[ORAL ARGUMENT NOT YET SCHEDULED]

Nos. 19-5095 & 19-5097

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

RONNIE MAURICE STEWART, *et al.*,

Plaintiffs-Appellees

v.

ALEX MICHAEL AZAR, II, in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*, and the COMMONWEALTH OF KENTUCKY

Defendants-Appellants

On Appeal from the United States District Court for the District of Columbia
No. 1:18-cv-152

BRIEF OF KENTUCKY HOSPITAL ASSOCIATION AS AMICUS CURIAE SUPPORTING APPELLANTS AND REVERSAL

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

A. Parties and *Amici*. All parties, intervenors, and *amici* appearing before the district court and in this Court are listed in the Brief of Defendant-Appellant the Commonwealth of Kentucky ("Commonwealth").

B. Ruling Under Review. References to the rulings at issue appear in Brief of Commonwealth.

C. Related Cases. The only related cases of which counsel is aware are identified in Brief of Commonwealth.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Rule 26.1 of the D.C. Circuit, *amicus curiae* the Kentucky Hospital Association submits the following corporate disclosure statement:

The Kentucky Hospital Association is a non-profit association organized under the laws of the Commonwealth of Kentucky. The Kentucky Hospital Association has no parent corporation. The Kentucky Hospital Association has no stock holders, and therefore, as of this date, no publicly held corporation owns 10% or more of the Kentucky Hospital Association's stock.

STATEMENT OF CONSENT AND SEPARATE BRIEFING

Pursuant to Rule 29(a)(2) of the Federal Rules of Appellate Procedure and Rule 29(b) of the D.C. Circuit, counsel for all parties have consented on the parties' behalf to the filing of an *amicus curiae* brief by the Kentucky Hospital Association. The Kentucky Hospital Association filed a notice of its intent to participate in this case as *amicus curiae* on May 21, 2019.

Pursuant to Rule 29(d) of the D.C. Circuit, the Kentucky Hospital Association certifies that a separate brief is necessary to provide the perspective of its member hospitals and health systems regarding the Medicaid waiver demonstration project called Kentucky Helping to Engage and Achieve Long Term Health ("Kentucky HEALTH") approved by the Secretary of the United States Department of Health and Human Services ("Secretary") pursuant to Section 1115 of the Social Security Act.

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GLOSSARY

AHRQ	Agency for Healthcare Research and Quality
Commonwealth	Commonwealth of Kentucky
Kentucky HEALTH	Kentucky Helping to Engage and Achieve Long Term Health
Secretary	Secretary of United States Department of Health And Human Services

STATUTES AND REGULATIONS

All pertinent statutes are contained in the Brief of Commonwealth.

STATEMENT OF IDENTITY, INTEREST IN CASE, AND SOURCE OF AUTHORITY

The Kentucky Hospital Association is Kentucky's non-profit state association of hospitals, related health care organizations, and integrated health care systems. The Kentucky Hospital Association has the distinction of claiming every hospital and health system in Kentucky as a member of the association. With a mission to develop and implement health policies that enhance its members' ability to deliver health care services to their communities, the Kentucky Hospital Association engages in advocacy and representation efforts that promote improvements to health care delivery in Kentucky. The Kentucky Hospital Association files *amicus curiae* briefs in cases that may have a significant impact upon Kentucky's health care providers and their delivery of health care services in the Commonwealth.

State Medicaid programs operate as a "three-legged stool" in which the interests of the government, Medicaid beneficiaries, and health care providers work together for a common end. The member hospitals and health care systems of the Kentucky Hospital Association not only are integral to furnishing Medicaid services to beneficiaries, but also will play a substantial and meaningful role in the implementation of Kentucky HEALTH, and the effects of the waiver demonstration program will significantly impact their health care operations. Because this appeal implicates the implementation and effect of Kentucky HEALTH, the Kentucky

Hospital Association offers a distinct voice that supports the Commonwealth's appeal.

STATEMENT OF AUTHORSHIP AND FINANCIAL CONTRIBUTIONS

Pursuant to Rule 29(a)(4)(E) of the Federal Rules of Appellate Procedure, the Kentucky Hospital states that no counsel for any party authored this brief in whole or in part, and that no entity or person, aside from the Kentucky Hospital Association, its members, and its counsel, made any monetary contribution toward the preparation or submission of this brief.

ARGUMENT

Health care, like all other market sectors, faces a reality of finite resources. Most Kentucky hospitals can attest that each day presents a new struggle to stretch available resources to meet the patient needs of the day. Health care providers strive for innovation to bridge the gap between need and resources – mission and means. Often, innovation requires venturing away from standard operations to try an educated hypothesis, with the hope that it proves the benefits of the change will outweigh the risks and burden of change itself. Rarely do matters of health care policy present risk-free options. In the end, innovation may prove a game-changer – or not; but the experiment almost always has value because, for hospitals, stagnation is unsustainable in an environment of ever-growing health care needs. Inaction leads to a provider's eventual demise.

The same may be said of the Kentucky Medicaid program. Kentucky providers are keenly aware of the precarious state of Kentucky's economy and, consequently, its Medicaid program. With approximately 1.2 million Kentuckians enrolled in Medicaid,[1] over one-quarter (1/4) of all Kentuckians have their medical care paid through Medicaid.[2] Kentucky's Medicaid budget appropriates over $11 billion to

[1] "February 2019 Medicaid & CHIP Enrollment Data Highlights," *available at* https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last accessed May 20, 2019).

[2] U.S. Census Bureau, "Quick Facts Kentucky," *available at* https://www.census.gov/quickfacts/ky (last accessed May 20, 2019).

administer the Medicaid program, roughly one-third (1/3) of the entire annual budget for Kentucky.[3] Contributing factors to these economic realities include debilitating social and public health concerns, of which health care providers also are uniquely aware – high rates of obesity, illicit opioid usage, and cancer prevalence, to name only a few – that have reached well-publicized epidemic proportions in Kentucky. There is a palpable sense that the physical health of Kentuckians is spiraling out of control, and the economic health of the Commonwealth-at-large is caught in its drag. The two are inextricably tied. Kentucky hospitals can appreciate the multiple stresses upon Kentucky's Medicaid program because they closely parallel the stresses upon Kentucky's hospitals, and both seek innovation to survive. It is within this context that Kentucky HEALTH was conceived, and it is upon this basis that the Kentucky Hospital Association supports the Commonwealth's appeal to reverse the district court's March 27, 2019 memorandum opinion and order.

I. Kentucky HEALTH is an innovative project to address specific conditions in Kentucky.

As the Commonwealth's opening brief treats the details of Kentucky HEALTH extensively, only a summary is addressed here. Moreover, the district

[3] Commonwealth of Kentucky Executive Budget 2018-2020, *available at* https://osbd.ky.gov/Publications/Documents/Budget%20Documents/2018-2020%20Executive%20Budget%20Recommendation/Executive%20Budget%20Vol%20I%20-%20Final.pdf (last accessed May 20, 2019). (The total executive branch budget is located on page 2 and the total Medicaid budget is located on page 147.)

court's ruling focuses substantially on the community engagement requirements of the waiver, and the Kentucky Hospital Association will limit this brief accordingly.

In its essential terms, the Kentucky HEALTH proposed waiver tests the hypothesis that able-bodied, working-age adults are more likely to be engaged with their health and well-being if their Medicaid benefits are connected with activities that benefit themselves and their communities. Community engagement opportunities comprise a long list of qualifying activities, including skills training, education, self-employment, community service, caregiving, or participation in substance use disorder treatment. AR6774-75 [JA__-__]. Medicaid beneficiaries that qualify for community engagement must report 80 hours of community engagement activities per month, AR6775 [JA__], or benefits may be suspended until the beneficiary gains compliance. AR6775-77 [JA__-__]. Beneficiaries have substantial due process rights to show good cause why benefits should not be suspended for non-compliance with the community engagement requirements. AR6776 [JA__].

Importantly, Kentucky HEALTH maintains the integrity of the Medicaid "safety net." Vulnerable populations – children, the elderly, the medically frail, pregnant women, former foster care youth, primary caregivers, and students – are exempt from the requirements. AR6774 [JA__]. Many other Medicaid beneficiaries will be "deemed" in compliance with community engagement requirements by virtue of participating in other activities involving state-oversight. AR6774-75 [JA__-__]. For those subject to the community engagement requirements, Kentucky HEALTH

does not result in the automatic dis-enrollment of any Medicaid beneficiary. Rather, Medicaid eligibility is linked to compliance with the community engagement requirements. Kentucky HEALTH's impact on Medicaid enrollment is one of several data elements the experiment intends to study. In fact, compliance and, consequently, non-compliance are the focus of the experiment to determine "whether these beneficiaries will be encouraged to obtain and maintain health coverage, even when healthy, and whether there will be a reduction in gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick." AR6724 [JA__].

II. Kentucky HEALTH satisfies the objectives of the Medicaid program.

On behalf of its member hospitals and health systems, the Kentucky Hospital Association submits that Kentucky HEALTH is "likely to assist in promoting the objectives" of the Medicaid Act, and is otherwise consistent with the Secretary's Congressionally-granted authority to allow States to experiment with implementing the Medicaid program. 42 U.S.C. §1315(a). The Medicaid Act, when viewed as a whole, does not support the district court's narrow view of the Secretary's authority under Section 1115 of the Social Security Act. The prospective effect of the district court's short-sighted analysis will suppress the innovation Congress sought to encourage by its grant of broad waiver authority to the Secretary under Section 1115.

The district court determined that the Secretary's approval of Kentucky HEALTH was arbitrary and capricious because he "did not adequately consider whether his § 1115 waiver promotes the objectives of the Medicaid Act[.]" *Stewart v.*

Azar, 2019 U.S. Dist. LEXIS 51490, *23 (D.D.C. March 27, 2019) ("*Stewart II*"). That determination, however, flows from a narrow view of the Act's objectives that ignores both the context of the Act and the practical reality of its implementation. The court held that the "central objective of the Act is 'furnish[ing] medical assistance' to needy populations," and the "Secretary's failure…to adequately consider the effects of Kentucky HEALTH on coverage is alone…fatal to the approval." *Id.*, at *23-24 (quoting *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018)). Yet the district court reaches this conclusion by reading the Medicaid Act in a manner that embraces its idealism, while dismissing its economic grounding. Instead, "[i]n ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole." *K Mart Corp. v. Cartier*, 486 U.S. 281, 291 (1988) (citation omitted). When the construct of the Act is viewed in its totality, it is clear that furnishing medical assistance is not the *only* objective of the Medicaid Act, nor can it be viewed in isolation apart from the practical means of actually accomplishing it. When looking at the "statute as a whole," as the Court is required to do, the Secretary was well within his statutory authority to approve Kentucky HEALTH as being consistent with the objectives of the Medicaid Act. *Id.* at 291.

The district court begins its critique of the Secretary's waiver authority under 42 U.S.C. §1315(a) with a cautious judgment that the "objectives" of the Medicaid Act "may be ambiguous." *Stewart II*, 2019 U.S. Dist. LEXIS 51490, at *24. However,

although the Medicaid Act is often described as "Byzantine," *see Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981), the "objectives" of the Act are not so hidden as to invite judicial speculation on the Act's meaning and purpose. *See N. Broward Hosp. Dist. v. Shalala*, 172 F.3d 90, 93 (D.C. Cir. 1999) (finding that even "if the intent of Congress is not clear, we do not impose our own construction of the [Medicaid] statute, but instead examine only whether the agency's answer is based on a permissible construction of the statute."). Despite the complexity of its details, the Act sets forth a *financing* construct for the provision of health care. And Congress' use of the word "objective" in the context of the Secretary's waiver authority evidences *breadth*, not ambiguity, in the context of experimenting with the financial implications of health care. *See Sedima v. Imrex Co.*, 473 U.S. 479, 499 (1985) (citation omitted).

In appraising Kentucky HEALTH solely on whether it promotes the Act's objective to cover vulnerable populations, the district court's evaluation is too narrow. *Stewart II*, 2019 U.S. Dist. LEXIS 51490, at *24-26. Although it is reasonable to say that coverage is *one* object of the Act, the district court's opinion casts coverage as the Act's singular, uncompromising objective. The Act, however, does not support such an impracticable view. A more complete view of the text and construct of the Medicaid Act shows that Congress did not elevate coverage as an unqualified, illimitable objective to be achieved at all or any costs. Instead, Congress weaves within the text of the Medicaid Act innumerable layers of limitations and conditions to coverage and payment that reflect the nature of Medicaid as a health care *financing*

program. *See McCreary v. Offner*, 172 F.3d 76, 78 (D.C. Cir. 1999) ("Medicaid, a cooperative federal-state program, *finances* medical care for the poor….") (emphasis added). In fact, these financial guardrails are in place to make the Medicaid program sustainable to ensure that all of the Act's objectives can be met.

Therefore, while true that the Medicaid Act endeavors to "furnish medical assistance" to vulnerable populations, the coverage goal of the Act cannot be siloed from the practical financing mechanisms of the Act without doing damage to the entire Medicaid construct built by Congress. Congress wrote the Act in such a manner that removing the financing "thread" from the Medicaid "fabric" unravels the whole. By ignoring this reality, the district court's interpretation of the Act invites instability into the Medicaid program, where its mission swallows its means.

Congress anticipated that flexibility in the Medicaid program would lead to its sustainability. As the district court concedes, Congress does not direct that the *government* "furnish medical assistance" to Medicaid beneficiaries, but rather the Act sets forth a scheme by which both federal and state governments jointly pay others – such as hospitals and physicians – for the costs of actually furnishing medical care and services. *Stewart II*, 2019 U.S. Dist. LEXIS 51490, at *25 (citing 42 U.S.C. §1396-1 and *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176, 180 (D.C. Cir. 2008)).

And even here, Congress did not construct the Medicaid program to be implemented directly by the federal government. Instead, each state submits a proposal to the federal government explaining how the state will ensure that medical

assistance will be provided to the state's Medicaid-eligible persons. 42 U.S.C. §1396a. If the Secretary is satisfied that a state's proposed Medicaid plan satisfies the statutory conditions of the Act, then Congress authorizes the Secretary to pay the federal portion of costs associated with providing medical care and services to the eligible population. 42 U.S.C. §1396b. Notably, the only express prohibition the Act places upon the Secretary while evaluating a state's Medicaid plan is that he "shall not approve" any state's plan that imposes conditions of eligibility relative to specific requirements on age, residency, and citizenship. 42 U.S.C. §1396a(b)(1)-(3) (emphasis added). Except for these expressly prohibited matters, however, Congress delegates to the Secretary's judgment whether a state's Medicaid plan "fulfills the conditions" of the Medicaid Act. *Id.*; *see also Cooper Hosp. / Univ. Med. Ctr. v. Burwell*, 179 F. Supp. 3d 31, 41 (D.D.C. 2016) ("In the case of the Medicare and Medicaid statutes in particular, '[t]he identification and classification of medical eligibility criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns. In those circumstances, courts appropriately defer to the agency entrusted by Congress to make such policy determinations.'") (quoting *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991)).

The unique arrangement of state implementation and federal oversight created by the Act recognizes that, for Medicaid programs, one size does not fit all – a point Congress makes expressly. *Louisiana Dep't of Health & Hosps. v. Ctr. for Medicare & Medicaid Servs.*, 346 F.3d 571, 572 (5th Cir. 2003) ("The Medicaid statute gives each

state flexibility in designing and administering its own Medicaid program."). The express purpose for which Congress appropriates funds for the Medicaid program is to "*enable[e]* each State, as far as practicable under the conditions in such State," to administer its Medicaid program. 42 U.S.C. §1396-1 (emphasis added). For emphasis, Congress directs the Medicaid program to be implemented within means that are "practicable" and in consideration of the unique "conditions in [the] State." *Id.* The Medicaid Act allows the states to submit 50 different Medicaid plans representing 50 different solutions for 50 different problems. *See, e.g.*, *Michael Reese Physicians & Surgeons, S.C. v. Quern*, 606 F.2d 732, 735 (7th Cir. 1979) *reh'g en banc*, 625 F.2d 764 (1980), *cert. denied*, 449 U.S. 1079 (1981) ("Medicaid is an experiment in cooperative federalism … which literally abounds with options. Medicaid is designed to be flexible enough to meet the varying needs of each state which elects to participate….") (internal citations omitted). The variability of the Medicaid scheme certainly supports the breadth and discretion Congress grants the Secretary to achieve the goals of the Act while respecting the practical limitations of each state.

The Act's numerous conditions upon state Medicaid plans ostensibly further its goals, but Congress anticipated that rigid compliance with these conditions would stifle innovation and frustrate state Medicaid programs with "[im]practicable" obligations that fail to consider the unique "conditions in [the] State." 42 U.S.C. §1396-1. To avoid this conflict, Congress granted the Secretary broad authority to

waive a state's compliance with "any" condition the Act imposes upon a state Medicaid plan. 42 U.S.C. §1315(a)(1).

The mere grant of the waiver authority speaks volumes of Congress' view of a flexible Medicaid program, but the language of the waiver statute removes any doubt. First, the waiver process is available for "any" state Medicaid projects that are "experimental, pilot, or demonstration" – phrases that are inherently abstract. *Id.* Second, the Secretary's approval of a waiver proposal is satisfied for those projects "*likely to assist* in promoting the objectives of" the Medicaid Act. *Id.* (emphasis added.) A waiver proposal would hardly qualify as an "experiment" if its efficacy must be empirically proven prior to implementation.

As demonstrated by the Act's text, Congress built Medicaid as a flexible health care financing program and grants the Secretary discretion to oversee the implementation of state Medicaid programs so that competing interests may be balanced. In this context Kentucky HEALTH represents a reasonable experiment consistent with Medicaid Act objectives. In essence, Kentucky's waiver proposal tests a limited population of Medicaid beneficiaries on the theory that linking Medicaid benefits to community engagement, similar to work-sponsored commercial insurance, may encourage beneficiaries to maintain – and use – health care coverage even while healthy, because wellness health care tends to decrease prevalence of illness and its associated higher costs. Will Kentucky HEALTH prove its theory true? If that could be known there would be little need to implement it as an experimental

demonstration project. But the theory is rational and has a reasonable corollary to health care delivery. *See Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417-18 (1993) ("In the circumstances of this case, where the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction. We should be especially reluctant to reject the agency's current view which, as we see it, so closely fits 'the design of the statute as a whole and . . . its object and policy.'") (quoting *Crandon v. United States*, 494 U.S. 152, 158 (1990)).

It is axiomatic in health care that patient engagement contributes to improved health care outcomes. The federal Agency for Healthcare Research and Quality ("AHRQ"), an agency under the auspices of the Secretary's authority charged with improving safety and quality in America's health care system, has endorsed patient engagement as a "featured innovation" in health care.[4] Kentucky HEALTH seeks to test whether this commonly accepted health care principle can be extended through a similar connection between benefits eligibility and beneficiary engagement. Notwithstanding the speculation of whether the theory will be proved effective, Kentucky's waiver proposal presents an intriguing question that Congress has permitted the Secretary to approve under 42 U.S.C. §1315(a).

[4] *See* AHRQ's Health Care Innovations Exchange, November 23, 2011, *available at* https://innovations.ahrq.gov/issues/2011/11/23/patient-engagement (last accessed May 20, 2019).

CONCLUSION

Expanding health care needs and contracting budgets are not new challenges to the Medicaid program. Congress authorized the Secretary's broad waiver authority under 42 U.S.C. §1315 precisely to confront these challenges. The Secretary's approval of Kentucky HEALTH appropriately considered the extraordinary "conditions [in Kentucky]" in exercising his discretion under the statute. The limited experiment of community engagement is innovative in the context of Medicaid, but not itself a new concept, and bears examination in light of the daunting challenges facing Kentucky. For these reasons, the Kentucky Hospital Association supports the Commonwealth's appeal to reverse the district court's ruling.

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May 21, 2019

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(g)(1) and Rule 29(a)(4)(G) of the Federal Rules of Appellate Procedure, I hereby certify that this brief complies with the type-volume limitation of Rule 29(a)(5) of the Federal Rules of Appellate Procedure because it contains 3,299 words, excluding the parts of the brief exempted by Rule 32(f) of the Federal Rules of Appellate Procedure. I further certify that this brief complies with the typeface and type-style requirements of Rule 32(a)(5) and Rule 32(a)(6) of the Federal Rules of Appellate Procedure because the brief was prepared in a proportionally spaced serif typeface using Microsoft Word 2010 in 14-point Garamond font.

/s/ Wesley R. Butler
Wesley R. Butler

CERTIFICATE OF SERVICE

I hereby certify that on May 21, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. All participants in this case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Wesley R. Butler
Wesley R. Butler