ORAL ARGUMENT NOT YET SCHEDULED

Nos. 19-5094 & 19-5096 (Gresham); Nos. 19-5095 & 19-5097 (Stewart)

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

CHARLES GRESHAM, et al.,
Plaintiffs-Appellees
v.
ALEX M. AZAR II, Secretary of Health & Human Services, et al.,
Defendants-Appellants

STATE OF ARKANSAS
Intervenor-Defendant-Appellant

RONNIE MAURICE STEWART, et al.,
Plaintiffs-Appellees
v.
ALEX M. AZAR II, Secretary of Health & Human Services, et al.,
Defendants-Appellants

COMMONWEALTH OF KENTUCKY
Intervenor-Defendant-Appellant

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BRIEF OF DEANS, CHAIRS, AND SCHOLARS AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS-APPELLEES

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

All parties, intervenors, and amici appearing before the District Court and this Court are listed in the Brief for Federal Appellants. All references to the rulings at issue appear in the Brief for Federal Appellants. These cases were not previously before this Court. Substantially similar issues appear in *Philbrick v. Azar*, No. 1:19-cv-773 (D.D.C.) (Boasberg, J.), which is pending in District Court.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Rule 26.1 of the United States Court of Appeals for the D.C. Circuit (the "D.C. Circuit"), *amici curiae* submit the following corporate disclosure statement:

The Deans, Chairs, and Scholars are individuals and as such do not have a parent company and no publicly held company has a ten percent or greater ownership interest in any *amici*.

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 this *amici curiae* brief by Deans, Chairs, and Scholars. The *amici* filed a notice of their intent to participate in this case as *amici curiae* on June 27, 2019.

Pursuant to Rule 29(d) of the D.C. Circuit, the Deans, Chairs, and Scholars certify that a separate brief is necessary to provide appropriate insight into how the U.S. Department of Health and Human Services' use of Section 1115 of the Social Security Act, 42 U.S.C. § 1315, to allow States to impose work or community engagement requirements on Medicaid beneficiaries, is inconsistent with the Medicaid program, the Social Security Act, Congress's intent in permitting this waiver authority, and the historical use of such waivers.

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

The Deans, Chairs, and Scholars are researchers and academics who are experts in the fields of health law, health policy, health services research, and national health reform. They seek to inform this Court about the history of Section 1115 of the Social Security Act, the essential elements of Medicaid demonstration evaluation, the validity of the assumptions on which Federal Appellants' actions rest, and the likely effects of permitting Defendants' actions to continue to take effect. Given the scope of Federal Appellants' actions and that they have authorized or will authorize similar activities in other States, *amici* believe this case provides an appropriate vehicle for the Court to find that Appellants' actions are contrary to federal law.

Pursuant to Rule 29(a)(4)(E) of the Federal Rules of Appellate Procedure, *amici* certify that no party or counsel for a party authored this brief in whole or in

part. *Amici* further certify that no party, counsel for a party, or any other person contributed money that was intended to fund preparing or submitting this brief.

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Medicaid and CHIP Payment and Access Commission .....MACPAC

Social Security Act..... SSA

State Medicaid Directors Letter .....SMDL

U.S. Department of Health and Human Services .....HHS

U.S. Government Accountability Office .....GAO

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Congress enacted the Medicaid program, Title XIX of the Social Security Act ("SSA"), to provide medical assistance to people whose income and resources are insufficient to pay the cost of necessary care. 42 U.S.C. § 1396-1. Despite this clear mandate, the U.S. Department of Health and Human Services' ("HHS") Centers for Medicare and Medicaid Services ("CMS") (collectively "Federal Defendants") allowed Kentucky and Arkansas to make "community engagement" or work requirements a condition for Medicaid eligibility. These demonstration proposals only served to reduce Medicaid coverage and create barriers to eligibility. For example, within six months of implementation, over 18,000 Arkansans lost coverage with no significant change in employment, and despite the fact that over ninety-six percent of those targeted by the policy appeared either to meet the work requirements or qualify for an exemption. The uninsured rate for the initial work requirements group (ages 30-49) increased seven percent; Medicaid coverage decreased by seven percent compared to working age beneficiaries not included in the initial experimental wave. *See* Benjamin Sommers et al., *Medicaid Work Requirements – Results from the First Year in Arkansas*, THE NEW ENGLAND JOURNAL OF MEDICINE (June 19, 2019); Benjamin Hardy, *Study says Medicaid work requirement increased uninsured rate for Arkansas but did not boost employment*, ARKANSAS TIMES (June 19, 2019).

These consolidated appeals now before this Court challenge the District Court's well-reasoned ruling that, by failing to consider evidence critical to his demonstration authority under § 1115, the Secretary acted in violation of the Administrative Procedure Act. This Court should affirm.

Section 1902 of the SSA sets forth detailed conditions of State participation in Medicaid. *See* 42 U.S.C. § 1396a. Longstanding decisions hold that while States have options to expand eligibility and coverage, they cannot impose eligibility or coverage restrictions not authorized by law. *See T.H. v. Jones*, 425 F.Supp. 873, 877 (D. Utah 1975), *aff'd sub nom. Jones v. T.H.*, 425 U.S. 986 (1976) (invalidating Utah's parental consent requirements for Medicaid family planning services); *Comacho v. Tex.Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005) ("Texas cannot add additional requirements for Medicaid eligibility."); Congressional Research Service, *Judicial Review of Medicaid Work Requirements Under Section 1115 Demonstrations* (Report No. R44802) at 3, n. 17 (Mar. 28, 2017).

Section 1115 of the SSA authorizes the Secretary to modify certain State plan requirements under § 1902 "[i]n the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of…[Medicaid]." 42 U.S.C. § 1315(a)(1). This unique experimental authority allows the Secretary to authorize Medicaid demonstrations

likely to promote program objectives. Medicaid's core, statutory objective is provision of medical assistance to eligible persons. 42 U.S.C. § 1396-1. Yet in approving the Arkansas and Kentucky experiments, Federal Defendants failed to consider the flaws in their experimental design or the extensive evidence pointing to the major, negative impact on enrollment and coverage. Through administrative fiat, and without statutory authority or notice-and-comment rulemaking, Defendants reversed their long-standing position that work requirements do not promote the objectives of the Medicaid program. *See* Letter from Thomas E. Price, Secretary of HHS, and Seema Verma, Administrator of CMS to State Governors (Mar. 14, 2017) (the "Dear Governor Letter").

Defendants have further misused § 1115 by allowing States to launch their experiments yet submit their evaluation design proposals months later. As noted, an independent evaluation of Arkansas's implementation revealed the experiment's widespread damage; this research underscored the folly of disregarding evidence regarding the experiment's adverse impact on beneficiaries and postponing evaluation to an uncertain post-launch date. Defendants' actions have defeated the very purpose of the special experimental authority conferred by Congress. Section 1115 is not a mechanism for refashioning Medicaid in ways that federal officials might prefer but that lack statutory basis. This law is a unique grant of power from Congress to test, measure, and evaluate the impact of policy modifications that

have the potential to promote Medicaid objectives. As discussed below, Defendants' use of § 1115 is contrary to the terms, purpose, and history of this special federal experimental authority. Hence, Defendants' approval of these two demonstrations was arbitrary, capricious, and contrary to law. The District Court correctly ordered vacatur and remanded the instant matters. *See Stewart v. Azar*, 313 F.Supp.3d 237 (D.D.C. 2018) and *Stewart v. Azar*, 366 F.Supp.3d 125 (D.D.C. 2019) (Kentucky); *Gresham v. Azar*, 363 F.Supp.3d 165 (D.D.C. 2019) (Arkansas). Consequently, *amici* urge this Court to affirm.

ARGUMENT

I. Congress Enacted § 1115 to Permit States to Test New Approaches to Expand Access, Provide Better Services, and Strengthen Social Programs.

In 1962, the Kennedy Administration asked Congress to enact legislation authorizing "[d]emonstration projects that states could undertake without having to meet all the conditions of the federal [Social Security] act." Public Welfare Amendments of 1962, P. L. No. 87-543, § 122, 76 Stat. 172, 192 (1962); *see also* S. Rep. No. 1589, at 1(1962), *reprinted in* 1962 U.S.C.C.A.N. 1947. The President identified "needed improvements" in safety net programs including liberalization of eligibility requirements and benefit rules. *See* SOCIAL SECURITY ADMINISTRATION, SOCIAL SECURITY HISTORY: KENNEDY'S STATEMENTS ON SOCIAL SECURITY (Feb. 20, 1961). President Kennedy viewed this additional authority as a

way to help, not penalize, the poor: "[c]ommunities which have – for whatever motives – attempted to save money through ruthless and arbitrary cutbacks in their welfare rolls have found their efforts to little avail. The root problems remained…." *President's Special Message to the Congress on Public Welfare Programs* (Feb. 1, 1962).

Explaining that demonstration authority would enable states "to improve the techniques of administering assistance and the related rehabilitative service under the assistance titles," the Senate envisioned demonstrations of limited scope and limited geographic impact, and disfavored duplication of demonstration projects. S. Rep. No. 1589, *supra*, at 1943, 1961. Furthermore, "[a]t the committee hearing, no witness suggested – nor did the Finance Committee ever intimate- that section 1115 was to be used to reduce benefits by varying eligibility criteria…. In short…Congress and the Administration intended this section to be a narrow, technical, and beneficent research option." Lucy A. Williams, *The Abuse of Section 1115 Waivers: Welfare Reform in Search of a Standard*, 12 YALE L. & POL'Y REV. 1, 12, 13 (1994).

II. Early § 1115 Demonstrations Heeded Congressional Intent that Waivers Strengthen Medicaid and other Social Programs.

In implementing § 1115, the agency clarified that its purpose was to "develop and improve the methods and techniques of administering assistance and related services designed to help needy persons achieve self-support or self-care or

to maintain and strengthen family life." U.S. DEP'T OF HEALTH, EDUC. & WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, H.T. No. 4, pt. IV, § 8421 (1963). Demonstrations were intended to augment and strengthen services, not eliminate them. Early § 1115 demonstrations focused on child care development programs and expanding benefits. Williams, *The Abuse of Section 1115 Waivers* at 14. Subsequent 1967 Department policy guidelines reaffirmed that demonstrations ought to strengthen programs by "provid[ing] assistance to needy individuals *who would not otherwise be eligible*; increas[ing] the level of payments; provid[ing] social services not presently available…; [and] experiment[ing] with new patterns and types of medical care…." U.S. DEP'T OF HEALTH, EDUC. & WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, H.T. No. 109, pt. IV, § 8432 (Feb. 17, 1967) (emphasis added) (*cited* in Williams, *supra*, at 14, n. 29); *see also* S. Rep. No. 744 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 2863 (appropriating additional funds for § 1115 projects "to develop demonstrations in improved methods of providing service to recipients or in improved methods of administration").

III. Since 1965 Congress Has Added Important Protections to Ensure Demonstrations Promote Medicaid's Purpose.

Since Medicaid's enactment, Congress has taken additional steps to ensure § 1115 promotes Medicaid's purpose. In 1982, Congress added § 1916 to the SSA to restrict § 1115 waivers that compel beneficiary participation in premium or cost-

sharing demonstrations. Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248, Title I, Subtitle B, § 131(b), 96 Stat. 367 (1982); 42 U.S.C. § 1396o. Congress again amended § 1115 in 2010 to require that, prior to approving demonstrations, the Secretary provide public notice and comment at both the state and federal levels and ensure that demonstrations comply with federal Medicaid law. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 2601(b)(2), § 10201(i), 124 Stat. 119, 922 (2010) (the "ACA"); 42 U.S.C. § 1315(d)(2).

Over decades, Medicaid demonstrations have tested new strategies for delivering health care or expand beneficiary services and supports. No past Administration has approved Medicaid demonstrations whose express purpose is to deprive people of eligibility or coverage and CMS has rejected proposals seeking such ends. Indeed, over the past quarter century, the Secretary has used this authority virtually always to permit experiments aimed broadly at expanding eligibility, improving coverage, and introducing health care innovations. Alexander Somodevilla et al., *How Far Do Section 1115 Medicaid Experiments Designed to Restrict Eligibility and Enrollment Veer From the Norm? A 25-Year Perspective*, GW HEALTH POLICY & MANAGEMENT MATTERS (June 13, 2019). The text and history of § 1115 clearly show that this experimental authority is not a blank check to rewrite law by stripping eligibility from beneficiaries; it is unlikely "that Congress would enact such comprehensive [Social Security Act] regulations,

frame them in mandatory language, require the Secretary to enforce them, and then enact a statute [§ 1115] allowing states to evade these requirements with little or no federal agency review." *Beno v. Shalala*, 30 F.3d 1057, 1068-69 (9th Cir, 1994); *see also Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011).

The history of welfare reform legislation reveals that HHS has consistently viewed Medicaid eligibility as a benefit to be "decoupled" from programs whose express purpose is to promote work, such as Temporary Assistance for Needy Families ("TANF"), which statutorily ties benefits to work activities. *See* Letter from Olivia Golden, Assist. Secretary for Children and Families and Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration to State Medicaid Directors and TANF Administrators (June 5, 1998). Until very recently, CMS has repeatedly opposed work requirements. *See* Vikki Wachino (CMS Deputy Administrator and Director for the Center for Medicaid and CHIP Services), Hearing on "Medicaid at 50," Responses to Additional Questions for the Record, U.S. House of Rep. Energy and Commerce Health Subcommittee at 37 (July 8, 2015) ("the Secretary does not have the authority to permit a state to require Medicaid beneficiaries to work or receive job training because that is not an objective of [Medicaid]"); *see also* Letter from Vikki Wachino to Jeffrey A. Meyers, Commissioner, New Hampshire Dept. of HHS (Nov. 1, 2016) (denying State's request for permission to implement Medicaid work requirements because

they "undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and do not support the objectives of the Medicaid program"); Letter from Andrew M. Slavitt, CMS Acting Administrator to Thomas Betlach, Director, Arizona Health Care Cost Containment System (Sept. 30, 2016); Sidney D. Watson, *Out of the Blackbox and into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y L. & ETHICS 213, 227 (Winter 2015) ("The Secretary has no Section 1115 authority to allow a work requirement or work incentive."). CMS' recent change of heart deserves little deference: "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view.'" *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n. 30 (1987).

IV. Defendants Cannot Use § 1115 as a Shortcut for Reversing Expansion.

The two experiments at issue in this consolidated appeal concern the "Medicaid expansion," which secured medical assistance for previously ineligible low-income adults up to age sixty-four. The ACA extended medical assistance to "the entire nonelderly population with income below 133 percent of the poverty level." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 583 (2012); *see* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (extending Medicaid coverage effective Jan. 1, 2014 to the "expansion population"). States may choose not to cover the ACA

expansion population. *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 587. However, States that decide to provide coverage must afford the expansion group "full benefits," which the statute defines as "medical assistance…that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for [other] individual[s] [covered under the Act]." 42 U.S.C. § 1396d(y)(2)(B). The federal government will cover ninety-three percent of a State's costs of providing medical assistance to the expansion group in 2019 (ninety percent in 2020 and thereafter). *Id*. § (y)(1)(D), (E).

Defendants have embraced a plan to roll back the expansion population's Medicaid eligibility as contrary to public policy, characterized, in their words, as "a clear departure from the core, historical mission of" the Medicaid program. *See* Dear Governor Letter at 3. To advance its views, in January 2018, CMS issued a State Medical Directors Letter (the "SMDL"), inviting States to submit Medicaid "community engagement" demonstration proposals containing a host of eligibility restrictions. *See* KYAR 90-99, Ark. AR 74-83. Upending its long-standing position that mandatory Medicaid work requirements do not promote Medicaid objectives, CMS made a policy about-face without notice and comment. The letter also promoted other coverage restrictions such as premiums, "lock-out" periods that could bar coverage for months at a time, and elimination of retroactive

eligibility. The policy expressly established an experimental design consisting of a year-round, hours-per-week work requirement despite evidence that fewer than one in six working-age low income adults can satisfy this standard. Low wage workers, particularly those in retail, hospitality, or transportation, are vulnerable to job insecurity and precarious work schedules – a reality especially common among low wage workers who also depend on government safety net programs. *See* Michael Karpman et al., *Precarious Work Schedules Could Jeopardize Access to Safety Net Programs Targeted by Work Requirements*, URBAN INSTITUTE (June 11, 2019). Defendants' policy also sanctioned volunteer work without wages or benefits and barred use of Medicaid experimental funds to underwrite work supports such as training, transportation, or child care. Defendants encouraged this model even though voluntary work programs have shown no measurable success in boosting work. Leighton Ku, et al., *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?*, THE COMMONWEALTH FUND (Nov. 6, 2018).

By the end of 2018, CMS had approved work requirements through § 1115 demonstrations in Kentucky, Arkansas, and other States. Notably, Defendants readily admit that "[t]he adults who are subject to the requirements of the demonstrations are overwhelmingly members of the ACA's adult expansion population…" Appellants' Br. at 24.

V. The Secretary's Approval of Eligibility Restriction Experiments in Kentucky and Arkansas was Contrary to Law Because the Secretary Failed to Ensure States Conduct Adequate Demonstration Evaluations.

The demonstrations at issue are unlawful because Defendants have not acted in accordance with the experimental authority set forth in § 1115. Defendants approved project terms and conditions that give Kentucky and Arkansas 180 and 120 calendar days, respectively, after authorizing the demonstration to submit a draft evaluation design for Defendants' comment and approval. *See* KYAR 7078 (Special Terms and Conditions, ¶ 82); Ark. AR 45 (STCs, ¶ 77). As a result, and contrary to fundamental principles of research, Defendants have failed to ensure that a federally approved independent evaluation is in place prior to initiation of experimental designs that carry significant risks for low income adults, such as inflexible work rules or forced volunteer work carrying little or no prospects of additional income or benefits, no new job supports such as child care or transportation, a complex exemption process, and convoluted reporting obligations. Yet, in the face of this high-risk design, Defendants failed to ensure that independent rigorous evaluation were in place to rapidly assess changes in employment and wages, coverage, health care access, and health. This policy of "experiment first and evaluate maybe" makes a mockery of § 1115's experimental powers and ignores the voluminous comments in the record that warned of the design's likely impact. This substantive and procedural flaw will leave the agency,

States, and Congress without objective evidence of the underlying causes for enrollment decline – precisely the result lawmakers sought to avoid through the 2010 amendments.

Consistent with applicable decisions, these demonstrations do not pass muster; the record is devoid of evidence showing the methodological soundness of the experiment. *See, e.g.*, *Newton-Nations*, 660 F.3d 370 (Medicaid) *and Beno*, 30 F.3d 1057 (Aid to Families with Dependent Children). Neither the original solicitation nor the approvals explain why it is methodologically sound to design work experiments that completely contradict the lessons of past compelled work demonstrations under other programs (*see* Ku et al., *Medicaid Work Requirements*, *supra*) and disregard known barriers low-wage workers face while barring use of experimental funds to provide work supports.

Furthermore, the demonstration must produce valuable information that could lead to program improvements, facilitate "true research data and serve interests beyond state fiscal concerns." *Recent Case: Ninth Circuit Holds Statutory Waivers for Welfare Experiments Subject to Judicial Review*, 108 HARV. L. REV. 1208, 1212 (1995). "[T]he Secretary must make at least some inquiry into the merits of the experiment—she must determine that the project is likely to yield useful information or demonstrate a novel approach to program administration." *Beno*, 30 F.3d at 1069. Moreover, "[t]he Secretary's second obligation under *Beno*

is to 'consider the impact of the state's project on the persons the Medicaid Act 'was enacted to protect.'" *Newton-Nations*, 660 F.3d at 381. The lack of a true, evidence-based experimental design will lead to confusion, contamination of research findings, and additional hardship to beneficiaries.

Regulations issued in 2012 require that demonstrations serve a legitimate experimental purpose. 42 C.F.R. Part 431, subpart G. These regulations require States to submit for CMS approval detailed evaluation designs of their demonstrations' "key programmatic features," including testable hypotheses, valid designs, reliable collection methods and approaches to minimize burdens on beneficiaries. *Id*. at § 431.424; *see also* U.S. Government Accountability Office ("GAO"), GAO-19-315, MEDICAID DEMONSTRATIONS: APPROVALS OF MAJOR CHANGES NEED INCREASED TRANSPARENCY at 23, n. 28 *and accompanying text* (April 2019) (hereinafter "Medicaid Demonstrations – 2019 Report") ("In the development of demonstration evaluations, states are to include hypotheses that will be tested through the demonstrations, which align with the demonstration's objectives or goals."). Rather than adhering to their own standards for ensuring reasonable experimentation, Defendants assert that they choose imply to rely on their own "predictive judgment" regarding the benefits their experiment will confer. Defendants cannot rehabilitate their complete failure to consider relevant information by claiming authority to make predictive judgments.

Defendants justify approving work experiments on the ground that "[t]he point of these experiments is to test hypotheses, and either validate a hypothesis that might lead to new innovations or else refute the hypothesis and help Congress and HHS avoid mistaken policies in the future." Appellants' Br. at 18; *see also id.* at 36 ("The essence of an experiment is to test a prediction…"). But Defendants are permitting high risk experiments to proceed with no evaluation in place, no testing at all – Arkansas's ran for ten months, with no approved or operational evaluation design before the District Court vacated approval. As such, the underlying hypotheses are not being tested, validated or refuted, putting the lie to calling these demonstrations "experiments" and clearly missing the point of what a § 1115 demonstration entails or requires. Defendants protest that "[b]y disrupting the statewide implementation of these demonstration projects, the District Court unnecessarily deprived the federal and state governments of valuable experimental learning." *Id.* at 43. Of course, Defendants do not alert this Court to the fact that they are authorizing States to proceed with these demonstrations without an approved evaluation design. In short, it is Defendants who deprived themselves of "valuable experimental learning."

Defendants note that "[d]emonstration projects are time-limited experiments, and even an unsuccessful experiment can provide useful information that informs [sic] future policy-making." *Id.* at 17; *see also id.* at 2, 28 ("Demonstration

projects are experiments, the results of which inform future policy-making."). The fact that experimental approval may be time limited does not obviate the requirement that the experimental design be reasonable and capable of yielding valuable policy findings or that the experiment be evaluated. Defendants' assertions beg the question of how they intend to inform future policy when they allow States to proceed without a sound evaluation in place to measure impact. *See* U.S. GAO, GAO-18-220, MEDICAID DEMONSTRATIONS: EVALUATIONS YIELDED LIMITED RESULTS, UNDERSCORING NEED FOR CHANGES TO FEDERAL POLICIES AND PROCEDURES (Feb. 20, 2018) (citing Defendants' poor record of § 1115 research oversight and failure to produce evaluation results).

VI. Defendants Consistently Sidestepped Evaluation Principles Contained in Their Own § 1115 Guidance.

Section 1115 contemplates that States file experimental applications accompanied by costs and coverage projections. 42 U.S.C. § 1315(d)(2)(B)(ii). It is not enough for States simply to report on the ongoing results of their demonstrations, although reporting is a requirement. *Id.* § 1315(d)(2)(D). Moreover, the statute provides that "[t]he Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final [state] report." *Id.* § 1315(e)(5). In other words, § 1115 demonstrations must be objectively evaluated for their impact, in contrast with routine Medicaid program administration. This obligation to assess coverage impact and to evaluate results

applies regardless of whether the demonstration is a new one, like Kentucky, or an extension or renewal as in Arkansas.

Further, applications for initial approval of a demonstration must include "an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures," along with "[c]urrent enrollment data, if applicable, and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration." 42 C.F.R. § 431.412(a)(1)(iii), (a)(1)(iv). In addition, the application must include "[t]he research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators." *Id.* § 431.412(a)(1)(vii).

Although the statute speaks to "applications for or renewals of demonstration projects" (42 U.S.C. § 1315(d)), the rules speak to "extensions." *Id.* § 431.412(c). If an extension changes an existing demonstration, as with Arkansas, CMS reserves the authority to determine if the changes are "substantial" and thereby treat the extension request as a new application. *Id*. Regardless, an application to extend a demonstration must include "[a]n evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for

evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions." *Id.* § 431.412(c)(2)(vi). Notably, Arkansas was allowed to simply submit a slapdash amendment to its original demonstration consisting of work and other eligibility restrictions; Defendants approved it absent any impact estimates, any determination of whether the amendment was "substantial," and notwithstanding the State's failure to submit new hypotheses or an evaluation design to test the added features. *See* Ark. AR 45-52 (XIV. EVALUATION OF THE DEMONSTRATION) (referencing only premium assistance; no hypotheses or evaluation design to test work requirements or coverage lock-out impacts).

The GAO recently evaluated CMS' compliance with this provision and "identified inconsistencies in how CMS applied the transparency requirements for amendment applications across states.…For amendments [to existing § 1115 demonstrations], states are required to describe how the demonstration's evaluation will be revised to incorporate amendment provisions." U.S. GAO, Medicaid Demonstrations – 2019 Report at 23, n. 29 *and accompanying text*. The report noted that CMS improperly found Arkansas's application to be "complete" despite lacking a revised evaluation design plan and further, that Arkansas had offered two

new hypotheses that did not address "the waiver for retroactive eligibility proposed in the application." *Id.*

More than a year after the initial § 1115 work approvals and about nine months after the Arkansas demonstration went live, CMS posted § 1115 online resources addressing State monitoring obligations (separate from evaluation) and evaluations. *See* CMS, Evaluation Design Guidance for Section 1115 Eligibility and Coverage Demonstrations (hereinafter "CMS 1115 Guidance") *and* CMS, Appendix to Evaluation Design Guidance for 1115 Eligibility and Coverage Demonstrations: Community Engagement.

CMS' evaluation design guidance discusses how States should evaluate § 1115 demonstrations and preferred methods and approaches. CMS acknowledges that to be effective, the evaluation should be ready to launch prior to implementation: "We encourage states to procure their evaluator to support the development of a robust draft evaluation design for CMS review; ideally, states should identify an evaluation team before implementation to consult on implementation plans that support robust research designs and plan early data collection." CMS 1115 Guidance at 1 (emphasis added). Moreover, CMS stated that beneficiary surveys are potential data sources for evaluation as such surveys "are particularly important data sources for community engagement demonstration evaluations because states must track beneficiaries after they separate from

Medicaid to understand employment, income, health status, and coverage transitions over time." *Id.* at 8. Furthermore, CMS "strongly recommends use of longitudinal beneficiary surveys and is available to provide further technical assistance to states if requested." *Id.*

CMS' approval of Kentucky's and Arkansas's demonstrations is inconsistent with this guidance. For instance, CMS did not require either State to prepare robust pre-launch evaluation designs that include beneficiary surveys from the outset. CMS is ignoring its own guidance and clearing States to implement demonstrations with far-reaching, immediate, and negative consequences without evaluation, entirely missing the opportunity to measure crucial early impacts.

VII. Medicaid Expansion's Remarkable Achievements in Providing Medical Assistance to Uninsured Adults Make the Impact of Imposing Work Requirements, Coverage Lock-Outs and Limited Retroactive Eligibility Even More Catastrophic.

A. Expansion in Arkansas and Kentucky Led the Nation with Dramatic Reductions in Total Uninsured Adults.

Both States posted the most impressive achievements in providing medical assistance to the expansion population. By the end of 2016, Arkansas's expansion had led to more than a fifty percent decline in the uninsured population. *See* Jessica Barnett and Edward Berchick, *Health Insurance Coverage in the United States: 2016 Current Population Reports*, U.S. CENSUS BUREAU at 19 (September 2017). Kentucky showed an even more dramatic decline, with uninsured rates

falling from over 14.3 percent (2013) to 5.1 percent (2016). *Id.* These important reductions translated into access to better healthcare for people across both States, whether poor or not, as communities with high levels of uninsured persons lack critical services even for insured people because of insufficient market conditions essential to financing health care. *See America's Uninsured Crisis: Consequences for Health and Health Care*, INSTITUTE OF MEDICINE at 4 (2009).

In addition, extensive evaluation has shown the Medicaid expansion's success in achieving stable coverage and more accessible health care. *See* Bethany Maylone and Benjamin D. Sommers, *Evidence from the Private Option: The Arkansas Experience*, THE COMMONWEALTH FUND (Feb. 2017); Lara Antonisse et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAMILY FOUNDATION (Mar. 2018). Arkansas's expansion annually reduced uninsured outpatient hospital visits (45.7 percent reduction), emergency room visits (38.8 percent reduction), and hospital admissions (48.7 percent reduction). *See* Arkansas Center for Health Improvement, *Arkansas Health Care Independence Program ("Private Option") Final Report* at i (June 30, 2018).

Kentucky posted equally important gains through Medicaid expansion, evidenced by its community health centers. In 2016, twenty-three health centers furnished primary and preventive care to over 423,000 Kentucky residents – ten

percent of State residents. *See* U.S. HHS Health Resources and Services Administration, *2016 Health Center Data: Kentucky Data* (2017). Health centers operate pursuant to Section 330 of the Public Health Service Act, 42 U.S.C. § 254b, to make health care accessible and affordable to medically underserved urban and rural populations regardless of ability to pay. Between 2013 (one year prior to Kentucky's Medicaid expansion) and 2016 (two years following expansion), health centers experienced a forty-six percent decline in the number of uninsured patients. Official data show that between 2013 and 2016 the number of health center patients grew by thirty-four percent, the number of clinical care sites grew by seventy-three percent; medical visits grew by thirty-three percent; dental visits grew by forty-one percent; mental health visits grew by 152 percent medical and dental staffing grew by over forty percent; mental health staff grew by 152 percent; and substance abuse staff by over 400 percent. *See* Peter Shin et al., *Kentucky's Medicaid Work Requirements: The Potential Effects on Community Health Centers*, HEALTH AFFAIRS BLOG (Apr. 12, 2018).

Defendants' improper use of § 1115 jeopardizes these healthcare coverage and access gains. More than 18,000 individuals lost coverage the first seven months of Arkansas's demonstration. *See* GAO, Medicaid Demonstrations – 2019 Report at 22. It is estimated that an additional 589,000 to 811,000 beneficiaries will lose coverage in the nine States with currently approved plans in the first year

if these experiments are fully implemented as designed. Losses of this magnitude reflect between one-quarter and one-third of the 2.5 million people who would become subject to the experimental requirements. In Kentucky and Arkansas, between 128,000 and 184,000 people would lose coverage. These losses are linked only to the experiments' work requirements and do not include losses attributable to other experimental elements such as premiums or complex new reporting rules. Leighton Ku & Erin Brantley, *Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage*, THE COMMONWEALTH FUND (June 21, 2019). Defendants should have been fully aware of what their approvals would trigger, since residents of both States experienced similar benefit losses following implementation of SNAP work requirements. *Id*.

The damage stemming from these demonstrations will affect not just individuals losing coverage but entire communities. One study estimates that, as health center patients lose coverage, these centers will see revenue losses, loss of patient care capacity between 104,000 and 147,000 patients, and staffing capacity declines of between 815 and 1,145 full-time equivalent staff members. Jessica Sharac et al., *How Would Medicaid Losses in Approved Section 1115 Medicaid Work Experiment States Affect Community Health Centers?*, THE GEORGE WASHINGTON UNIVERSITY (June 2019). Despite the spillover ravaging effects, Defendants have instructed States to tell people who lose Medicaid to seek care at

their closest community health center – not only completely disregarding the consequences of their experiments but a tacit admission of the absurdity of their claim that positive results will flow from experiments that imperil Medicaid coverage. *See* Ark. AR 34 (Ark. Special Terms & Conditions, ¶ 54.q); KY AR 7063 (KY STCs, ¶ 47(k)).

Moreover, hospitals face dramatic revenue reductions. Research estimates that, in States with both pending and approved § 1115 work experiments, hospital revenue losses would range from a low of 10.1 percent revenue loss to a high of 22.4 percent. Depending on the experimental particulars, average hospital uncompensated care costs in affected States could grow between thirteen percent per hospital at the low end to a high of 140 percent. *See* Randy Haught et al., *How Will Medicaid Work Requirements Affect Hospitals' Finances?*, THE COMMONWEALTH FUND (Mar. 14, 2019).

B. Extensive Commentary in the Administrative Record Made Clear the Risks Created by Work Requirements and Coverage Restrictions.

Experiments to reduce Medicaid coverage fly in the face of extensive research demonstrating the adverse effects of denying low income people access to health insurance. *See, e.g.*, KAISER FAMILY FOUNDATION, *Sicker and Poorer: The Consequences of Being Uninsured* (Apr. 2002). Yet Defendants simply ignored or provided unresponsive answers to extensive public comments presenting well-supported research opposing their assumptions in the SMDL and their

demonstration approvals for Kentucky and Arkansas. Repeated comments in the record underscore how these demonstrations would harm beneficiaries while doing little to improve incomes or access to employer insurance or to promote better health outcomes. CMS responded that "[w]e believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment," without citing specific evidence to explain how gaining employment promotes the Medicaid objective to furnish medical assistance. Ark. AR 6. The agency also invoked vague notions of experimentation to justify "community engagement," stating, again without any basis in the record, that "it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence." Ark. AR 6.

For instance, the record contains extensive opposition to CMS' "community engagement" policy as an eligibility condition, based on the large body of evidence showing the catastrophic impact of work requirements seen in programs such as cash assistance or TANF. *See, e.g.*, Ark. AR 1269-73, 1276-8, 1301-05, 1330-43; KY(I) AR 3834. In addition, an examination of eight pending State Medicaid work demonstration proposals by the Medicaid and CHIP Payment and Access Commission ("MACPAC") reported that: (1) only one third of people losing TANF benefits found jobs that included employer-sponsored coverage; (2) almost

half of the jobs held by Medicaid beneficiaries were at small businesses not required under the ACA to provide health insurance; and (3) 40 percent worked in the agriculture and service industries, known for their low employer-sponsored insurance offer rates. MACPAC, *Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF* (Oct. 2017); *see also* MaryBeth Musumeci and Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience*, KAISER FAMILY FOUNDATION (Aug. 2017).

The only experimental question CMS conceivably could be trying to answer – so harmful as to take one's breath away – is whether attaching a similar requirement to medical assistance would produce similar catastrophic results. To the many concerns raised in the record, CMS provided a cursory response best summarized as it "has considered those comments," and embracing uncritically the premise that a work requirement somehow "improves beneficiaries' health" or "promote[s] beneficiary independence." Ark. AR 6; *see also* KY(I) AR 8.

CMS was also warned repeatedly with respect to extensive research showing the adverse impact of coverage lock-outs such as the "potential 9-month length of the non-eligibility period" that could result from noncompliance with the community engagement requirement and the two-months reduction of retroactive eligibility in Arkansas' demonstration. *See* Ark. AR 1265-68, 1276-1280, 1294-95, 1296-1300, 1306-1329. CMS' unresponsive answer was that "[w]e believe

that the overall health benefits to the effected [sic] population through community engagement outweigh the health-risks with respect to those who fail to respond and who fail to seek exemption from the programs [sic] limited requirements." Ark. AR 7. CMS never explained what health risks or what health benefits it evaluated or what risks-to-benefits analysis it conducted, if any, to reach its decision to approve the community engagement requirement and other demonstration changes in Arkansas.

CMS' cavalier approach to approving these demonstrations is self-evident. CMS turned a blind eye to actual research findings, undertook actions contrary to compelling evidence against it, implemented a major policy change after the mandatory comment periods had concluded, and failed to weigh the health risks these demonstrations will trigger. *See* 42 U.S.C. § 1315(d)(2)(A), (C). In sum, CMS did not meaningfully consider the relevant factors, failed to document a reasoned decision to approve these demonstrations, and offered implausible explanations of the health gains to be had by imposing work requirements or depriving expansion beneficiaries of medical assistance. The record contains nothing to show that the agency actually considered critical public comments. "Stating that a factor was considered…is not a substitute for considering it." *Getty v. Federal Savs. & Loan Ins. Corp.*, 805 F.2d 1050, 1055 (D.C. Cir. 1986) (rejecting as "conclusory" an agency statement that all relevant factors had been

considered); *see also* U.S. GAO, Medicaid Demonstrations – 2019 Report at 12-13 (noting "CMS did not apply a consistent approach to ensuring transparency" and that, in the case of Kentucky's original § 1115 application, "the extent to which these [public] comments were considered at the state and federal levels was not transparent to the public"). The records were simply insufficient to justify approval of the §1115 demonstrations at issue in this appeal.

C. There is No Realistic Expectation That Those Leaving Medicaid for Work will Find Alternative Sources of Health Insurance.

In approving these two demonstrations, the Secretary asserts, without explaining on what basis, that work requirements create "appropriate" incentives for beneficiaries to gain employment or help individuals and families attain or retain capability for independence or self-care. *See* Ark. AR 3, 6; KY AR 6868. These assertion rests on two assumptions: (1) part time work at low wages offers employer health benefits and (2) threatening people with the loss of Medicaid will lead them to find the jobs with generous benefits. However, CMS cites no evidence to support these misbeliefs. Indeed, with Arkansas, CMS permitted the State to abandon the subsidized employer insurance component of the original demonstration – one that, it should be noted, had produced exactly forty participants. Ark. AR 3. All evidence points in the opposite direction: part-time, low wage jobs come without health benefits. Employee health benefits for low wage workers are uncommon: an average of 16 percent of poor adults had access

to employer-sponsored insurance in the United States in 2016. *See Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUNDATION (2016).

There is zero evidence to suggest that depriving people of Medicaid will lead to greater levels of employer-sponsored insurance. For the people who lose Medicaid because they fail to satisfy work and "community engagement" requirements, a return to persistently uninsured status will be the norm. Unsurprisingly, in addressing the Arkansas demonstration at issue in this appeal, MACPAC noted that "[w]ork and community engagement waivers represent a significant new policy direction for the Medicaid program," expressed its concern that "there was not an approved evaluation design in place at the time of implementation," and "urge[d] HHS to pause disenrollments under the waiver." *See* Letter from Penny Thompson, MACPAC Chair, to Alex Azar II, Secretary of HHS at 2, 4 (Nov. 8, 2018). Indeed, the independent research into the first-year consequences of the Arkansas experiment found no significant change in employer coverage.

Defendants' sanctioned actions are the antithesis of a carefully designed experiment. They amount to a naked move to fundamentally alter Medicaid eligibility policy nationally. Beyond the nine approved States, seven others have pending applications; another six are preparing proposals. Sara Rosenbaum et al., *Are 1115 Medicaid Work Requirement Demonstrations Experimental Initiatives or*

a Way to Side-Step Congress?, GW HEALTH POLICY & MANAGEMENT MATTERS (June 4, 2019). Within a year, Defendants could have nearly half the country operating Medicaid work experiments grounded in profoundly flawed assumptions, lacking any consideration of beneficiary impact, and without a single, government-approved objective evaluation in place to test their hypotheses.

CONCLUSION

For the reasons detailed above, this Court should affirm the decisions of the U.S. District Court for the District of Columbia.

June 27, 2019

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 27th day of June, 2019, the foregoing Brief of Deans, Chairs and Scholars as Amici Curiae in Support of Plaintiffs-Appellees has been served by this Court's Electronic Case Filing System ("ECF").

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CERTIFICATE OF COMPLIANCE

Pursuant to Rules 29(a)(5), 32(a)(7)(B) and 32(g)(1) of the Federal Rules of Appellate Procedure and D.C. Circuit Rule 28(c), I hereby certify that the foregoing Brief of Deans, Chairs and Scholars as Amici Curiae in Support of Plaintiffs-Appellees, which consists of 6451 words, complies with the type-volume limitation.

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