That choice has determined the present state of affairs, in which she suffers no injury and will not do so unless she makes a further choice to subject herself to it.").

Plaintiffs respond by arguing that "[t]he theoretical ability to comply with the law does not undermine a plaintiff's ability to challenge it." (Pls.' Resp. at 8.) Their primary case is the one allowing individuals to challenge the ACA's individual mandate even though they could comply with it. *See Mead v. Holder*, 766 F. Supp. 2d 16 (D.D.C. 2011). *Mead* is distinguishable for the simple reason that the plaintiffs there alleged that they *would not* comply with the law. *Id.* at 20 ("Plaintiffs are individual federal taxpayers who specifically allege that they can afford health insurance coverage, but that they have chosen not to participate in the past and do not wish to purchase it in the future."). Here, by contrast, Plaintiffs have merely speculated about whether they *can* comply with the reporting and redetermination requirements. This difference between refusing to comply with the law and worrying about whether compliance is possible distinguishes *Mead*. *See Espy*, 29 F.3d at 725–26 (finding no standing where plaintiff worried about his ability to comply with the law).

Plaintiffs' other favored case is similarly inapplicable. They cite *Oklahoma Department of Environmental Quality v. E.P.A.*, 740 F.3d 185, 190 (D.C. Cir. 2014), for the proposition that "[t]he

possibility of an alternative remedy, of uncertain availability and effect, does not render its injury self-inflicted." The D.C. Circuit so held because it was not convinced that the plaintiff's alternative remedy would secure its requested relief. *See id.* ("We do not think relief under SAFETEA is so certain or complete as to render Oklahoma's injury self-inflicted."). Here, by contrast, if Plaintiffs comply with the redetermination and reporting requirements, they will not lose their Medicaid coverage by virtue of their failure to comply with those requirements.

NEMT. For the waiver of NEMT, Plaintiffs argue that they have standing because "[s]everal Plaintiffs lack a driver's license and/or vehicle and do not have access to public transportation." (Pls.' Br. at 7.) That, however, does not equate to an injury-in-fact that is "certainly impending and immediate." *Food & Water Watch*, 808 F.3d at 914 (citation omitted). Plaintiffs do not even mention the sworn affidavit submitted by the Commonwealth demonstrating that, according to its records, none of Plaintiffs "has reported a claim for [NEMT] in the past." (ECF No. 50-4.) Plaintiffs' abstract worry that, at some undefined point in the future, they might use a benefit that they have not used in the past or even alleged that they likely will use in the future is not an actionable injury. *See Lujan*, 504 U.S. at 564 (finding no standing from "'some day' intentions—without any description of concrete plans, or indeed even any specification of *when* the some day will be").

Non-emergency use of emergency room. Plaintiffs argue that they have standing on this issue because they have "show[n] a substantial likelihood that they will be required to use the emergency room for sudden needs." (Pls.' Resp. at 6.) That confuses the inquiry. The issue is not recipients using the emergency room for "sudden needs," but recipients using the emergency room for non-emergency conditions. (*See* AR at 34.) As the Commonwealth has explained, Kentucky HEALTH requires recipients who present at an emergency room with a non-emergent condition

to be informed of "the name and location of an available and accessible alternative non-emergency services provider" before care is provided at the emergency room. *Id.* (incorporating 42 C.F.R. § 447.54(d)(2)). With good reason, Plaintiffs cannot explain why they will need non-emergency care at an emergency room after being told about an "available and accessible" provider. In addition, Plaintiffs fail to mention that their *My Rewards* account will not be reduced for going to the emergency room if they merely contact a 24-hour nurse hotline in advance. (*Id.*) Put simply, Plaintiffs have no theory for how this aspect of Kentucky HEALTH *as it actually will operate* creates a "certainly impending and immediate" risk of injury. *Food & Water Watch*, 808 F.3d at 914 (citation omitted).

Retroactive coverage. Plaintiffs' only argument for why they have standing to challenge the waiver of retroactive coverage is that it could lead to "gaps in coverage," which in turn could lead to services that are not covered by Medicaid. (Pls.' Resp. at 7–8.) But that purported injury depends on any number of what ifs, and an "attenuated chain of possibilities" cannot create an actionable injury. *In re Science Applications Int'l Corp. Backup Tape Data Theft Litig.*, 45 F. Supp. 3d 14, 24 (D.D.C. 2014). Before Kentucky HEALTH could lead to any gaps in coverage, a series of events, including being informed of a possible gap in coverage, must first occur. (Ky. Op. Br. at 8–9; AR at 29.)

Community-engagement and premium requirements. At this point, the Commonwealth does not know for certain whether any or all of Plaintiffs will be subject to the community-engagement and premium requirements. The Commonwealth will have a better understanding of this issue on or about June 11, 2018.

Regardless, Plaintiffs necessarily concede that they lack standing to challenge Kentucky HEALTH's community-engagement initiative. They acknowledge that the heart of their purported

injury is the possibility of losing Medicaid for failing to meet the "work requirements." (Pls.' Resp. at 6.) In so doing, they perpetuate the misleading narrative that Kentucky HEALTH imposes "work requirements." As the Commonwealth has already explained, its community-engagement program is not solely, or even mostly, a work program. (Ky. Op. Br. at 19–20.) To be sure, working 80 hours per month will satisfy Kentucky HEALTH. (AR at 42–43.) But so will any combination of the following—pursuing education or occupational training, looking for a job, volunteering, and participating in substance use disorder treatment, to name a few. (AR at 42.) Notwithstanding the numerous activities that will satisfy Kentucky HEALTH's community-engagement requirements, Plaintiffs' claimed injuries are mostly speculation about whether they can work 80 hours per month. (Pls.' Resp. at 6 (summarizing Plaintiffs' declarations about work concerns).) Plaintiffs have not alleged, for example, that they all cannot volunteer, pursue education, or look for a job. For this reason, Plaintiffs have essentially admitted that they lack standing to challenge the broader initiative, which extends well beyond simply working 80 hours each month.

II. Plaintiffs' attempts to second-guess the Secretary's judgment should be rejected.

The Commonwealth's opening brief devoted significant effort to explaining how the Court should approach Plaintiffs' arguments about the legality of Kentucky HEALTH. (*E.g.*, Ky. Op. Br. at 9–10.) In particular, Kentucky explained how, in considering a challenge to a Section 1115 waiver, both the Second and Third Circuits have asked whether the Secretary had a rational basis for concluding that the project likely assists in promoting the objectives of Medicaid. *See Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973); *C.K. v. N.J. Dep't of Health & Human Servs.*, 92 F.3d 171, 183 (3d Cir. 1996). Rather than address these two circuits' long-held views, Plaintiffs dismiss them and ask the Court to chart a different path, and *they do all of this in a single footnote*. The Second and Third Circuits, Plaintiffs argue, did not engage in the required analysis. But merely

saying this does not make it true. Plaintiffs make no effort to explain why Judge Friendly's studied analysis in *Aguayo* is wrong. Nor do they explain why the Third Circuit's opinion in *C.K.* is mistaken.

The closest that Plaintiffs come to explaining why *Aguayo* and *C.K.* should be rejected is their passing suggestion that, at the time *Aguayo* was decided, "HHS used technical review panels of outside experts who evaluated the research design and possible harmful effects of the experiment on its participants." (Pls.' Resp. at 27 n.10.) However, this issue did not come up in *Aguayo*. 473 F.2d at 1093–112. Nor was it mentioned in the underlying district court decision. *Aguayo v. Richardson*, 352 F. Supp. 462 (S.D.N.Y. 1972).[3] Moreover, Judge Friendly's decision in *Aguayo* upheld the Secretary's waiver under Section 1115 even though there was "no adversary hearing, no record, no statement of the grounds for the Secretary's action, except as these may be inferred from the papers on which he acted and from the largely unhelpful documents prepared specifically for this litigation." 473 F.2d at 1103 (footnote omitted). Clearly, the issue of "technical review panels" was not even on the Second Circuit's radar, much less part of its analysis.

In addition to ignoring *Aguayo* and *C.K.*, Plaintiffs urge that *Chevron* deference is not appropriate here. (Pls.' Resp. at 12.) Their alleged reason: this case involves an issue of "deep economic and political significance that is central to [a] statutory scheme." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (citation & internal quotation marks omitted). But *King* has no bearing

[3] In fact, at the time of *Aguayo*, a regulation regarding such "technical review panels" was not on the books, but merely was a "subregulatory policy." *See* Lucy Williams, *The Abuse of Section 1115 Waivers: Welfare Reform in Search of a Standard*, 12 Yale L. & Pol'y Rev. 8, 19 (1994). In addition, it is far from clear that this process was actually followed in *Aguayo*. *Cf. Crane v. Mathews*, 417 F. Supp. 532, 543 (N.D. Ga. 1976) ("The regulations only apply if a determination is made that the project in question involves human subjects. Although the regulations do not explicitly state who is to make the initial decision as to whether human subjects are involved, it appears from the regulations and the testimony at trial that the initial determination is made by the institution submitting the project application, subject to review by the Secretary of HEW.").

here. For one thing, Kentucky HEALTH does not involve a question of "deep economic and political significance that is central to [a] statutory scheme" in nearly the way that *King* did. Unlike the ACA, Kentucky HEALTH is a temporary waiver that only affects certain Kentuckians covered by expanded Medicaid. Moreover, even if this case does raise sufficiently important issues, *King* made clear that agencies still receive deference if Congress has given the agency discretion over the matter. *See id.* ("[H]ad Congress wished to assign that question to an agency, it surely would have done so expressly."); *Util. Air Regulatory Grp. v. E.P.A.*, 134 S. Ct. 2427, 2444 (2014) ("We expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'" (citation omitted)). Here, Congress directed that the determination of whether "any experimental, pilot, or demonstration project" is "likely to assist in promoting [Medicaid's] objectives" be made "*in the judgment of the Secretary*." 42 U.S.C. § 1315(a) (emphasis added). Through this "express delegation of specific interpretive authority," *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001), Congress manifested its intent that the Secretary's interpretation of Section 1115, and more specifically his interpretation of the objectives of Medicaid, should have the force of law. *See Pharm. Res. & Mfrs. Am. v. Thompson*, 362 F.3d 817, 821–22 (D.C. Cir. 2004).

Plaintiffs also continue to press the argument that the Secretary did something other than "waive compliance with any of the requirements of section . . . 1396a" in approving Kentucky HEALTH. Plaintiffs claim that the Secretary instead "wrote additional eligibility criteria into Section 1396a(a)(10)(A)." (Pls.' Resp. at 20.) However, Section 1115 as written permits the Secretary to waive "any" requirement of Section 1396a "*to the extent* . . . he finds necessary to enable such State or States to carry out" an "experimental, pilot, or demonstration project." 42 U.S.C. § 1315(a)(1) (emphasis added). This necessarily means that a state can create a project, as

Kentucky has done here, and the Secretary can waive any of the requirements of Section 1396a "to the extent" necessary to implement the project. Plaintiffs can cite no case law that has interpreted Section 1115 in any other way.

Plaintiffs also remain committed to *MCI Telecommunications Corp. v. American Telephone & Telegraph Co.*, 512 U.S. 218 (1994). To recap, that case dealt with a statute that allowed an agency to "modify any requirement" of the statute. *Id.* at 225. In its opening brief, the Commonwealth explained that the word "modify" drove the result in *MCI*, which means that *MCI* is of no value in discerning the scope of the Secretary's ability to "waive"—not modify—"compliance with any of the requirements of section . . . 1396a." Rather than admit this basic point, Plaintiffs accuse the Commonwealth of a "myopic[]" focus on the word "modify." The Court's opinion in *MCI*, it seems, is susceptible to that criticism as well, being that it contains at least 20 mentions of the word "modify." Same for the *MCI* dissent, which mentions the word 9 times. Plaintiffs nevertheless claim that *MCI*'s analysis went "beyond the word itself." (Pls.' Resp. at 21.) True, *MCI* said this, but the Court went "beyond the word itself" in a single paragraph merely to note a "further indication" that the word "'modify' does not contemplate fundamental changes," not to explain why the word "modify" was irrelevant to its analysis. 512 U.S. at 228–29.

III. Plaintiffs' arguments about the objectives of Medicaid are irreconcilable with Medicaid itself.

Plaintiffs' arguments about the objectives of Medicaid try to over-complicate a simple issue. According to Plaintiffs, the objectives of Medicaid for purposes of Section 1115 are listed in 42 U.S.C. § 1396-1 and that provision only. For starters, it is implausible to claim that the objectives of a program as complicated, intricate, and expansive as Medicaid can be distilled to only Section 1396-1's two sentences. Section 1115, moreover, does not cross-reference Section

1396-1. Nor does Section 1396-1 state that it sets forth the "objectives" of Medicaid for the purpose of Section 1115 or even generally. And Plaintiffs cannot cite a single case from any court anywhere holding that, for purposes of Section 1115, the Secretary must discern the objectives of Medicaid from Section 1396-1 and nothing else.

Plaintiffs nonetheless insist that Section 1396-1 is the end-all-be-all for the objectives of Medicaid. They primarily claim that Congress "did not create two programs"—*i.e.*, traditional Medicaid and expanded Medicaid. (Pls.' Resp. at 15.) However, as *NFIB* recognized, "the manner in which the expansion is structured indicates that while Congress may have styled the expansion a mere alteration to existing Medicaid, it recognized it was enlisting the States in *a new health care program*." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 584 (2012) (plurality opinion) (emphasis added). Plaintiffs' argument also runs headlong into the fact that Section 1396-1 does not mention those enrolled in expanded Medicaid. As Kentucky explained in its opening brief, Section 1396-1 as written only applies to "families with dependent children," the "aged," the "blind," and "disabled individuals." 42 U.S.C. § 1396-1; *see also NFIB*, 567 U.S. at 583 ("The original [Medicaid] program was designed to cover medical services for four particular categories of the needy . . . ."). Section 1396-1 therefore does not mention those covered by expanded Medicaid. It follows that this provision does not define the universe of objectives for expanded Medicaid or, at the very least, it is not an unreasonable reading of Section 1396-1 to so conclude.

Plaintiffs have no substantive response to the federal government's point that Section 1396-1 itself contemplates objectives other than those listed therein. Section 1396-1 appropriates "for each fiscal year a sum sufficient to carry out the purposes of this subchapter." 42 U.S.C. § 1396-1. This provision does not appropriate sums for only "the purposes" listed in Section 1396-1, but rather more broadly for "the purposes of this subchapter." By directing the reader to "this

subchapter" generally as opposed to Section 1396-1 specifically, Section 1396-1 conveys that it is not the final word on Medicaid's purposes. Plaintiffs' rebuttal to this argument is unavailing. They make much of the fact that Section 1396-1 "uses the definite article 'the' [before the word 'purposes'] to refer to the enumerated purposes that appear immediately prior." (Pls.' Resp. at 18.) But Section 1396-1 does not say "the purposes that appear immediately prior." It instead refers to "the purposes of this subchapter."

Plaintiffs try to play "gotcha" in arguing that the Secretary relied on Section 1396-1 and nothing else in approving Kentucky HEALTH. They thus assert that relying on anything other than Section 1396-1 is simply the Secretary's litigation position. (Pls.' Resp. at 16.) That argument cannot stand up to scrutiny. It is true that the January 12 approval of Kentucky HEALTH and the January 11 letter to State Medicaid Directors mentioned Section 1396-1. (AR at 5, 90.) But neither document claimed to rely on only Section 1396-1. In fact, both documents expressly disclaimed doing so. The January 12 approval mentioned Section 1396-1 only once as an additional basis for approving Kentucky HEALTH, noting that the policy goal underlying Kentucky HEALTH "*also* aligns with the authorizing language in [Section 1396-1], which cites attaining or retaining independence as one of the program's purposes." (AR at 5 (emphasis added).) The January 11 letter likewise discussed Section 1396-1 "separately" from the other objectives of Medicaid. (AR at 90.)

Plaintiffs also argue that the Secretary is claiming that he can "approve any policy that he subjectively concludes might influence health outcomes." (Pls.' Resp. at 18 (emphasis omitted).) The Secretary has not claimed such authority here. Instead, in ascertaining the objectives of Medicaid, the Secretary has carefully examined, among other things, the Medicaid Act as well as the health care needs and barriers of the Medicaid expansion population in Kentucky. By way of

example, the Secretary recognized that recipients of expanded Medicaid could use incentives to encourage healthy behavior. (AR at 4 ("During the first year of Kentucky's Medicaid expansion, fewer than 10 percent of beneficiaries received an annual wellness or physical exam.").) He also relied on the churn rate between Medicaid and private coverage. (*See* AR at 6 ("Kentucky's application noted the significant number of individuals estimated to move between Medicaid eligibility and Marketplace coverage.").) The Secretary also relied on the upside of increased community engagement for the able bodied. (AR at 4 ("Kentucky HEALTH's community engagement requirement is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that research has shown to be correlated with improved health and wellness."). In short, the Secretary has never claimed that the objectives of Medicaid are whatever he subjectively wants them to be. Instead, the Secretary has determined the objectives of Medicaid by, among other things, analyzing the Medicaid Act in connection with the health care issues facing the Medicaid expansion population in Kentucky.

Plaintiffs have no answer for the logical point that a permissible objective of Medicaid is preserving Medicaid. As the federal government noted, this objective is actually spelled out in Section 1396-1, which states that appropriations for Medicaid should enable a state "*as far as practicable under the conditions in such state*, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services" and so on. 42 U.S.C. § 1396-1 (emphasis added). The italicized portion of Section 1396-1 demonstrates that Congress recognized that even traditional Medicaid must take account of the situation in each individual state. Surely expanded Medicaid can do the same. Here, Kentucky has explained, and CMS has recognized, that Medicaid in Kentucky will suffer without Kentucky HEALTH. (AR at 7

("Kentucky's efforts should also help to promote the fiscal sustainability of the program to better protect services for the Commonwealth's most vulnerable.").) Plaintiffs have cited no case law for the illogical proposition that making Medicaid sustainable in Kentucky is not an objective of Medicaid. Nor can they counter the case law marshalled by the Commonwealth demonstrating that it is in fact an objective of Medicaid. *See Crane v. Mathews*, 417 F. Supp. 532, 540 (N.D. Ga. 1972); *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 496–97 (N.D. Cal. 1972); *see also Aguayo*, 473 F.2d at 1103.

IV. The Secretary had ample legal authority to approve Kentucky HEALTH.

Community-engagement requirements. Plaintiffs persist in arguing that Congress's failure to enact two bills that contain Medicaid work requirements different from Kentucky HEALTH's community-engagement program somehow signals that Congress does not think a community-engagement program can be part of a Section 1115 waiver. As the Commonwealth has explained, binding case law undermines Plaintiffs' reliance on legislative inaction as a tool of statutory interpretation. *See Solid Waste Agency of N. Cook Cnty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 156, 169–70 (2001). After being informed of this binding case law, Plaintiffs repeated their argument without citing any contrary authority. (Pls.' Resp. at 28.) They clearly lose here.

Plaintiffs offer a weak rebuttal to Kentucky's argument, which is supported by scholarly research, that states' use of Section 1115 waivers during the 1980s and 1990s contributed to Congress's passage of welfare reform in 1996 that included work requirements. (Ky. Op. Br. at 21.) Plaintiffs do not appear to dispute that Section 1115 waivers were a catalyst for the 1996 reforms. They instead argue that "AFDC is an entirely separate program from Medicaid, and it was created to achieve different ends." (Pls.' Resp. at 29.) But that misses the point. The point is

not the similarity of Medicaid and AFDC, but rather that states have tested public-benefits work requirements through Section 1115 before, and that led to lasting policy changes.

Plaintiffs double down on their narrative that this is the first time in Medicaid's "50-plus year history" that "work requirements" have been approved for Medicaid. (Pls.' Resp. at 29–30.) Putting aside that Kentucky HEALTH's community-engagement program is not a work program, there are good reasons why a community-engagement program has not been approved before now. (*See* Ky. Op. Br. at 22–26.) Primary among them is that expanded Medicaid did not take effect until 2014. This introduced an entirely different population into the Medicaid program—as relevant here, the able-bodied who are capable of community engagement. Thus, a community-engagement program only began to make sense in 2014.

Plaintiffs respond by noting that Kentucky HEALTH could apply to a member of a low-income family with dependent children, a population that was eligible for Medicaid before the Medicaid expansion. (Pls.' Resp. at 30.) Their point, it appears, is that the Secretary never approved a community-engagement program for this population before now even though this population received Medicaid before 2014. Kentucky HEALTH, however, exempts the primary caretaker of a dependent as well as those under the age of 19 from the community-engagement requirements. (AR at 42.) Consequently, Kentucky HEALTH's community-engagement program only applies to low-income, able-bodied, non-primary caretakers of a dependent, which means that there will be very few participants subject to Kentucky HEALTH's community-engagement requirements who were eligible for Medicaid prior to 2014. It would have made no sense for Kentucky to expend significant resources to create a community-engagement program for only this discrete population.

Plaintiffs also argue that the Secretary did not announce his change in policy on community-engagement requirements with sufficient clarity. (Pls.' Resp. at 30.) Plaintiffs essentially ask the Court to impose a magic-words requirement for an agency's change in position. Plaintiffs' lead citation itself rejects this notion, holding that an agency need only "display awareness that it is changing position." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (citation omitted); *see also Hermes Consol., LLC v. E.P.A.*, 787 F.3d 568, 576 (D.C. Cir. 2015) (finding this met where agency "acknowledged the change"). CMS displayed the requisite awareness here. It did not gloss over the Secretary's shift on community engagement. The January 12 approval recognized that "CMS has not previously approved a community engagement requirement as a condition of eligibility" and that "CMS has rejected similar proposals in the past." (*See* AR at 4, 8.) Similar statements were made in the January 11 letter to State Medicaid Directors. (AR at 92.) All of this establishes that the Secretary displayed awareness of his change.

Premiums. Plaintiffs' arguments about premiums are merely a reiteration of the arguments from their opening brief. They do not substantively respond to the following points from Kentucky's opening brief: (i) if the Secretary cannot waive limits on premiums, then his ability to waive Section 1396a(a)(14) is meaningless with respect to premiums; (ii) Section 1396o(f) does not apply to premiums and therefore does not affect Section 1115 as to premiums; (iii) Section 1396o(f)'s mention of "any waiver authority of the Secretary" expressly affirms the Secretary's ability to waive limits on premiums under Section 1115; and (iv) Section 1396o-1(B)(6)(b) underscores the Secretary's Section 1115 waiver authority.

The only one of Plaintiffs' arguments that merits a response is the assertion that Congress's enactment of Section 1396o demonstrated its intent to restrict the Secretary's ability to waive limits on premiums. But Plaintiffs' favored legislative history only concerns waiving limits on cost-

sharing. Plaintiffs obscure this point through an incomplete quotation of a legislative report. (Pls.' Resp. at 32.) They omit the first sentence of the following: "The Committee notes that a large number of States have sought waivers of current law relating *to the imposition of cost-sharing* under the demonstration authority at section 1115 of the Act. The Committee believes that this bill gives the States sufficient flexibility *in this regard* to make further exercise of the Secretary's demonstration authority unnecessary." H. Rep. 97-757, Pt. 1, at 6 (1982) (emphases added). Clearly, the excised first sentence gives meaning to the phrase "in this regard" in the second sentence—*i.e.*, it establishes that Section 1396o only affects Section 1115 as it relates to cost-sharing.

Non-emergency use of the emergency room. Plaintiffs' argument on this issue boils down to their belief that "'virtual dollars' function as 'actual money' for enrollees." (Pls.' Resp. at 35.) Their novel theory is that if Kentucky reduces the virtual dollars in an enrollee's *My Rewards* account, then in the future an enrollee will have to pay more for dental or eye care services. This notion of cost-sharing as less virtual money leading to paying more actual money would stretch cost-sharing beyond recognition. If accepted, anything that Kentucky does that indirectly increases the cost of health care for Medicaid recipients somewhere down the line becomes prohibited cost-sharing. For example, is the Commonwealth susceptible to a cost-sharing challenge by a recipient who pays for a bus fare because of the NEMT waiver? At a minimum, the Secretary's conclusion that cost-sharing does not include Plaintiffs' attenuated theory is entitled to *Chevron* deference.

V. The Secretary did not act arbitrarily and capriciously.

Community-engagement requirements. Plaintiffs' argument that the Secretary acted arbitrarily and capriciously in approving Kentucky HEALTH's community-engagement program reduces to their one-sided views about the evidence and studies in the administrative record. They

offer their interpretations of what "the literature does not show," what "nothing in the literature even comes close to suggesting," what "the literature highlights," and how to avoid a "selective and inaccurate reading of the relevant research." (Pls.' Resp. at 36–37.) This approach suffers from two fatal flaws (among many other problems). First, Section 1115 allows the Secretary—not Plaintiffs or the Court—to exercise "judgment" in deciding whether a project likely assists in advancing the objectives of Medicaid. Plaintiffs' invitation for the Court to become a social scientist is irreconcilable with Section 1115.

Second, Plaintiffs' argument about what the data regarding community engagement shows evidences a belief that the Secretary has to act with near certainty in approving a Section 1115 waiver. According to Plaintiffs, the Secretary must essentially know in advance, as demonstrated by research and studies, whether a project will in fact advance the objectives of Medicaid. Section 1115 itself refutes this assertion. It allows the Secretary to approve a program based on his "judgment," not on the best view of the available research and studies. 42 U.S.C. § 1315(a). It also allows the Secretary to approve a program that is "likely to assist in promoting"—not certain to promote or even certain to assist in promoting—the objectives of Medicaid. *Id.* And Section 1115 allows the Secretary to approve an "*experimental*, pilot, or demonstration project." *Id.* (emphasis added). One court summed up these aspects of Section 1115 as follows:

> Of course, it is possible that the Secretary could reasonably conclude that a project was likely to assist in promoting the objectives [of Medicaid], only to discover at the completion of the project that nothing of the sort, in fact, was accomplished. The requirements of § 1115 do not require certainty much less prescience, on the Secretary's part as to the results. Moreover, the experimental project which "fails" may well assist in promoting the objectives precisely by demonstrating what will not work, and what should therefore, be avoided in formulating the requirements for state plans.

Richardson, 348 F. Supp. at 497; *see also C.K.*, 92 F.3d at 187 ("[E]xperiments are supposed to demonstrate the failings or success of such programs.").

Plaintiffs next downplay the Secretary's reliance on particular aspects of Kentucky HEALTH that he concluded adequately addressed commenters' concerns about enrollees who lose coverage due to their failure to comply with the community-engagement requirements. (*See* Ky. Op. Br. at 28–29.) The Secretary did not respond to these commenters' concerns, according to Plaintiffs, because "Kentucky included many of these features in its initial application to CMS, meaning that commenters raised significant concerns about coverage losses despite these so-called protections." (Pls.' Resp. at 37–38.) According to Plaintiffs, the Secretary can only respond to comments by requiring changes to a state's waiver application. However, there is nothing wrong with the Secretary, as he did here, exercising his judgment to conclude that aspects of the state's application already addressed commenters' concerns. Unlike commenters, which frequently focus on discrete aspects of a waiver application, the Secretary looks at the application as a whole, asking whether its parts interact such that the project is "likely to assist in promoting" the objectives of Medicaid.

Premiums. Plaintiffs allege that the Commonwealth failed to "directly confront[]" the research on premiums. (Pls.' Resp. at 39.) Putting aside that the validity of a Section 1115 waiver does not turn on who in the Court's view has the best interpretation of the research, the Commonwealth took on the available research head on, discussing Indiana's experience with premiums at a granular level. (Ky. Op. Br. at 34–35.) That Plaintiffs and the Commonwealth dispute the meaning of Indiana's data is a reason for approving Kentucky HEALTH, not invalidating it.

Plaintiffs also minimize the Commonwealth's argument that many of Plaintiffs' favored studies are not in the administrative record. (*E.g.*, *id.* at 27.) The Commonwealth did not make this argument casually, but instead included case law from this Court that has so held. Plaintiffs,

however, dismissed this argument without so much as a legal citation. (Pls.' Resp. at 39.) According to Plaintiffs, merely because commenters cited and explained studies and research that are not in the administrative record, those studies and research are deemed part of the record. But how is the Secretary to determine whether commenters correctly explained the cited research? Presumably, he would have to locate the research himself. And how much of an explanation is enough to incorporate a study into the record? Is one paragraph enough or is more required? The rule previously applied by the Court, which avoids this uncertainty, is that "references to documents in the administrative record do not prove that the documents were 'before' the deciding agency." *Marcum v. Salazar*, 751 F. Supp. 2d 74, 80 (D.D.C. 2010); *Cape Hatteras Access Preservation Alliance v. U.S. Dep't of Interior*, 667 F. Supp. 2d 111, 114 (D.D.C. 2009) ("[T]he fact that some comments . . . mentioned the BiOp, does not mean that the BiOp itself was considered by FWS.").

Plaintiffs also claim that the Secretary cannot approve premiums as part of Kentucky HEALTH because premiums already have been tested in other states. As Plaintiffs put it, "the fact that these policies have been tested many times before defeats any argument that they retain any experimental value." (Pls.' Resp. at 42.) Here again, Plaintiffs forget that the Secretary approves an "experimental, pilot, or demonstration *project.*" 42 U.S.C. § 1315(a) (emphasis added). Plaintiffs cannot claim that the Secretary has previously approved a project like Kentucky HEALTH, which contains a unique combination of components specifically tailored to Kentucky's demographics and needs. (AR 4 ("Kentucky HEALTH is designed to address the unique challenges the Commonwealth is facing as it endeavors to maintain coverage and promote better health outcomes among its residents.").)

CONCLUSION

The Court should grant the Commonwealth's motion for summary judgment. Plaintiffs lack standing and, in any event, their objections to Kentucky HEALTH are mostly policy arguments that the Secretary, in his judgment, rejected.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on May 24, 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 following:

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