UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

CHARLES GRESHAM, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	
ALEX M. AZAR II, et al.,	)	No. 1:18-cv-01900-JEB
	)	
Defendants.	)	
	)	
STATE OF ARKANSAS	)	
	)	
Defendant-Intervenor	)	

PLAINTIFFS' MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

In *Stewart v. Azar*, this Court held that the Secretary of the Department of Health and Human Services violated the Administrative Procedure Act ("APA") by approving Kentucky's Medicaid waiver application without adequately considering whether it "would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." 313 F. Supp. 3d 237, 243 (D.D.C. 2018).

Now the Court considers a similarly deficient agency action—the Secretary's approval of the Arkansas Works Amendment. Like Kentucky, Arkansas requested permission to require low-income people to complete "work and community engagement" activities to maintain Medicaid eligibility and to limit retroactive Medicaid coverage. And, as he did when approving Kentucky's request, the Secretary "entirely failed to consider" whether the Arkansas Works Amendment would help the State furnish medical assistance to residents with limited incomes. *Id*. at 262. That is, he ignored substantial evidence in the administrative record indicating that the proposed Amendment would significantly *reduce* Medicaid coverage, rather than assist the State in furnishing medical assistance to its residents. Yet when faced with that evidence, the Secretary did not even attempt to make any "bottom-line estimate of how many people would lose" access to medical assistance. *Id.* Tellingly, in just the first two months of the State terminating individuals for non-compliance with the work requirement, over 8,400 Arkansans have lost Medicaid coverage—a number that will grow as the rollout of the Amendment continues.

What is more, in approving the Arkansas Works Amendment, the Secretary again exceeded his statutory authority. The purpose of Medicaid, specified by Congress in the statute itself, is to enable states, as far as practicable, 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. The Secretary may "waive" certain

Medicaid requirements only for experimental projects that are likely to promote the objectives of the Medicaid Act. 42 U.S.C. § 1315(a). That simply cannot be said of the Arkansas Works Amendment.

In the end, it is transparent that the Federal Defendants ("Defendants") granted the Amendment not to promote the objectives of Medicaid, but to "fundamentally transform" the Medicaid program through agency action. They have issued a State Medicaid Director Letter announcing a new policy establishing requirements for states that wish to condition medical assistance on compliance with work requirements, with minimal evidence for how work requirements will further Medicaid's purpose. And, Defendants have unilaterally rewritten the objectives of the Medicaid Act to include the a-textual policy goals of "help[ing] individuals and families rise out of poverty and attain independence," AR 0074, "promot[ing] responsible decision-making," AR 0084, and "encouraging movement up the economic ladder, and facilitating transitions from [Medicaid]" to private coverage. AR 2057. Defendants have no statutory authority to change the Medicaid program's objectives. That is Congress's job.

Defendants thus have overstepped their authority under the Social Security Act and failed to adequately support or explain their approval of the Arkansas Works Amendment. Summary judgment should be granted in Plaintiffs' favor on their APA claims.[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 any agency action constitutes "reasoned decisionmaking." *Stewart*, 313 F. Supp. at 259 (quoting *Michigan v. EPA*, 135 S. Ct. 2699, 2706 (2015)). This means that the agency must have

[1] Plaintiffs do not seek summary judgment on their constitutional claim, which they believe is more than sufficient to overcome a motion to dismiss.

"examine[d] all relevant factors and record evidence," *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. 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, 42-43 (1983) (internal quotation marks omitted). Courts "do not defer to the agency's conclusory or unsupported suppositions." *United Techs. Corp. v. U.S. Dep't of Def.*, 601 F.3d 557, 563 (D.C. Cir. 2010) (internal quotation marks and citation omitted). Similarly, "[s]tating that a factor was considered . . . is not a substitute for considering it." *Getty v. Fed. Savs. & Loan Ins. Corp.*, 805 F. 2d 1050, 1055 (D.C. Cir. 1986).

As this Court has recognized, "[s]ummary judgment is the proper mechanism for deciding, as a matter of law, whether an agency action is supported by the administrative record and consistent with the [APA] standard of review." *Stewart*, 313 F. Supp. 3d at 249 (citations omitted).

STATEMENT OF FACTS

I. The Federal Medicaid Program

The Social Security Act establishes a number of 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 enacted 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. Medical assistance is "payment of part or all of the cost of . . . care and services or the care and services themselves, or both. . . ." *Id.* § 1396d(a) (listing the care and services states must or can cover).

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" or "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. 42 U.S.C. §§ 1396a, 1316(a)(1); 42 C.F.R. § 430.10.

The Medicaid Act describes the population groups that are eligible to receive medical assistance. 42 U.S.C. §§ 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 all 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, 583 (2012); *see also id*. ("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. *Id*. at 585. However, this population group continues to be described in the Medicaid Act as a mandatory coverage group. To date, 34 states have approved state plans covering the expansion population. Arkansas 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).

Since its enactment, the Medicaid Act has required 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, 435.912(c)(3). States must use a streamlined process to determine initial and ongoing eligibility for Medicaid, 42 U.S.C. § 18083, and applicants must be

able to file streamlined eligibility forms online, in person, by mail, or by telephone. *Id*. § 18083(b)(1)(A); *see also id*. § 1396w-3; 42 C.F.R. §§ 435.907(a), 435.908(a). Through so-called "presumptive" eligibility, the Medicaid Act gives states a mechanism to provide immediate, temporary coverage to individuals who appear to their health provider to meet the eligibility requirements based on preliminary information. 42 U.S.C. § 1396a(a)(47). The ACA amended the Medicaid Act to require states to allow qualified hospitals to provide presumptive eligibility to their patients. *See* Pub. L. No. 111-148, 124 Stat. 119, 291, § 2202 (codified at 42 U.S.C. § 1396a(a)(47)(B)). In addition, 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).

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 to allow a state to implement an "experimental, pilot, or demonstration" project. *Id*. § 1315(a); *see also* 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); H.R. Rep. No. 97-3982, pt. 2 at 307-08 (1981). Under this authority, the Secretary may approve only an experimental project 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 also 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."). As

described above, the central purpose of the Medicaid program 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; *Stewart*, 313 F. Supp. 3d at 260.

If the Secretary determines that a proposed project meets the above criteria, the Secretary may waive compliance *only* with the requirements of Section 1396a of the Medicaid Act and *only* to the extent and for the period necessary to enable the state to carry out the experiment. *Id*. § 1315(a)(1). The costs of such an approved Section 1115 project are then regarded as Medicaid expenditures under the state plan. *Id*. § 1315(a)(2).

III. Medicaid Expansion in Arkansas

Arkansas expanded its Medicaid program to include the expansion population, effective January 1, 2014. It did so through a Section 1115 project called the "Arkansas Health Care Independence Program" ("HCIP"), an experiment to provide medical assistance through a private health plan, with the Medicaid program covering the individual's portion of the premiums and cost sharing. *See* Letter from Marilyn Tavenner, Admin., Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Ark. Dep't of Human Servs. (Sept. 27, 2013), https://bit.ly/2afNzLQ (approving HCIP through December 31, 2016).

In 2014 and 2015, more than 225,000 individuals received medical assistance through HCIP. Ark. Ctr. for Health Improvement, *Ark. Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report* 16, 21 (2016), http://bit.ly/2qpPNjU. During that same time period, Arkansas saw "a reduction in the uninsured rate for adults from 22.5 percent to 9.6 percent, the largest reduction observed nationwide." *Id*. at 20.

Medicaid expansion in Arkansas has been associated with a variety of positive health outcomes, including increased utilization of preventive services, out-patient office visits, and

chronic disease care; decreased reliance on emergency rooms; fewer skipped medications due to cost; better quality care; and improved self-reported health. *See* 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), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420. Plaintiffs in this case illustrate the positive gains achieved through Medicaid expansion. With Medicaid coverage, Plaintiffs have been able to access valuable and even lifesaving health care. They have also gained a measure of financial stability. *See, e.g.*, Gresham Decl. ¶¶ 7-8, 14-15; McGonigal Decl. ¶¶ 3, 6-7, 13-14; Cesar Ardon Decl. ¶¶ 6-7, 17-19; Watson Decl. ¶¶ 6-7, 10-12; Robinson Decl. ¶¶ 7-8, 11-13; Deyo Decl. ¶ 5.

In mid-2016, Arkansas requested permission from HHS to extend and amend HCIP, renaming the project "Arkansas Works." The Secretary extended the Section 1115 project through the end of 2021 and also approved several of the proposed amendments. AR 0904-43. Most notably, the Secretary granted Arkansas a conditional waiver of retroactive eligibility, which permitted the State to implement the waiver only if it demonstrated compliance with the following conditions: (1) provide Medicaid coverage during a reasonable period to individuals who are otherwise eligible for Medicaid and attest to eligible immigration status, while they verify their immigration status, as required under 42 U.S.C. § 1320b-7(d); (2) complete a Mitigation Plan to address backlogs in processing Medicaid applications and provide written assurance to the Secretary that "eligibility determinations and redeterminations are completed on a timely basis;" and (3) allow qualified hospitals to enroll their patients in Medicaid through presumptive eligibility, as required under 42 U.S.C. § 1396a(a)(47)(B). AR 0908, 0917-18. Arkansas agreed to

the conditions; however, it did not implement hospital presumptive eligibility. *See* State of Ark. Ans. ¶ 63.

In early 2017, the Trump administration began its efforts to, in its own words, 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://wapo.st/2DirehA. 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 sent a letter to state Governors announcing the Centers for Medicare & Medicaid Services' ("CMS") disagreement with the purpose and objectives of the ACA. Sec'y U.S. Dep't Health & Human Servs., Dear Governor Letter, http://bit.ly/2zvx2zV. Despite Congress's clear directive in passing the ACA, Defendant Verma stated 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." AR 0085. 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.[2]

[2] *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://go.cms.gov/2SFu1ph (declaring that the 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 waiver projects that contain work requirements); *The Future Of: Healthcare*, Wall St. J. (Nov. 10, 2017), https://on.wsj.com/2AI1vMI (declaring Medicaid expansion a "major, fundamental flaw[]" and announcing CMS's efforts to "fundamentally transform Medicaid" and "restructure the

Against this backdrop, Governor Hutchinson submitted a request to the Secretary to amend Arkansas Works. AR 2057. The State asked for permission to impose a work and community engagement requirement, to require individuals to report compliance with the requirement online, and to eliminate retroactive coverage, among other changes. *Id.* The Governor stated that the Amendment was designed to "promot[e] personal responsibility and work, encourage[e] movement up the economic ladder, and facilitate[e] transitions from Arkansas Works" to private coverage. *Id*. He said the changes would better position Arkansas Works to focus on "the most vulnerable enrollees." *Id*. The Amendment did not provide an estimate of the number of individuals who would lose coverage as a result of the work requirement and associated online reporting requirement. Likewise, Arkansas did not indicate the number of individuals who would incur medical costs due to the waiver of retroactive coverage or the amount of those costs.

CMS held a public comment period on the Arkansas Works Amendment from July 11, 2017 to August 10, 2017. On January 11, 2018, well after the federal comment period for the Arkansas Works Amendment had closed, CMS issued a State Medicaid Director letter ("SMD Letter") announcing a "new policy" to "Promote Work and Community Engagement Among Medicaid Beneficiaries." AR 0074. The policy established guidelines for states wanting to "make participation in work or other community engagement a requirement for continued Medicaid eligibility." *Id*. It outlined several program features that states have since adhered to and HHS has used as the checklist for waiver approval.

The very next day, the Secretary applied the "new policy" for the first time, approving Kentucky's request to implement a work requirement. Letter from Demetrios L. Kouzoukas,

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Medicaid program"); Seema Verma, *Lawmakers have a rare chance to transform Medicaid. They should take it*, Wash. Post (June 27, 2017), https://wapo.st/2AJeZbg.

Principal Dep Adm'r, Ctrs. for Medicare & Medicaid Servs. to Stephen P. Miller, Comm'r, Ky. Cabinet for Health & Family Servs., (Jan. 12, 2018) (attached as Exhibit 1, Ky. Approval). On February 1, 2018, the Secretary applied the SMD Letter for a second time, approving Indiana's request to implement a work requirement. Letter from Demetrios Kouzoukas, Principal Dep. Adm'r., Ctrs. for Medicare & Medicaid Servs. to Allison Taylor, Medicaid Dir., Ind. Family & Soc. Servs. Admin. (Feb. 1, 2018), http://bit.ly/2EZcMfO ("Ind. Approval").

Then, on March 5, 2018, the Secretary approved the Arkansas Works Amendment. AR 0001. Again, pointing to the policy announced in the SMD Letter, the Secretary gave Arkansas permission to implement a work requirement on June 1, 2018. AR 0002-03. Under the work requirement, individuals ages 19 to 49 must engage in 80 hours of specified work activities each month to maintain eligibility for Medicaid coverage. AR 0028. If they do not meet the work requirement for any three months of the year, the State will terminate their coverage and prohibit them from re-enrolling in the program for the remainder of the calendar year. AR 0030-31.[3]

Defendants approved the work requirement "based on [their] determination that it is likely to assist in promoting the objectives of the Medicaid program." AR 0003. Specifically, the Secretary described the "ultimate objective" of the work requirement as "improving health and well-being for Medicaid beneficiaries." AR 0002; *see also* AR 0003 (approval will allow "the state to test whether coupling the requirement for certain beneficiaries to engage in and report work or other community engagement activities with meaningful incentives to encourage compliance will lead to improved health outcomes and greater independence"); 0004 (work requirement "is designed to encourage beneficiaries to obtain and maintain employment or undertake other

[3] For example, people who are terminated from the program at the end of March 2019 cannot re-enroll until 2020, leaving them without medical assistance for nine months.

community engagement activities that research has shown to be correlated with improved health and wellness" as noted in the SMD Letter).

The Secretary approved Arkansas's request to limit individuals to online reporting, meaning they cannot report work hours or seek an exemption from the work requirement by telephone, mail, or in person at their county Department of Human Services office. AR 0010, 0029. Nothing in the approval letter outlined his rationale for granting that request. The Secretary also authorized Arkansas to waive three-month retroactive coverage and limit it to one month, explicitly retracting the condition that Arkansas implement hospital presumptive eligibility. AR 0003, 0005. The approval letter described the shift as "[c]onsistent with CMS's commitment to support states in their efforts to align Medicaid and private insurance policies for non-disabled adults to help them prepare for private coverage." AR 0005. The Secretary added that the waiver of retroactive coverage "is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick with the ultimate objective of improving beneficiary health." *Id*.

Arkansas began implementing the work requirement in June 2018 for individuals ages 30 to 49. The State phased in those individuals in four separate groups over a period of four months. Beginning in January 2019, the State will implement the work requirement in a similar way for individuals ages 19 to 29. Ark. Works Eligibility and Enrollment Monitoring Plan, ECF No. 26-3, at 6-8.

To date, approximately one-quarter of all individuals subject to the work requirement have failed to meet it each month. More precisely, the overwhelming majority—82 percent—of individuals who had to report their work hours or seek an exemption in September 2018 did not do so. And, on August 31, 2018, the first date on which individuals could lose coverage, Arkansas

terminated more than 4,300 individuals from Medicaid for non-compliance. On September 30, 2018, Arkansas terminated an additional 4,100 individuals. At that time, an additional 4,800 people had accrued two months of noncompliance, placing them at risk of termination on October 31, 2018. *See* Arkansas Works Program June-September 2018 Reports, ECF No. 26-4.[4]

The Arkansas Works Amendment is harming thousands of people, including Plaintiffs, who have lost or are at risk of losing Medicaid coverage when they cannot find or maintain work or submit monthly reports as required. Plaintiffs anticipate that, as they did before they enrolled in Medicaid, they will incur medical bills they cannot afford to pay. Or, they will forego the care they need to stay healthy, causing their quality of life to diminish. *See, e.g.*, Gresham Decl. ¶¶ 7-8,14-15 ("Without coverage, my medical conditions will get worse and eventually put me in the ground."); McGonigal Decl. ¶¶ 9-10, 13-14 ("Losing my coverage caused my health conditions to worsen. Even off work, I struggle with the COPD."); Cook Decl. ¶¶ 7-9, 11-12 ("If you lose one thing, you lose everything. It's like a chain reaction . . . Not having health insurance makes it harder."); Deyo Decl. ¶¶ 13-16 ("I need access to my doctors and medications for there to be any hope of me getting better and working again.").

ARGUMENT

As part of their campaign to "explode" the Medicaid expansion, Defendants, working closely with Arkansas, have misused Section 1115 to fundamentally alter the design and purpose of Medicaid. *See* note 2, *supra*. In approving the Arkansas Work Amendment, the Secretary exceeded his authority. *See Clean Air Council v. Pruitt*, 862 F.3d 1, 9 (D.C. Cir. 2017) ("[I]t is 'axiomatic' that 'administrative agencies may act only pursuant to authority delegated to them by Congress'") (quoting *Verizon v. FCC*, 740 F.3d 623, 632 (D.C. Cir. 2014)). Section 1115 does not

[4] Arkansas has not released data indicating the number of individuals who lost coverage as a result of not meeting the work requirement in October 2018.

permit the Secretary to rewrite the objectives of the Medicaid program in an effort to transform it from a program to furnish medical assistance to a work program. And even if it did, the Secretary neglected his statutory duty to adequately analyze how the Arkansas Works Amendment would affect coverage. Among other things, he failed to assess "whether the project would cause recipients to lose coverage . . . [or] . . . whether the project would help promote coverage." *Stewart*, 313 F. Supp. 3d at 262; *see also Newton-Nations v. Betlach*, 660 F.3d 370, 381-82 (9th Cir. 2011); *Beno v. Shalala*, 30 F.3d 1057, 1074 (9th Cir. 1994). The Secretary compounded his errors by authorizing the State to limit individuals to online-only reporting and to terminate three-month retroactive coverage. These federal Medicaid requirements exist outside of Section 1396a and thus are not waivable under Section 1115. Finally, the Secretary improperly implemented work and community engagement requirements on the basis of a State Medicaid Director Letter that is arbitrary and capricious and was not subjected to the required notice and comment procedures.

In sum, if the Secretary and Arkansas want to radically restructure the decades-old Medicaid program, then they must secure the consent of Congress. It is not for them to achieve that end by administrative fiat. Plaintiffs therefore are entitled to summary judgment on their APA claims.

I. The Secretary Cannot Fundamentally Restructure Medicaid by Rewriting the Objectives of the Act.

Congress expressly listed 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. The Medicaid Act defines "medical assistance" as "payment of part or

all of the cost of the following care and services or the care and services themselves, or both . . . ." *Id*. § 1396d(a). Thus, Congress created the Medicaid program to enable states, as far as practicable, to furnish health care coverage to people who cannot otherwise afford it. This Court has held as much. *See Stewart*, 313 F. Supp. 3d at 260-61 (discussing what it means to furnish medical assistance and concluding that "the purpose of [M]edicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it") (quoting *W. Va. Univ. Hosp., Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989)).[5]

In approving the Arkansas Works Amendment, the Secretary purported to advance an entirely different set of objectives. The Secretary justified the Amendment by stating that the work and community engagement requirement would "lead to improved health outcomes and greater independence," AR 0003, and "help individuals and families rise out of poverty and attain independence" AR 0074; *see also* AR 0085-86.[6] Those, however, are not the objectives Congress identified.

As the Court pointed out in *Stewart*, the Secretary's reasoning is "little more than a sleight of hand" that "impermissibly conflate[s]" improved health outcomes with Medicaid's stated purpose of furnishing medical assistance and rehabilitation and other services. *Stewart*, 313 F. Supp. 3d at 265. "Put another way, this focus on health is no substitute for considering Medicaid's central concern: covering health costs." *Id*. And, while improving health outcomes might be a desirable *result* of furnishing medical assistance, the Secretary has no authority to "choose his own

[5] The Court has also determined that the objectives of Medicaid apply with equal force to both traditional Medicaid eligibility groups and the expansion population. *Stewart*, 313 F. Supp. 3d at 269.

[6] Arkansas described similar goals for the Amendment, stating that it would "promot[e] personal responsibility and work, encourage[e] movement up the economic ladder, and facilitat[e] transitions from Arkansas Works" to private coverage. AR 2057.

means to that end." *Id.* at 266-67 (citing *Waterkeeper Alliance v. EPA*, 853 F.3d 527, 535 (D.C. Cir. 2017) ("Agencies are . . . bound not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes."). "To the extent Congress sought to 'promote health' and 'well-being' here, it chose a specific method: covering the costs of medical services. *Stewart*, 313 F. Supp. 3d at 267. Defendants may believe that mechanisms other than furnishing medical assistance are more effective at improving health outcomes, but they must nevertheless abide by the choices Congress made. *See Americans for Clean Energy v. Envt'l Prot. Agency*, 864 F.3d 691, 712 (D.C. Cir. 2017) ("[T]he fact that EPA thinks a statute would work better if tweaked does not give EPA the right to amend the statute."); *see also Stewart*, 313 F. Supp. 3d 267 (noting that Congress was also concerned with "making healthcare more affordable" for low-income individuals).

Permitting Defendants' broad reading of Medicaid's objectives would lead to absurd outcomes. If Defendants were correct, Section 1115 would permit the Secretary to approve *any* policy that he subjectively concludes might influence health outcomes. For instance, the Secretary could authorize states to require individuals to adopt a vegetarian, low-carb diet as a condition of eligibility because such diets could lead to positive health outcomes. *See Stewart*, 313 F. Supp. 3d at 267-68. An interpretation that rests on such expansive and nebulous concepts would allow the Secretary to expand his own authority to include areas governed by other statutes and other agencies (*e.g.*, housing, environmental regulations, or workplace safety standards—all of which likely have stronger correlations with "health outcomes" than the work and reporting requirements and limits on retroactive coverage at issue in this case). *Cf. Food & Drug Admin. v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 161 (2000) ("[An] agency's power to regulate in the public interest must always be grounded in a valid grant of authority from Congress. And in our

anxiety to effectuate the congressional purpose of protecting the public, we must take care not to extend the scope of the statute beyond the point where Congress indicated it would stop.") (internal quotation marks and alterations omitted).

Nor can Defendants salvage their misguided approval by asserting that the Arkansas Works Amendment will help 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 claim) "financial" independence. To the contrary, in the context of a clause that requires coverage of "rehabilitative services" to help Medicaid enrollees 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" and "economic self-sufficiency" cannot be squared with the sentence as a whole. AR 0004, 0223; s*ee 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"). As the Court previously stated, "[t]he [Medicaid Act] text . . . quite clearly limits its objectives to helping States furnish rehabilitation and other services that might promote self-care and independence. It does not follow that limiting access to medical assistance would further the same end." *Stewart*, 313 F. Supp. 3d at 271.

Ultimately, Defendants are free to disagree with Congress amending the Medicaid Act to provide medical assistance to additional low-income individuals. But, they must nevertheless abide

by the choices Congress made. *See, e.g.*, *Waterkeeper Alliance*, 853 F.3d at 535. Defendants' attempt to rewrite the objectives of the Medicaid Act usurps these legislative choices.

II. Approval of the Arkansas Works Amendment is Arbitrary and Capricious and Exceeds Statutory Authority.

To avoid vacatur, the administrative record must demonstrate that the Secretary reasonably concluded that the Arkansas Works Amendment is a valid experiment that is likely to assist in promoting the objectives of the Medicaid Act. 42 U.S.C. § 1315(a); *Beno*, 30 F.3d at 1069; *Newton-Nations*, 660 F.3d at 380. The record does no such thing. Rather, it reveals that the Secretary "entirely failed to consider" whether the Arkansas Works Amendment "would help provide health coverage for Medicaid beneficiaries." *Stewart*, 313 F. Supp. 3d at 262. Alternative rationales offered by the Secretary for approving the Amendment do not withstand even minimal scrutiny. Moreover, even if the Secretary had not failed to address this most "salient factor," *id*. at 261, he lacked the statutory authority to approve each feature of the Amendment.

A. The Secretary Failed to Adequately Examine If the Arkansas Works Amendment Met the Section 1115 Conditions.

1. The Secretary Ignored Evidence Indicating That the Amendment Would Result in Substantial Coverage Loss and Did Not Reasonably Conclude It Would Promote Coverage.

The Secretary failed to adequately analyze whether the Amendment "would cause recipients to *lose* coverage [and] whether the project would help *promote* coverage." *Stewart*, 313 F. Supp. 3d at 262. Multiple commenters stated that the Arkansas Works Amendment would reduce coverage. *See* A.R. 1268, 1269-73, 1278-79, 1281-88, 1290-92, 1294, 1302-04, 1307-08 1311-15, 1319-21, 1326-29, 1334-39, 1340-41. With respect to the work requirements, comments highlighted that most Arkansas Works enrollees are already working, but due to the nature of low-

wage jobs, not all consistently work 80 hours every month.[7] *See, e.g.*, AR 1269, 1312-13.[8] Commenters also stated that many low-income Arkansans do not have access to transportation, making it difficult for them to work additional hours or complete work-related activities. *See, e.g.*, AR 1286, 1308.

Other comments noted that the administrative burden associated with reporting hours worked or seeking an exemption from the work requirement will cause individuals to lose coverage. AR 1315 (every requirement to report or verify a change makes individuals more likely to lose benefits), 1311 (reducing unnecessary steps is important for accessing and retaining benefits), 1326-27 (administrative burden and short exemption periods will lead to coverage loss), 1329 (administrative issues will lead to terminations), 1270 (administrative barriers in Arkansas have caused terminations in the past), 1313 (burden of understanding requirements and seeking exemption will be challenging for people "people struggling with an overload of demands on their time and executive functioning capacities").

[7] Comments also raised concerns about the interaction between the work requirement and the Fair Labor Standards Act. AR 1287. Nothing in the record indicates that Defendants addressed this issue.

[8] These comments are supported with citations to research, including Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (finding the majority of adults under age 65 whose Medicaid eligibility is not based on disability are already working); Susan J. Lambert et al., Univ. of Chicago, *Precarious Work Schedules among Early-Career Employees in the USA*: *National Snapshot*, (2014), https://www.researchgate.net/publication/267037950_Precarious_Work_Schedules_among_Early-Career_Employees_in_the_US_A_National_Snapshot; Stephanie Luce et al., Retain Action Project, *Short Shifted* (2014), http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits* (2015), https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf.

In particular, comments highlighted that the online-only reporting requirement would be especially problematic and add to the administrative burden for the many beneficiaries who do not have easy access to the internet. *See, e.g.*, AR 1287, 1292, 1308, 1336.[9] Without home internet access, individuals must rely on facilities with public internet access, like libraries or local government offices, and those facilities are often not accessible to individuals where and when they need them. AR 1292, 1336.

Comments also warned that the possible annual nine-month lockout penalty for failure to comply with the work requirements would create significant gaps in coverage. *See, e.g.*, AR 1270, 1278-79 (stating lockouts block coverage and are antithetical to Medicaid's purpose), 1292, 1294, 1312-14, 1320, 1338.[10]

Commenters noted that coverage losses would be particularly high among subsets of the Arkansas Works population, citing the difficulties individuals with chronic conditions—including

[9] These comments are supported with citations to research, including Victoria Rideout & Vikki Katz, The Joan Ganz Cooney Ctr., *Opportunity for All? Technology and Learning in Lower-Income Families* (2016); Fed. Commc'ns Comm., *Connecting America: The National Broadband Plan*, https://transition.fcc.gov/national-broadband-plan/national-broadband-plan.pdf (last visited Nov. 5, 2018) (highlighting National Broadband Report finding about 20% of Arkansas counties have broadband available in 50% or fewer households, with 28% of counties having 50-70% of households with broadband internet available, at 19, and that low-income households and rural residents are left behind in terms of access to broadband internet, at 167).

[10] These comments cited research documenting the negative effects of even short coverage disruptions, including Jennifer Hayley & Stephen Zuckerman, Kaiser Family Found., *Is Lack of Coverage A Short or Long-Term Condition?* (2013), https://www.kff.org/uninsured/issue-brief/is-lack-of-coverage-a-short-or/; Matthew J. Carlson et al., *Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results from a Prospective Cohort Study of the Oregon Health Plan*, 4 Annals Fam. Med. no. 5 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1578659/; Andrew Bindman et al., *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 Annals of Internal Med. 854 (2008) (finding interruptions in Medicaid coverage was associated with higher risk of hospitalization, which was costly for the state and avoidable); Lewin Group, *Health Indiana Plan 2.0: POWER Account Contribution Assessment*, 22-23 (2017) (showing individuals locked out of Medicaid are likely to remain uninsured and report higher barriers to care).

those that do not prevent someone from working altogether—will have in meeting the work requirements. *See* AR 1292, 1313, 1294-95, 1335 1326, 1270;[11] *see also* AR 1417-18. Other organizations cited the impact of coverage loss on individuals ages 19 and 20, who stand to lose robust Medicaid screening, diagnostic, and treatment benefits. AR 1270, 1304. Commenters also noted that the work requirements would likely have a disproportionate impact on people in rural communities, which commonly have fewer jobs and higher poverty rates and are harder hit in times of economic downturns. *See, e.g.*, AR 1326.

Numerous commenters also indicated the obvious—waiving retroactive coverage will create gaps in coverage and ultimately reduce access to Medicaid services by discouraging providers from participating in the program. *See, e.g.*, AR 1297-99, 1307, 1320, 1338-39. Commenters highlighted the particular importance of hospital presumptive eligibility in ensuring access to coverage. *See* AR 1271-72, 1328, 1307.

Although the Secretary generally acknowledged concerns raised about "disruptions in care," AR 0007, for several reasons his response to those concerns "is no answer at all." *Stewart*,

[11] These comments are supported with citations to research showing that in other public benefits programs, individuals with a disability are not exempted from work requirements as they should be and are more likely to lose benefits. *See, e.g.*, Hannah Katch, Ctr. on Budget & Policy Priorities, *Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment* (2016), https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly; Andrew J. Cherlin et. al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 Soc. Serv. Rev. 387, 398 (2002) (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health"); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 Soc. Serv. Rev. 199 (2008), https://academiccommons.columbia.edu/doi/10.7916/D8MW2SXZ; Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004) (Departmental Paper University of Pennsylvania School of Social Policy and Practice), https://repository.upenn.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1028&context=spp_papers; Ohio Ass'n of Foodbanks, *Comprehensive Report: Able-Bodied Adults without Dependents* (2015).

313 F. Supp. 3d at 263. First, the Secretary cited the exemptions from the work requirement for certain populations. AR 0007. But, Arkansas had included these exemptions in its waiver application, meaning commenters expressed their concerns about coverage losses *even though* those exemptions exist. In fact, commenters criticized the exemptions as "not an effective way to alleviate the harm of a work requirement." *See* AR 1286-87, 1336.[12] The Secretary did not even attempt to address any of these concerns.

Second, the Secretary pointed to "an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements." AR 0007. Arkansas included that same assurance in its waiver application. AR 2107. Providing assurance that the State will inform Arkansas Works beneficiaries about the work requirements does nothing to address commenters' concerns that individuals will be unable to meet them. Thus, the Secretary "failed to consider an important aspect of the problem." *Stewart*, 313 F. Supp. 3d at 264 (citing *Motor Vehicle Mfrs.*, 463 U.S. at 43).

Arkansas provided the Secretary with preliminary information about the size of the population that could be subject to the work requirements (over 120,000 "Young Able-Bodied Childless Adults").[13] Despite the unrefuted evidence in the record indicating that the Arkansas Works Amendments would reduce Medicaid coverage, the Secretary never used that information to identify "a bottom-line estimate of how many people would lose Medicaid" with the

[12] Similarly, in response to comments warning that individuals with chronic conditions will be particularly likely to lose coverage, the Secretary stated that "[t]o mitigate these concerns," Arkansas will provide individuals with "reasonable modifications." AR 0006. However, existing federal ant-discrimination laws already require Arkansas to provide such "reasonable modifications," and commenters were well aware of that fact. *See, e.g.*, AR 1336 at n. 24.

[13] Arkansas only estimated the number of Arkansas Works beneficiaries earning less than 100% FPL. AR 0649. As approved, the work requirement applies to a much larger population, as it also includes individuals with incomes 100 to 138% FPL. AR 0022.

Amendment in place. *Stewart*, 313 F. Supp. 3d at 262. So far, the work requirement alone puts that number at 8,462.

The Secretary also failed to identify how the Arkansas Amendment would promote coverage. Just as with the now-vacated Kentucky approval, the Secretary pointed to only one way in which the waiver application could possibly promote coverage. Once again, in a single conclusory sentence, he claimed that the waiver of the required three months of retroactive eligibility will "encourage[] beneficiaries to obtain and maintain health coverage, even when they are healthy." AR 0008. "This sort of 'conclusory' reference cannot suffice, 'especially when viewed in light of' an obvious counterargument." *Stewart*, 313 F. Supp. 3d at 265 (quoting *Getty v. Fed. Sav. & Loan Ins. Corp.*, 805 F.2d 1050, 1057 (D.C. Cir. 1986)). The comments document strong counterarguments based in evidence and experience that the waiver will decrease coverage, create coverage gaps, harm providers, diminish access to providers, and put low-income Arkansans at risk of negative health outcomes and crushing medical debt. *See, e.g.*, AR 1288, 1328. The idea that *withholding* coverage and services will promote the *furnishing* of coverage and services is nonsensical.

Not only did the Secretary neglect to explain how the Amendment would promote coverage, but he also did not explain his rationale for reversing course and granting Arkansas an unconditional waiver of the retroactive coverage requirement. *See* AR 0008, 0071. A little over one year earlier, CMS took the position that Arkansas could not waive retroactive coverage unless and until it met three conditions. AR 0908. Although the Secretary appeared to indicate that Arkansas satisfied the conditions, he expressly eliminated one of them, removing the condition that Arkansas implement hospital presumptive eligibility. AR 0003, 0005, 0008, 0071, 0073; *see also* 42 U.S.C. § 1396a(a)(47)(B). Despite knowing that Arkansas was failing to implement

hospital presumptive eligibility, the Secretary provided scant justification for retracting the requirement, saying only that it was "[c]onsistent with CMS's commitment to support states in their efforts to align Medicaid and private insurance policies for non-disabled adults to help them prepare for private coverage." AR 0005. However, preparation for the private insurance market is not an objective of the Medicaid program. Moreover, the Secretary did not explain why he found hospital presumptive eligibility to be a necessary safeguard in 2016, but not in 2018. Even assuming for argument's sake that retroactive coverage could be waived, this "unexplained inconsistency" in agency position with respect to a waiver of retroactive coverage in Arkansas was arbitrary and capricious. *Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005); *see also Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (finding agency "fell short of [its] duty to explain why it deemed it necessary to overrule its previous position" when it "offered barely any explanation"). The lack of explanation is particularly arbitrary given the comments in the administrative record noting the importance of hospital presumptive eligibility in mitigating the damage caused by any waiver of retroactive coverage. *See, e.g.*, AR 1271-72, 1307, 1328.

2. The Secretary Could Not Have Reasonably Concluded that the Amendment Would Further His Preferred Alternative Objectives for the Medicaid Program.

Instead of examining whether the Arkansas Works Amendments would promote the State's ability to furnish medical assistance, the Secretary evaluated the waiver application with alternative objectives in mind. Defendants considered whether the Amendment would "assist in improving health outcomes," "address behavioral and social factors that influence health outcomes," and "incentivize beneficiaries to engage in their own health care and achieve better health outcomes." AR 0004, 0006; *see also* AR 0074-76 (claiming that work requirements are designed to improve health outcomes and promote independence). As the Court already pointed

out, such a "focus on health is no substitute for considering Medicaid's central concern: covering health costs." *Stewart*, 313 F. Supp. 3d at 266; *see also id.* at 271 (noting the Secretary's stated goal of promoting financial independence and expressing "doubts whether such an objective is proper"). Even if it were proper for the Secretary to have considered his alternative objectives, he did not reasonably determine that the Arkansas Works Amendment was likely, on balance, to improve health outcomes and financial independence among low-income Arkansans, including those who will lose Medicaid coverage.

a. The work and community engagement requirement

The Secretary granted Kentucky permission to require individuals ages 19 to 49 to complete work-related activities (including work, community service, job search, job training, and other education) for 80 hours every month. AR 0002, 0027-36. If individuals who are subject to the requirement do not comply for any three months of the year, the State will terminate their coverage and lock them out of the program for the remainder of the calendar year. AR 0030-31.

Defendants' conclusion that the work requirement will improve health and financial outcomes is based on a selective and inaccurate reading of the administrative record. *See* AR 0004, 0006; *see also* AR 0074-76. First, the literature Defendants cited does not show that working causes individuals' health to improve.[14] Rather, it highlights the fact that people need to be healthy to work, and working in low-wage, low-status jobs—the jobs largely available to Medicaid enrollees in Arkansas—can have a negative effect on health and well-being. *See, e.g.*, AR 1686-

[14] *See, e.g.*, AR 2031-48 (healthier people may be more inclined to volunteer and the causal "direction of effects" between health and community service is unclear), 1686-92 (noting possible "overestimation of the findings" since health impacts likelihood of entering or leaving work), 1693-99 ("causal direction of the relationship" between mental health and work is "not clear," since having mental health condition makes it "harder to land a job"), 2025-30 ("individuals may be more likely to be found in a disadvantaged social position [such as without a job] because of their health difficulties").

92. More fundamentally, nothing in the literature even comes close to suggesting that requiring individuals to work or complete work-related activities as a condition of maintaining their health coverage will improve health outcomes. *Cf.* AR 1791 (summarizing research showing that when benefits are disallowed, many people do not find work, their income falls, and they feel their health remains unchanged or gets worse).

Second, even assuming that a stable job causes an improvement in overall health, the comments and research in the record indicate that work requirements like those approved here do not help people obtain stable jobs; rather, they have increased poverty and financial insecurity. *See, e.g.*, AR 1269, 1285-86, 1303-04, 1336, 1341, 1277, 1327, 1416-21.[15] Nothing in the record indicates that CMS even considered this evidence. Similarly, nothing in the record shows that CMS wrestled with the research in the record concluding that Medicaid coverage itself is a work support, making it easier for people to find and maintain work. *See, e.g.*, AR 1314, 1285, 1304, 1335, 1419.[16]

Third, CMS approved the work requirement with the conclusory statement that "the overall health benefits to the [a]ffected population through community engagement outweigh the health-

[15] These comments are supported with citations to research, including LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. Pol'y Analysis & Mgmt. 231 (2016); Pamela Loprest & Austin Nichols, Urban Inst., *Dynamics of Being Disconnected from Work and TANF* (2011), https://www.urban.org/sites/default/files/publication/27521/412393-Dynamics-of-Being-Disconnected-from-Work-and-TANF.PDF; Gayle Hamilton et al., MDRC, *National Evaluation of Welfare-to-Work Strategies; How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs* (2001).

[16] These comments are supported with citations to research, including Ohio Dep't of Medicaid, Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly (2017), http://medicaid.ohio.gove/Portals/0/Resources/Reports/Annual/Group-VII-Assessment.pdf; Renuka Tipirneni et al., Univ. of Michigan, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, (2017), http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches).

risks with respect to those who fail to respond and who fail to seek exemption from the programs limited requirements." AR 0007. The evidence in the record directly contradicts that statement. Comments raised significant concerns about the health of individuals who do not meet the work requirements and lose health coverage. *See, e.g.*, AR 1265-66 (American Heart Association and American Stroke Association pointing to research showing that individuals with cardiovascular conditions who lack health insurance or are underinsured have worse health outcomes, including higher death rates than their insured counterparts), 1295 (Cystic Fibrosis Foundation noting negative health consequences associated with interruptions in coverage for people with cystic fibrosis), 1320 (American Cancer Society noting negative health consequences associated with interruptions in coverage for cancer patients and cancer survivors), 1276 (American Congress of Obstetricians and Gynecologists highlighting that coverage loss will harm women and increase rate of unintended pregnancies), 1311-14 (citing research finding that people without coverage are less likely to have regular care, more likely to be hospitalized for avoidable health problems and to experience declines in overall health and that insurance coverage improves a wide range of health outcomes), 1304 (noting that loss of coverage will likely lead to deterioration in health, especially for people with common chronic conditions, and to increased use of the emergency room), 1270 & 1304 (raising concerns about the health effects on young adults ages 19 and 20).[17]

Faced with such cumulative and unrebutted evidence, the Secretary made no attempt to estimate the number of individuals who would lose coverage for failure to comply with the work

[17] These comments are supported with citations to research, including Kaiser Family Found., *Key Facts About the Uninsured Population* (2017), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/; Benjamin D. Sommers, et al., *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 New England. J. Med. 586 (2017), https://www.nejm.org/doi/pdf/10.1056/NEJMsb1706645. *See also* note 10, *supra*.

requirement, and he made no effort to grapple with the magnitude of the health consequences that those individuals would suffer as a direct result of his approval. *See generally* AR 0001-09. In other words, the Secretary failed to weigh any benefits of the work requirement against the costs, rendering his decision to approve the requirement arbitrary and capricious.

b. Retroactive coverage

Similarly, Defendants did not rationally conclude that limiting retroactive coverage would lead to improved health and increased financial stability among low-income Arkansans. Defendants claim that the waiver would give enrollees an incentive to obtain and maintain health coverage even when healthy, thereby reducing gaps in coverage, increasing continuity of care, and improving health outcomes. AR 0005, 0008. Yet Defendants point to no evidence that low-income individuals decide not to enroll in Medicaid because they are healthy or that eliminating retroactive coverage will reduce coverage gaps.

In fact, Congress enacted retroactive coverage in part to help those who do not know they are eligible for Medicaid coverage. *See Cohen ex rel. Cohen v. Quern*, 608 F. Supp. 1324, 1332 (N.D. Ill. 1984) (noting the purpose of retroactive coverage is to protect individuals "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") (quoting H. Rep. No. 92-231, 92d Cong., 2d Sess., *reprinted in* [1972] U.S. Code Cong. & Ad. News 4989, 5099); S. Rep. No. 92-1230 at 209 (Sept. 26, 1972), http://bit.ly/2P9HU0O; *see also* Amends. to the Soc. Sec. Act 1969-1972: Hrg. on H.R. 17550 Before the S. Comm. on Fin., 91st Cong. 1262 (1970) (stmt. of Elliot L. Richardson, Sec'y, Dep't of Health, Edu., & Welfare) (indicating Congress also wanted to encourage providers to "furnish necessary medical assistance and ensure financial protection to otherwise eligible persons

during the retroactive period"); *Blanchard v. Forrest*, 71 F.3d 1163, 1167 (5th Cir. 1996) (affirming purpose of retroactive eligibility provisions "is to make Medicaid coverage during this period just as effective as it would have been if the individual had already been certified for Medicaid"). Commenters also raised the purpose and function of retroactive coverage and that people are unaware of their eligibility for Medicaid. *See, e.g.*, AR 1297.

What is more, Defendants failed to address substantial evidence in the record indicating that limiting retroactive coverage will create gaps in coverage, decrease continuity of care, and lead to worse overall health outcomes. *See, e.g.*, AR 1307 (Arkansas Hospital Association requesting at least two months of retroactive coverage), 1320. Similarly, as described in Section II.A.1. above, the agency failed to address evidence in the record showing that retroactive coverage itself promotes financial well-being among low-income individuals; comments make clear that removal of retroactive coverage will increase medical debt and bankruptcy and damage the credit of Arkansas Works enrollees. *See, e.g.*, AR 1267, 1307, 1288, 1292, 1298.[18]

B. The Secretary Lacks the Authority to Approve the Arkansas Works Amendment.

When an agency exercises discretion using the wrong legal standard, the agency action must fall. *See SEC v. Chenery Corp.*, 318 U.S. 80, 94 (1943) ("[A]n [agency] order may not stand if the agency has misconceived the law."). That has happened here. The Secretary used Section 1115 of the Social Security Act to approve the Arkansas Works Amendment. But, Section 1115 does not authorize HHS to grant that approval. It does not allow the Secretary to apply his own

[18] Notably, commenters also warned that the waiver would increase financial losses for those who provide Medicaid-covered services to eligible persons and could weaken the provider network serving the Medicaid population, decreasing access to care. *See, e.g.*, AR, 1288 (waiver of retroactive coverage will lead to increased uncompensated care costs and declining provider participation), 1297-99 (describing adverse impact of waiver on providers), 1338-39 (role of retroactive coverage in provider financial stability and Medicaid program participation).

alternative objectives for the Medicaid program, and it does not allow him to modify the Medicaid Act to add a new eligibility requirement, namely work and community engagement. In addition, under Section 1115, the Secretary does not have the authority to require online-only reporting of work activities or to waive three-month retroactive coverage, both of which are mandated in provisions outside of Section 1396a.

1. The Secretary Lacks the Authority to Approve Work Requirements.

In approving the work requirements, the Secretary exceeded his authority under Section 1115. For the reasons stated above, the provision does not allow the Defendants to rewrite the objectives of the Medicaid Act, transforming Medicaid from a program to ensure that the poorest Americans receive health insurance into a work program. *See* pp. 14-18, *supra*. And, the text and history of the Social Security Act make clear that such a transformation is a job for Congress, not the agency.

In the text of Section 1115, Congress gave the Secretary narrow, limited authority to alter the Medicaid program. The Secretary may only "waive compliance" with certain provisions of the Medicaid Act. *See* 42 U.S.C. § 1315(a). The term "waive" is unambiguous: It means "[t]o refrain from insisting on (a strict rule, formality, etc.); to forgo." Black's Law Dictionary (10th ed. 2014). It does not include the authority to fundamentally modify, amend, or change statutory provisions. Authorizing a policy *creating* new, mandatory work requirements cannot in any way be understood as a *waiver* of compliance with an existing condition or requirement of coverage under the Medicaid Act. *See Syed v. M-I, LLC*, 853 F.3d 492, 502 (9th Cir. 2017) ("To authorize is to 'grant authority or power to.' *American Heritage Dictionary* 120. To waive is to 'give up ... voluntarily' or 'relinquish.' *Id.* at 1947. Authorization bestows, whereas waiver abdicates.").

The remaining text of Section 1115 further constrains the Secretary's authority to "waive compliance"—permitting a waiver only for an "experimental, pilot, or demonstration project" that is likely to promote Medicaid objectives. Nothing in Section 1115 thus suggests a broad agency authority to "transform" or "restructure" the scheme Congress has enacted via waiver approvals that completely rewrite Medicaid's requirements. "[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, 2444 (2014)). In fact, it is well-settled that Congress does not implicitly or in ancillary provisions give agencies the authority to transform statutes. *See MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 231 (1994) (finding that "[i]t is highly unlikely that Congress would leave" an "essential characteristic" of the statutory scheme "to agency discretion—and even more unlikely that it would achieve that through such a subtle device as permission to 'modify' [statutory] requirements"); *Cyan, Inc. v. Beaver Cty. Emps. Ret. Fund.*, 138 S. Ct. 1061, 1071 (2018) ("Congress does not hide elephants in mouseholes.") (internal quotation marks and citations omitted).

And here, time and again, Congress has made its intent clear—Medicaid is a medical assistance program, not a work program. First, the statutes governing TANF (which is also part of the Social Security Act) and SNAP expressly authorize work requirements, while the Medicaid Act does not. *Compare* 42 U.S.C. § 607 (requiring states to ensure that most TANF recipients engage in "work activities" and that TANF benefits will be reduced or terminated if an individual does not engage in the work activities) *and* 7 U.S.C. § 2015(d), (o) (requiring individuals to meet work requirements as a condition of participation in SNAP) *with* 42 U.S.C. § 1396a(a)(10) (requiring states to provide medical assistance to individuals who meet the criteria listed). This difference shows that Congress knows how to include work requirements in a program and choose

not to include them in Medicaid. *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 marks omitted)); *Jama v. Immigration & Customs Enf't*, 543 U.S. 335, 341 (2005) (same). Moreover, Congress did not just permit work requirements in SNAP and TANF; it prescribed detailed regimes outlining their nature and scope, including how they would balance against other congressional policy priorities, such as minimum wage and nondiscrimination protections. *See, e.g.*, 42 U.S.C. § 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 detailed regimes reveal that the nature and scope of any work requirement is a policy decision that must be left to Congress in the first instance.

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, but has not done so. For example, when Congress repealed AFDC in favor of TANF in 1996, it amended Medicaid's Section 1396u to maintain consistency for certain joint TANF/Medicaid recipients, including by allowing states to terminate the Medicaid benefits of individuals—and only those individuals—who had their TANF benefits terminated for failure to comply with TANF's work requirements. 42 U.S.C. § 1396u-1(b)(3)(A). At that time, Congress could have

amended the Medicaid Act to permit work requirements for non-TANF recipients, but did not. That is revealing. It is fundamental that where a statute "expressly describes a particular situation to which it shall apply, what was omitted or excluded was intended to be omitted or excluded." *Teles AG v. Kappos*, 846 F. Supp. 2d 102, 111 (D.D.C. 2012) (quoting *Reyes–Gaona v. N.C. Growers Ass'n*, 250 F.3d 861, 865 (4th Cir. 2001)); *see also Leatherman v. Tarrant Cty. Narcotics Intelligence & Coordination Unit*, 507 U.S. 163, 168 (1993). Here, the fact that Congress allows states to terminate Medicaid eligibility based upon a failure to meet work requirements in one limited circumstance provides a clear indication that Congress did not intend for states to have that same power in all circumstances.

Moreover, Congress has explicitly rejected recent efforts to add a work requirement to the Medicaid program. *See* American Health Care Act, H.R. 1628, 115th Cong., § 117 (2017) (proposing to amend Section 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) (proposing to amend Section 1396a to require states to "condition medical assistance . . . upon . . . an individual's satisfaction of a work requirement").

In short, Section 1115 does not permit the Secretary to circumvent the will of Congress and add work requirements to the Medicaid program, particularly when Congress itself has consistently refrained from doing so. Defendants cannot seek refuge from that basic fact through a plea for deference. Prior to 2017, in the 50-plus years of Medicaid, CMS had neither authorized nor approved a work requirement as a condition of Medicaid eligibility. Instead, HHS has consistently *denied* states' requests, recognizing that work requirements "could undermine access

to care" and are therefore not consistent with the purposes of Medicaid.[19] The agency's prior interpretation of work requirements as *outside* its own Section 1115 waiver authority indeed undermines any plea for deference here. *See United States v. Nat'l Ass'n of Sec. Dealers, Inc.*, 422 U.S. 694, 717 (1975). And 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. *Brown & Williamson Tobacco*, 529 U.S. at 144. Accordingly, the Secretary lacks statutory authority to allow Arkansas to condition eligibility for Medicaid on work or completion of work-related activities.

2. The Secretary Lacks the Authority to Approve the Online-Only Reporting Requirement.

As part of the ACA, Congress added a provision to the Social Security Act requiring that states allow individuals to apply for and continue participation in Medicaid through forms that "may be filed online, in person, by mail or by telephone." Pub. L. No. 111-148, § 1413(b)(1)(A)(ii) (codified at 42 U.S.C. §§ 18083(a), (b)(1)(A)(ii)). Such forms must be "structured to maximize an

[19] Lettter from Sylvia M. Burwell, Sec'y U.S. Dep't Health & Human Servs. to Asa Hutchinson, Gov. Ark. (April 5, 2016), ECF No. 26-5; Letter from Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs., HHS to Thomas Betlach, Dir. Az. Health Care Cost Containment Sys. (Sept. 30, 2016), http://bit.ly/2PHb0Ek (hereinafter "Letter to Thomas Betlach"); *see also* Letter from Vikki Wachino, Dir., Ctrs. for Medicare & Medicaid Servs., 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 had previously denied a work requirement request from Indiana. *See* CMS.Gov, *CMS and Indiana Agree on Medicaid Expansion* (Jan. 27, 2015), https://www.cms.gov/newsroom/press-releases/cms-and-indiana-agree-medicaid-expansion (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), https://www.kff.org.medicaid/fact-sheet/medicaid-expansion-in-pennsylvania/.

applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify." 42 U.S.C. § 18083(b)(1)((A)(iv). The ACA incorporated these requirements into the Medicaid Act, 42 U.S.C. § 1396w-3, and duly promulgated regulations reflect the same. *See* Pub. L. No. 111-148, §2201 (codified at 42 U.S.C. § 1396w-3); 42 C.F.R. §§ 435.907(a), 435.908(a). These laws help ensure that medical assistance "will be provided[] in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

In approving of the Arkansas Works Amendment, the Secretary allowed the State to evade these requirements and limit recipients to using *only* an online portal for reporting monthly work activities or exemptions. The Secretary admits this limitation is inconsistent with Medicaid law, but claims that Section 1115(a)(2) creates an independent "expenditure authority" that allows him to approve and fund it. AR 0010. This interpretation flatly misreads the statute. Section 1115(a)(2) does not give the Secretary an independent, unlimited power to ignore, waive, impose, or re-write Medicaid program features willy-nilly. It merely provides for federal reimbursement of necessary expenditures for a project that *already* qualifies for a waiver.

Section 1115 allows the Secretary to approve experimental projects that are likely to promote the objectives of the Medicaid Act. For such projects, the Secretary may

> (1) . . . waive compliance with any of the requirements of . . . 1396a of this title, . . . to the extent and for the period he finds necessary to enable such State or States to carry out such project, *and*
>
> (2)(A) costs of such project which would not otherwise be included as expenditures under section . . .1396b of this title, . . .shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate.

42 U.S.C. § 1315(a) (emphasis added). By its very terms, the statute authorizes one waiver process. "By using the conjunction 'and,' Congress intended for all of the requirements of the statute to be fulfilled." *Comtec, Inc. v. Nat'l Technical Sch.*, 711 F. Supp. 522, 524 (D. Ariz. 1989); *see also Ortiz v. Sec'y of Def.*, 41 F.3d 738, 742 (D.C. Cir. 1994) (stating that use of the conjunction "and" means that *both* provisions of the regulation must be satisfied). Put another way, Section 1115(a)(1) provides the Secretary with a limited authority to approve experimental projects that waive (and allow the state to ignore) otherwise mandatory state plan requirements of Section 1396a. *And*, Section 1115(a)(2)(A) provides the budgetary housekeeping tool that brings the costs of these projects under the state's Medicaid plan, thus qualifying them for federal funds. Section 1115 provides no authority for the Secretary to establish independent, freestanding "expenditure" programs untethered from the Medicaid Act provisions. *See* 42 U.S.C. § 1315(a); *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1097 (9th Cir. 2005) ("Section 1115 does not establish a new, independent funding source."). Thus, demonstration projects must meet all the requirements of Section 1115(a).

The Secretary cannot authorize states to ignore requirements outside of Section 1396a. An online-only reporting requirement, by the Secretary's own account, is inconsistent with federal requirements that exist outside of Section 1396a and require states to maximize the avenues for individuals to submit information to the Medicaid agency. The online-only policy also ignores requirements of 42 U.S.C. § 1396a(a)(19), a provision that was not waived, and that require states to operate their Medicaid programs using safeguards that will ensure that eligibility is provided "in a manner consistent with simplicity of administration and the best interests of the recipients." The Secretary, therefore, is not authorized to allow Arkansas to restrict individuals only to online reporting of monthly work activities or exemptions.

3. The Secretary Lacks the Authority to Waive Retroactive Coverage.

In approving the Arkansas Works Amendment, the Secretary improperly permitted Arkansas to waive the requirement to provide three months of retroactive coverage. AR 0003, 0012. Such approval exceeded his authority.

As noted, Section 1115 only permits the Secretary to waive Medicaid Act requirements that appear in Section 1396a. *See* 42 U.S.C. § 1315(a)(1). Section 1396a(a)(34), which the Secretary waived, requires states to extend coverage for up to three months before the month a person submits an application, provided the person was otherwise eligible for Medicaid during that time. *See* 42 U.S.C. § 1396a(a)(34). The Medicaid Act, however, also separately mandates retroactive coverage through provisions independent of Section 1396a(a)(34). Specifically, the statute obligates states to "provide – for making *medical assistance* available" to individuals who meet the federal eligibility requirements. *Id.* § 1396a(a)(10) (emphasis added). And, the statute defines "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). Combined, these two provisions also require states to provide retroactive coverage.

The Secretary did not waive Section 1396a(a)(10) to allow the State to eliminate retroactive coverage for medical assistance. In addition, he could not, and did not purport to, waive Section 1396d(a). Waiving the retroactive coverage requirement under Section 1396a(a)(34) did not implicitly or automatically waive the obligation as provided for in the other sections of the Medicaid Act. Accordingly, regardless of the approval of the waiver of Section 1396a(a)(34), the three-month retroactive coverage requirement remains in effect and still protects Arkansas Works enrollees, separate and apart from Section 1396a(a)(34).

III. The State Medicaid Director Letter Violates the Administrative Procedure Act.

On January 11, 2018, CMS issued a State Medicaid Director Letter that reversed its longstanding policy against conditioning medical assistance on work and community engagement. The SMD Letter also identified the requirements for states wanting to impose work requirements. Although the SMD Letter characterized these requirements as "considerations for states," CMS has consistently used the Letter as the basis for deciding states' waiver requests. AR 0074. CMS's decision to authorize work requirements in the SMD Letter was arbitrary and capricious under the APA, for the same reasons described in Section II., above. Moreover, CMS failed to follow the notice-and-comment procedures required under the APA for a substantive rule, which is exactly what the SMD Letter implements. *See* 5 U.S.C. § 553(b), (c). Thus, the SMD Letter violates the APA and must be vacated.

A. The SMD Letter's Authorization of Work Requirements Is Arbitrary and Capricious.

The SMD Letter violates the APA's ban on arbitrary and capricious action. In the Letter, CMS did not provide any logical reasoning to conclude that work requirements advance the objectives of Medicaid, failed to discuss any alternatives to implementing work requirements for achieving those objectives, and insufficiently explained the about-face from its longstanding stance against work requirements.

The SMD Letter provides inadequate support for this wholesale policy change. Its high-level focus on the benefits of work ignores the obvious distinction between the demonstrated benefits of having a stable job and the unsupported conclusion that withholding or terminating health insurance coverage for individuals who do not work a sufficient number of hours will yield the same benefits. AR 0075-76. Indeed, none of the "authorities" cited in the SMD Letter address work requirements or come close to supporting them. For example, two of the "authorities" focus

on the benefits of volunteering—*i.e.*, something done *voluntarily*. AR 0075 & nn.8-9. As discussed in Section II.A.2. above, these studies do not provide reasons why a no-work-no-coverage *requirement* will capture equivalent health benefits.

CMS also failed to mention any alternative course of action that the agency considered. "[F]ail[ure] to provide any explanation for [the agency's] implicit rejection of alternatives . . . or to consider such alternatives" is arbitrary and capricious. *Int'l Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 815 (D.C. Cir. 1983). While the SMD 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," it does not explain why that approach was ineffective or insufficient. AR 0075. Undoubtedly, an agency need not consider and explain "every alternative device and thought conceivable by the mind of man." *Motor Vehicle Mfrs.*, 463 U.S. at 51. But nowhere in the SMD Letter does CMS weigh any of the many obvious and compelling alternatives to the authorization of work requirements. *See Donovan*, 722 F.2d at 817 (agency's failure to consider options "specifically mentioned" to the agency or that are "an obvious response" was arbitrary and capricious). "[S]uch an artificial narrowing of options is antithetical to reasoned decisionmaking and cannot be upheld." *Id.* at 817 (internal quotation marks omitted).

Defendants also failed to discharge their "duty to explain why [they] deemed it necessary to overrule [their] previous position" on work requirements. *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 Stations, 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). CMS failed to do so here.

Rather than confront the scope of their actions as the APA requires, Defendants instead downplayed the SMD Letter as a mere "shift from prior agency policy" on work requirements. AR 0076. But the Letter is a complete repudiation of the agency's longstanding position. Until this year, Defendants had *never* approved a Medicaid waiver application containing a mandatory work requirement. The agency's longstanding position was simple: Work requirements jeopardize access to health 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." Sylvia Burwell, Sec'y of Health & Human Servs., Hearing on The President's Fiscal Year 2017 Budget, Attachment—Additional Questions for the Record, U.S. House of Rep. Energy & Commerce Health Subcomm. at 13 (Feb. 24, 2016), http://bit.ly/2QcKnEi.[20]

Finally, the SMD Letter did not adequately explain the about-face. The Letter claims the mandatory work and community engagement requirement "is anchored in historic CMS principles that emphasize work to promote health and well-being." AR 0076. Yet Defendants do not identify those principles or explain why they support *conditioning* health coverage on satisfaction of work requirements. Moreover, the studies they cite in the SMD Letter all predate agency decisions to

[20] *See also* 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"), *supra* note 19.

reject work requirements as fundamentally incompatible with the Medicaid Act, so they cannot contend that new information supported the shift. *Compare* AR 0075 nn.3-9, *with* note 19. 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 the decision to convert policies that support and incentivize work for Medicaid-enrolled individuals to policies that withhold Medicaid coverage from those who are not working sufficient hours. AR 0075. Defendants' decision to "simply disregard" their earlier rationale confirms that they undertook no reasoned analysis of the complex issues at stake and their vital importance for millions of Americans. *Fox*, 556 U.S. at 515.

From a long-held stance that the Secretary cannot condition medical assistance on mandatory work requirements, Defendants have reversed course—with no evidentiary support or explanation for the reversal—and since used the SMD Letter's conclusory authorization to issue cookie-cutter waiver approvals. Thus, CMS's decision to authorize work requirements, as expressed in the SMD Letter, was arbitrary and capricious.

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

The SMD 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 did not go through notice-and-comment procedures before issuing the SMD Letter. Because the SMD Letter announces a substantive rule that cabins CMS's discretion, drives its outcomes, and alters the regulatory framework, the lack of notice and comment provides an independent reason to invalidate the SMD 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 SMD Letter clearly meets that test. Under the guise of "guidance," the Secretary has upended a 50-year-old interpretation of his waiver authority and undermined the very purposes of the Medicaid program. Through this SMD Letter, the Secretary "comprehensively transforms" Medicaid from medical coverage for the poorest Americans to a work program with health coverage 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 SMD 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) (citation omitted). It "effects 'a substantive regulatory change' to the statutory or regulatory regime." *EPIC*, 653 F.3d at 6-7 (citation omitted); *see also Time Warner Cable Inc. v. FCC*, 729 F.3d 137, 169 (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 SMD Letter leaves the agency with some case-by-case discretion does not change its character as a binding agency document. First, the SMD Letter "constrains the agency's

discretion." *McLouth Steel Prods. Corp. v. Thomas*, 838 F.2d 1317, 1320 (D.C. Cir. 1988). The SMD Letter introduces a new policy and sets out 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 1022-23 (agency action telling applicants what is required for certification supplements the statute and is a substantive rule). It speaks of the 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 0077, 0080-82. For example, the SMD Letter states that individuals who comply with a TANF or SNAP work requirement "must automatically be considered to be complying with the Medicaid work requirements," and that "States must also create exemptions for individuals determined to be medically frail." AR 0078. 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.* at 1320-21 ("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 SMD Letter that it has binding effect. *See Gen. Elec.*, 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.'"). As the basis for approving Arkansas's waiver Amendment, 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 SMD Letter]." *See* AR 0003. To explain how work

requirements will promote the purposes of Medicaid, Defendants rely on the SMD Letter: "As noted in [the SMD Letter], these activities have been positively correlated with improvements in individuals' health." AR 0004. Thus, Defendants deemed the SMD Letter controlling by invoking it to justify their decision to approve.[21]

Moreover, Defendants' reliance on the SMD Letter in this case is not an isolated occurrence. Since its issuance, the SMD Letter has driven each outcome the agency has reached on a request to impose work requirements. "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). In approving the Kentucky waiver application at issue in *Stewart*, Defendants conceded that many of the commenters had "opposed the community engagement requirement" and "emphasized that CMS has rejected similar proposals in the past." Ex. 1, Ky. Approval, at 7. Rather than addressing those comments in any meaningful way, as was their obligation, Defendants relied on 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." *Id*. at 7-8 ("X" in original). In Indiana, the agency was even more explicit. It justified approval of work requirements because the "terms and conditions of Indiana's community engagement requirement that accompany this approval are aligned with the guidance provided to states through [the SMD Letter]." *See* Ind. Approval, at 2; *see also* Letter from Seema

[21] Arkansas understood the SMD Letter as controlling. *See* AR 0335 (Feb. 12, 2018 letter from Arkansas to CMS stating: "In reviewing SDM 18-002 [the SMD Letter], and the Kentucky and Indiana approvals, the Arkansas Works amendments do not raise any new legal issues. The issues raised by your staff are design and operational matters which deal with timing, frequency, and methods of reporting.")

Verma, Adm'r, CMS, to Henry D. Lipman, Medicaid Dir., N.H. Dep't of Health & Human Servs., (May 7, 2018), http://bit.ly/2JE4wR2.

The SMD Letter replaces a policy against work requirements with a command to support state efforts to implement work requirements and apply enumerated criteria to reach that result. It substantively changed the regulatory regime. Because the APA requires notice and comment before promulgating such substantive changes, the SMD Letter must be vacated. *See Cmty. Nutrition Inst.*, 818 F.2d at 949.

CONCLUSION

For the reasons above, Plaintiffs respectfully ask the Court to vacate the approval of the Arkansas Works Amendment and the SMD Letter.

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Respectfully submitted,

Thomas J. Perrelli
(D.C. Bar No. 438929)
Ian Heath Gershengorn
(D.C. Bar No. 448475)
Natacha Y. Lam
(D.C. Bar No. 1030168)

Jenner & Block LLP
1099 New York Avenue, N.W.
Suite 900, Washington, DC 20001
Phone: 202 639 6004
TPerrelli@jenner.com
IGershengorn@jenner.com
NLam@jenner.com

Counsel to National Health Law Program

By: /s/ Jane Perkins
Jane Perkins
Elizabeth Edwards
Catherine McKee
National Health Law Program
200 N. Greensboro Street, Suite D-13
Carrboro, NC 27510
Phone: 919-968-6308 (x101)
perkins@healthlaw.org
mckee@healhtlaw.org
edwards@healthlaw.org

/s/ Kevin De Liban
Kevin De Liban
Trevor Hawkins
Legal Aid of Arkansas
310 Mid-Continent Plaza, Suite 420
West Memphis, AR 72301
Phone: 870-732-6370 (x2206)
kdeliban@arlegalaid.org
thawkins@arlegalaid.org

/s/ Samuel Brooke
Samuel Brooke
Emily C.R. Early
Neil K. Sawhney
Ellen Degnan
Southern Poverty Law Center
400 Washington Avenue
Montgomery, AL 36104
Phone: 334-956-8200
samuel.brooke@splcenter.org
neil.sawhney@splcenter.org

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on November 5, 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:

Vinita B. Andrapalliyal
U.S. DEPARTMENT OF JUSTICE
Civil Division, Federal Programs Branch
P.O. Box 883
Washington, D.C. 20530
(202) 305-0845
vinita.b.andrapalliyal@usdoj.gov

Matthew Charles Skurnik
U.S. DEPARTMENT OF JUSTICE
Civil Division, Federal Programs Branch
1100 L. Street, NW
Washington, DC 20005
(202) 616-8188
matthew.skurnik@usdoj.gov

Counsel for Defendants

Nicholas Jacob Bronni
Dylan L. Jacobs
ARKANSAS ATTORNEY GENERAL'S OFFICE
323 Center Street
Suite 200
Little Rock, AR 72201
(501) 682-6203
nicholas.bronni@arkansasag.gov
dylan.jacobs@arkansasag.gov

Counsel for the State of Arkansas

By: /s/ Catherine McKee
CATHERINE MCKEE