Nos. 20-37, 20-38

In The
Supreme Court of the United States

NORRIS COCHRAN, ACTING SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Petitioners,

v.

CHARLES GRESHAM, ET AL.,

Respondents.

STATE OF ARKANSAS,

Petitioner,

v.

CHARLES GRESHAM, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The District Of Columbia Circuit

BRIEF OF TEXAS MEDICAL-LEGAL PARTNERSHIPS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amici Texas Legal Services Center, People's Community Clinic, and Texas Health Action (d/b/a KIND Clinic) are individual entities that collaborate using the national medical-legal partnership (MLP) model. MLPs embed legal professionals as part of healthcare teams to address the health-harming legal needs of low-income patients in the clinical setting. MLP attorneys bring legal expertise to the delivery of healthcare in a way that both improves outcomes for patients and allows healthcare providers to focus on medical needs rather than socio-legal factors outside their expertise. MLP lawyers also help doctors and patients navigate administrative and legal obstacles to healthcare.

Under federal law, the legal assistance MLPs provide is a "primary health service" because it "enable[s] individuals to use the services of [a] health center" and is "designed to assist health center patients in establishing eligibility for and gaining access to [certain] Federal, State, and local programs." 42 U.S.C. § 254b(b)(1)(A)(iii), (iv). Additionally, some Medicaid state plans and demonstration projects provide for MLPs. Due to the nature of MLPs' work and the multi-professional composition of their staff, MLPs see firsthand the administrative obstacles to

[1] All parties have consented to the filing of this brief. Pursuant to Supreme Court Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part, and no person other than *amici* or their counsel made a monetary contribution to its preparation or submission.

coverage that eligible Medicaid recipients face and too-often fail to overcome.

Amici are well-positioned to identify those obstacles in the current Medicaid system and are concerned that experiments like the work-requirement programs before this Court will exacerbate existing administrative impediments to coverage. *Amici* believe that this increase in administrative burdens will undermine the fundamental purpose of Medicaid by excluding the vulnerable population that Medicaid serves from access to healthcare.

SUMMARY OF ARGUMENT

Congress created Medicaid to improve access to healthcare for a specific subset of those "whose income and resources are insufficient to meet the costs of necessary medical services," including children from low-income households, low-income pregnant women, and certain low-income individuals with disabilities. *See* 42 U.S.C. § 1396-1; 42 C.F.R. § 430.0. In light of the limited resources and logistical challenges faced by Medicaid's target population, the program's express directive is to enhance access to healthcare "in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

The reality of the Medicaid administrative scheme falls far short of that goal. The application process—designed to ensure that only eligible applicants

receive coverage—is so complex that it too-often functions as a barrier rather than a gateway to care. And the renewal and appeals processes are equally convoluted, further impeding access to Medicaid benefits for would-be recipients who satisfy the program's substantive eligibility requirements but cannot successfully navigate Medicaid's administrative scheme.

The unintended consequences that stem from existing administrative obstacles to coverage caution against layering on additional reporting requirements such as those incorporated in Arkansas Works and the New Hampshire Granite Advantage Health Care Program. Although the Centers for Medicare & Medicaid Services (CMS) previously touted work programs as a means to "promote better mental, physical, and emotional health in furtherance of Medicaid program objectives," *see* CTRS. FOR MEDICARE & MEDICAID SERVS., ST. MED. DIR. LETTER SMD 18-002, OPPORTUNITIES TO PROMOTE WORK AND COMMUNITY ENGAGEMENT AMONG MEDICAID BENEFICIARIES (Jan. 11, 2018), https://web.archive.org/web/20210212202937/https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf (hereinafter "CMS Letter SMD 18-002"), that goal is undermined by administrative requirements that inhere in these programs. While employment ideally may provide some of the benefits that CMS cited and the Secretary of Health and Human Services echoed in the proceedings below, *see* Pet. App. 12a-13a, the reporting aspects of the work requirements instituted by states like Arkansas and

New Hampshire create new problems as well. Specifically, Medicaid recipients who meet federal eligibility standards and comply with state-imposed work requirements may nonetheless lose coverage because they are unable to successfully report their work. *See, e.g.*, Benjamin D. Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 HEALTH AFFS. 1522, 1529 (2020).

Work is already a part of most Medicaid recipients' lives. Nationally, more than 60% of non-disabled, non-elderly recipients work full-time or part-time. *See* Chris Lee, *Only Six Percent of Adult Medicaid Enrollees Targeted by States' New Work Requirements Are Not Already Working and Are Unlikely to Qualify for an Exemption*, KAISER FAM. FOUND. (June 12, 2018), https://www.kff.org/medicaid/press-release/only-six-percent-of-adult-medicaid-enrollees-targeted-by-states-new-work-requirements-are-not-already-working-and-are-unlikely-to-qualify-for-an-exemption/. Many other recipients fall within an exemption to the work requirement. Indeed, only 6% of recipients who are not exempt do not work. *Id.* (calculating percentage based on broadest state exemptions). For the more than 60% of non-disabled, non-elderly Medicaid recipients who already work full-time or part-time, *see id.*, a work requirement would likely have its greatest impact at the administrative level, imposing reporting requirements that tend to disenroll recipients. *See* Rachel Garfield et al., *Implications of a Medicaid Work Requirement: National*

Estimates of Potential Coverage Losses, KAISER FAM. FOUND. 3, 5 (June 27, 2018), http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses (hereinafter "Garfield, *Implications*"). In light of the threat to coverage posed by the additional administrative requirements of the experimental work-programs at issue here, the court below correctly determined that it was arbitrary and capricious for the Secretary of Health and Human Services to approve those state programs without addressing coverage-loss concerns. *See* Pet. App. 2a, 9a-10a, 18a (concluding that "the principal objective of Medicaid is providing healthcare coverage," and the Secretary's approvals rested on "an entirely different set of objectives"); *see also id.* 20a-21a.

The perspectives of clinicians and attorneys at MLPs shed light on the dangers of adding the administrative obstacles intrinsic to work-requirement programs. When Medicaid recipients who meet eligibility requirements are excluded from coverage because of administrative hurdles they lack the resources to clear, the system fails at a fundamental level. The proposed work requirements threaten to multiply these administrative hurdles, further limiting the availability of Medicaid to its intended recipients. Increased administrative burdens also threaten to undermine holistic efforts to reduce health disparities, diverting MLP and other resources away from more productive, heath-supporting initiatives. Given the vulnerability and serious medical needs of

Medicaid's target population, the federal government should not encourage states to experiment with work requirements that exacerbate the problem of lost coverage for reasons unrelated to beneficiaries' actual eligibility under federal and state law.

ARGUMENT

I. QUALIFYING INDIVIDUALS ALREADY FACE SUBSTANTIAL ADMINISTRATIVE OBSTACLES TO ACCESSING MEDICAID BENEFITS FOR WHICH THEY ARE ELIGIBLE.

Despite meeting federal and state eligibility requirements, would-be Medicaid recipients too-often fail to obtain or maintain the coverage to which they are entitled. Although "broad Federal rules" aspire to simplify access to Medicaid and set guidelines for states to follow, *see* 42 C.F.R. § 430.0, the process of applying for and maintaining Medicaid coverage is anything but simple.

Impediments to accessing care often stem from the logistical difficulties of navigating the Medicaid administrative scheme, which is particularly challenging for Medicaid's vulnerable target population. Would-be recipients may lack awareness of, or be unable to comprehend, administrative requirements. Even those who understand what information to provide may fail to obtain coverage because they lack the resources, technological and otherwise, to comply with

administrative obligations. Examining these existing obstacles to Medicaid coverage helps explain why the federal government should discourage state work-program experiments that add administrative requirements that threaten healthcare coverage. *See* Pet. App. 9a-10a (reasoning that approvals of state programs must be guided by Medicaid's purpose: to provide access to healthcare coverage).

A. Medicaid's Target Population Is Particularly Ill-Equipped To Navigate Complex And Ongoing Administrative Requirements.

Before individuals can apply for Medicaid, they must know the program exists. And that is never a given. Although federal law requires states to provide information "in plain language" about Medicaid eligibility requirements, available services, and "rights and responsibilities" of beneficiaries and applicants, 42 C.F.R. § 435.905(a)-(b), would-be recipients must know where to locate that plain language. Federal regulations mandate that this required information be available on the website of the state agency administering Medicaid, provided "orally as appropriate," and given to whoever requests it. *Id.* § 435.905(a), § 435.1200(f)(1). But if a would-be recipient does not know which agency website to check, is unaware of the "appropriate" means of oral communication, or is uncertain how to request information about eligibility or rights and responsibilities of applicants and beneficiaries, that individual may never even enter the system. And people often find out about Medicaid

only *after* becoming ill, so they begin the complicated application process burdened by health concerns and medical bills. As a result, the stakes can be incredibly high by the time a person decides to apply for coverage.

An overview of eligibility requirements demonstrates the inherent vulnerability of Medicaid's target population, as a practical matter, in accessing coverage. The Medicaid program creates three eligibility groups: "mandatory categorically needy," "optional categorically needy," and "medically needy." *List of Medicaid Eligibility Groups*, MEDICAID.GOV 1-2 (2019), https://www.medicaid.gov/sites/default/files/2019-12/list-of-eligibility-groups.pdf; *see* 42 C.F.R. § 435.4. If individuals meet "non-financial criteria" for a certain eligibility group—*e.g.*, age, disability status, or state citizenship—they then must also satisfy state-specific financial criteria. *Historical and Projected Trends in Medicaid*, OFF. ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T HEALTH & HUM. SERVS. 26 (2006), https://aspe.hhs.gov/system/files/pdf/74801/report.pdf.

An individual's eligibility-group classification affects states' obligations to provide coverage. For individuals categorized as "mandatory categorically needy," coverage is required. That group includes "aged, blind and disabled individuals," low-income families, Supplemental Security Income recipients, pregnant women, and children. *Id.*; *see* 42 U.S.C. § 1396a(a)(10)(A)(i). Coverage is noncompulsory, however, for those in the "optionally categorically

needy group." That category is based on "less restrictive" standards but similarly includes children, pregnant women, families, and "aged, blind or disabled" people. *Historical and Projected Trends in Medicaid*, *supra*, at 27; *see* 42 U.S.C. § 1396a(a)(10)(A)(ii). Finally, states have the option to provide coverage to "medically needy" individuals who fall within the preceding two categories but exceed income limits. *Historical and Projected Trends in Medicaid*, *supra*, at 28; *see* 42 C.F.R §§ 435.300-.350. Individuals can bring themselves within the "medically needy" category by "spending down," a process requiring proof of sufficient healthcare-expenditure income deductions to deem the person income eligible. *See* 42 U.S.C. § 1396a(a)(17); 42 C.F.R. § 435.831(d); *Historical and Projected Trends in Medicaid*, *supra*, at 3 n.4. The complexities of these categories and states' varying obligations can leave eligible individuals uncertain about where they stand.

Moreover, once would-be recipients identify their potential eligibility, logistical impediments—including seemingly simple administrative requirements—pose practical obstacles. For example, aspects of the process may require access to a computer, but 26% of adult Medicaid recipients nationwide report that they never use a computer. Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work: What Does the Data Say?*, KAISER FAM. FOUND. (Aug. 8, 2019), https://web.archive.org/web/20210202080918/https:/www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/. Even if

libraries or community centers offer public access to computers, applicants still need to find transportation to those locations during operating hours. *See, e.g.*, Ian Hill & Emily Burroughs, *Lessons from Launching Medicaid Work Requirements in Arkansas*, URB. INST. 15 (Oct. 2019), https://www.urban.org/sites/default/files/publication/101113/lessons_from_launching_medicaid_work_requirements_in_arkansas.pdf. And, once there, those individuals may be unfamiliar with the available technology.

Non-computer methods may also present impediments to establishing eligibility. To receive a mailed application or information, an individual needs a stable address at which to receive mail—which is not a given for those experiencing housing instability. And applying by phone requires both telecommunications access and knowing which number to dial. Add into the mix the intrinsic vulnerabilities of Medicaid's target population—which includes low-income individuals, the aged, children, pregnant women, and individuals who are blind or have other disabilities—and it becomes even clearer why administrative burdens that may seem routine in other contexts pose significant obstacles.

B. The Medicaid Application Process Presents Multiple Obstacles To Accessing Care.

Although states must adhere to federal guidelines, they maintain discretion regarding Medicaid applications. *See* 42 C.F.R. § 435.907(b)(2); *see also* Gary Cohen

& Cindy Mann, *Guidance on State Alternative Applications for Health Coverage*, CTRS. FOR MEDICARE & MEDICAID SERVS. 2-4 (2013), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/state-alt-app-guidance-6-18-2013.pdf. States have the option of either using the single, streamlined application developed by the U.S. Secretary of Health and Human Services or creating their own application, subject to the Secretary's approval, which can be "no more burdensome on the applicant" than the federally developed application. 42 C.F.R. § 435.907(b).[2] While State programs must comply with "simplicity of administration," *see id.* § 435.902,[3] the process nonetheless remains challenging in many respects.

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[2] Depending on how applicants intend to qualify, they may need to complete supplemental forms. *See, e.g.*, 42 C.F.R. § 435.907(c). And certain paths to qualification require demonstrating eligibility for a separate program. For example, proving eligibility for Medicaid for the Disabled generally requires meeting disability requirements under Title XVI of the Social Security Act. *See id.* § 435.120(c); *What is Medicaid*?, SOC. SEC. ADMIN., https://www.ssa.gov/disabilityresearch/wi/medicaid.htm (last visited Feb. 21, 2021).

[3] States must ensure that applications and supplemental forms are accessible to individuals with disabilities or limited English proficiency. 42 C.F.R. § 435.907(g). States also must accept applications online, by telephone, by mail, in person, and "[t]hrough other commonly available electronic means." *Id.* § 435.907(a). As noted in Part I.A *supra*, many would-be recipients may not get as far as locating forms or discovering the options for submitting them.

In Texas, for example,[4] would-be recipients can access the online Medicaid application through a portal. *See* YOURTEXASBENEFITS, https://www.yourtexasbenefits.com/Learn/Home (last visited Feb. 18, 2021). That online process requires a computer and a stable internet connection. Applicants who successfully access the portal must then navigate through a series of questions just to create an account, specifying the programs for which they are applying and stating whether they already receive state benefits, are a refugee, or fall within an eligible category (i.e., adults caring for a child, pregnant women, people over 65 or people with a disability "that is expected to last a year or longer," children, adult not taking care of a child, and "[p]erson who is (1) age 25 or younger, and (2) was in foster care"). *Get Benefits Now?*, YOURTEXASBENEFITS, https://www.yourtexasbenefits.com/Learn/GetBenefitsNow (last visited Feb. 21, 2021). If an otherwise-eligible individual misunderstands a question or selects the wrong category, that individual cannot create an account.[5] Finally, the application also

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[4] Unlike Arkansas and New Hampshire, which opted in 2014 and 2016, respectively, to expand Medicaid coverage beyond the original four federal categories (i.e., the disabled, the blind, the elderly, and low-income families with dependent children, 42 U.S.C. § 1396-1), *see* Pet. App. 2a, 70a, Texas covers only the original four categories and the medically needy, with limited exceptions. *See*, *e.g.*, TEX. HEALTH & HUM. SERVS., TEX. MEDICAID & CHIP IN PERSPECTIVE 12-21 (2020). But in *amici* MLPs' experience, Texas's basic administrative requirements to apply for and maintain coverage are fairly representative of expansion and non-expansion states alike.

[5] The rejection message given on the portal gives no guidance on what error an applicant may have made, simply saying: "Based

requires information from personal and financial documents that applicants must have with them while applying. *See id*. Some of these documents must be scanned and uploaded. *See How Do I Upload Files*, YOURTEXASBENEFITS, https://yourtexasbenefits.com/Learn/Help/Section?s=5AD00E3E85242CA7530B76CB6591E631#qid=2966768040AF442D0C69830AF636969A (last visited Feb. 22, 2021).

Paper applications present their own logistical challenges. For example, in Texas, the paper application requires an applicant to either print the form from the YourTexasBenefits website—which requires a computer, internet connection, and printer—or request that a form be mailed. *See Get a Paper Form*, YOURTEXASBENEFITS, https://www.yourtexasbenefits.com/Learn/GetPaperForm (last visited Feb. 16, 2021). Applicants who want to print an application must choose the correct option out of six forms—three of which are labeled, respectively, "Form to apply for Medicaid for the Elderly and People with Disabilities or Medicare Savings Program," "Form to apply for Medicaid for People with Disabilities who Work—Medicaid Buy-In," and "Form to apply for: (1) Medicaid or CHIP, or (2) help paying for private health insurance," with no further guidance on which form applies to which individuals. *See id*. Even when applicants locate and print the correct form, they need access to additional technology, such as a

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on your answers, we can tell that you should not apply for benefits on YourTexasBenefits.com. You aren't able to get Texas benefits." *Get Benefits Now?*, *supra*.

copier (or a scanner and printer) to submit necessary documentation. *See Application for Benefits Form H1010*, YOURTEXASBENEFITS C (2019), https://www.yourtexasbenefits.com/GeneratePDF/StaticPdfs/en_US/H1010_Nov_2019.pdf (hereinafter "Texas Application").[6]

Other states similarly require applicants to copy and mail documents. For example, the California application asks for applicants to provide proof of citizenship and "[e]mployer and income information for everyone in [their] family." *Application for Health Insurance*, COVERED CAL. 1, https://www.coveredca.com/pdfs/paper-application/CA-SingleStreamApp_92MAX.pdf (last visited Feb. 21, 2021) (hereinafter "California Application"). The New York application requires applicants to send proof of current or future income and lists a number of other potentially relevant documents, but it says to send only those "that apply to [the applicant] and the people living with [him or

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[6] Applicants in households with more than five people must copy and complete application pages for each "extra" household member. *See, e.g.*, Texas Application, *supra*, at 5. Other states have similar requirements. *See, e.g.*, *Application for Oregon Health Plan Benefits*, OHP 7219, OR. HEALTH PLAN 5 (May 1, 2020), https://sharedsystems.dhsoha.state.or.us/DHSforms/Served/he7210.pdf (hereinafter "Oregon Application") (requiring scans of additional application pages when households exceed four); *Application for Medical Assistance for Families with Children*, KC1100, KANCARE MEDICAID FOR KAN. 6, https://www.kancare.ks.gov/docs/default-source/consumers/apply/families-and-children/kc-1100-application-for-medical-assistance-for-families-with-children-11-18.pdf?sfvrsn=79ee4c1b_8 (last visited Feb. 21, 2021) (requiring attachments when households exceed six).

her]" without explaining how to make that determination. *Health Insurance Application*, N.Y. ST. DEP'T OF HEALTH 5-6, https://www.health.ny.gov/forms/doh-4220.pdf (last visited Feb. 20, 2021) (hereinafter "New York Application"). New York also warns that "[m]any local departments of social services do not accept original documents by mail" and requires applicants to "check with" their local department if applicants "wish to mail" certain required documents, such as proof of citizenship. *Id.* at 5.

Ohio's paper application says to mail signed applications to applicants' local County Department of Job and Family Services but does not include an address. *Application for Health Coverage & Help Paying Costs*, ODM 07216, OHIO DEP'T OF MEDICAID 7 (July 2014), https://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM07216fillx.pdf. It directs applicants instead to a website. *Id.* Thus, while a paper application may seem like the simplest and least technologically demanding option, it still presents obstacles by requiring extra equipment and, even more fundamentally, a stable mailing address—something many low-income applicants may not have.

Applying in person may be no easier than using the online portal or filling out a paper application because it requires applicants to have transportation and flexible job hours that enable a visit to the relevant state agency's local office during working hours. Moreover, the physical-mobility, job-flexibility, and transportation demands of the in-person application

process may be further complicated by outdated and inaccurate online information about the office's location and hours of business. For example, New York has a history of posting outdated links and incorrect phone numbers for local offices on its Local Department of Social Services website, creating needless barriers to initiating an in-person application. *See, e.g.*, *Local Departments of Social Services*, N.Y. ST. DEP'T OF HEALTH, https://www.health.ny.gov/health_care/medicaid/ldss (displaying 29 bad links when last accessed on Feb. 18, 2021).

Then there is the application itself. Paper applications can range from 12 to more than 40 pages in length, depending on how the applicant intends to qualify. *See*, *e.g.*, Texas Application, *supra* (32 pages); California Application, *supra* (36 pages); Oregon Application, *supra* (49 pages not including a 16-page accompanying "Application Guide," *Application Guide*, OHA 9025, OR. HEALTH PLAN (May 2020), https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he9025.pdf); New York Application, *supra* (15 pages).

For example, the Texas Application for Benefits Form H1010—the general Medicaid application form for pregnant women, children, and adults—is 24 pages long, excluding three appendices. *See* Texas Application, *supra*, at 1. It requires detailed contact information for the head of household and all people applying for Medicaid. *Id*. at 1, 4. The application also requires a full catalog of all assets and all money flowing into or out of the household, including any type

of government benefits, job income, child support, loans, rent payments, utility payments, medical payments, taxes, and costs of childcare or child support. *Id.* at 10-15; *see also* Oregon Application, *supra*, at 19-20 (requiring reported income including "tips and commissions" and household members' non-work income, including unemployment benefits, social-security benefits, interests or dividends, and alimony).

It is not difficult to imagine the logistical challenges of compiling the substantial documentation required to respond to these questions. And for some low-income applicants with unstable living situations, keeping that type of paperwork readily available may not be realistic due to frequent moves between housing or lack of reliable storage. Additionally, after beginning the online process at a local library or community center, applicants may learn they do not have documents needed to answer all questions. They therefore may need to make multiple trips to the library or community center, compounding transportation and physical-mobility challenges.

C. The Appeals Process Presents Another Set Of Administrative Obstacles To Coverage.

Like the Medicaid application process, the process for appealing a denial of coverage includes a number of procedural safeguards that sound valuable in the abstract. At a practical level, however, these safeguards fail to address the common logistical and

resource-related hurdles that may derail a would-be recipient's otherwise meritorious appeal.

To be sure, federal regulations do require states to take steps to inform applicants of coverage denials and the availability of an appeal. Thus, when a state determines that an applicant is ineligible for Medicaid, it must provide "timely and adequate written notice" of the denial with a "clear statement of the specific reasons supporting" the decision and information about the applicant's right to a fair hearing. *See* 42 C.F.R. §§ 431.210(a), (b), (d), 435.917(a), (b)(2). States generally must provide a 90-day window for applicants to request a hearing, and that request can be made online, by telephone, by mail, in person, and "[t]hrough other commonly available electronic means." *Id.* §§ 431.221(d), 435.907(a)(1-5); *see also id.* § 431.224(a)(1) (providing for "an expedited fair hearing" when an applicant's "life, health or . . . function" is in jeopardy).[7]

Nonetheless, pursuing a hearing can be daunting in practice. Determining how to schedule a hearing can be a barrier in and of itself. And if an applicant successfully obtains a hearing, the hearing "can be a scary, intimidating, and complex process that involves court-like procedures, public speaking, motion practice, entry of exhibits, objections to

[7] Hearings must occur "[a]t a reasonable time, date, and place," *id.* § 431.240(a)(1), and the applicant must have an opportunity to present witnesses, "[q]uestion or refute any testimony or evidence," and "[e]xamine . . . [a]ll documents and records to be used by the State or local agency . . . at the hearing." *Id.* § 431.242(a)(2), (b), (e).

evidence, and an understanding of complicated laws and procedures." *See* Lisa Brodoff, *Lifting Burdens: Proof, Social Justice, and Public Assistance Administrative Hearings*, 32 N.Y.U. REV. L. & SOC. CHANGE 131, 149 (2008) (discussing public-assistance appeals generally). Further, a person who struggles enough medically or financially to apply for Medicaid may lack the resources necessary to secure professional assistance with an appeal.

Applicants with disabilities and those who are severely ill often have the most urgent need for care and the strongest grounds to challenge denials of coverage. But this group may be especially disinclined to appeal due to poor health, physical limitations, or reduced resources. *See id.* at 150. And an appeal, even if successful, cannot make up for lost time-sensitive treatment, such as prenatal screenings and other pregnancy-related care. Additionally, children with serious medical needs may lose coverage because caretakers cannot leave children uncared for during the time needed to navigate an appeal.

Individuals seeking Medicaid coverage also typically have low incomes, which means they often lack the technological resources, job flexibility, and free time needed to successfully navigate an appeal. *Cf. id.* (discussing various challenges to appeals for low-income applicants). And literacy issues can lead to difficulties understanding denial notices or requests for more information, as "Medicaid recipients are at particular risk for both limited general and health literacy skills." Jocelyn Wilson et al., *Are State Medicaid Application Enrollment Forms Readable?*,

20 J. HEALTH CARE FOR POOR & UNDERSERVED 423, 424 (2009).

D. Once Applicants Qualify For Medicaid, They Must Continue Clearing Administrative Hurdles To Maintain Benefits.

Even if a state approves an applicant for Medicaid coverage, additional paperwork and ongoing administrative requirements make each Medicaid recipient's position precarious. One of the most significant barriers to continued coverage is the renewal process, an ongoing evaluation of eligibility by the state in which delays or errors by the recipient—or the state—can result in recipients' losing benefits before learning that those benefits were in danger.

Given the rigorous application process, Medicaid beneficiaries may think their coverage is set, subject only to a disqualifying development. But the reality is that recipients, once in the Medicaid system, must requalify on an ongoing basis. Generally, states must conduct periodic renewals, or redeterminations, of beneficiaries' Medicaid eligibility every twelve months. 42 C.F.R. § 435.916(a)(1), (b). Individuals whose eligibility is based on modified adjusted gross income (MAGI) must renew their eligibility "no more frequently than once every 12 months." *Id.* § 435.916(a)(1). And states must redetermine the eligibility of beneficiaries whose eligibility is not

MAGI-based "at least every 12 months." *Id.* § 435.916(b). However, if the state learns of a change in a beneficiary's circumstances that could affect eligibility, it "must promptly redetermine eligibility"—even between renewal periods. *See id.* § 435.916(d)(1).

During the renewal process, states must first attempt to redetermine eligibility with the information available to them. *See id.* § 435.916(a)(2), (b). But if the state concludes that it lacks sufficient information to make a redetermination, it sends a pre-populated renewal form to the beneficiary and provides at least 30 days for a response. *Id.* § 435.916(a)(3)(i).

Many of the administrative obstacles to a successful Medicaid application are also present in the renewal process. In Texas, for example, a Medicaid recipient who has been sent a renewal form may complete the process either online (requiring access to a computer and the internet), by mail (requiring access to a copier or a scanner and printer to prepare and submit copies of supporting documents), or by fax (requiring access to a fax machine). *See Sample Renewal Notice*, TEX. HEALTH & HUM. SERVS. COMM'N (2019), https://hhs.texas.gov/sites/default/files/documents/laws-regulations/forms/H1830-R/H1830-R.pdf.

The renewal process also presents challenges unique to this aspect of the Medicaid system. If the state is unable to independently determine that a recipient qualifies for coverage, it sends a request for

information by mail. *See* 42 C.F.R. § 435.917(a). So Medicaid recipients who recently changed their addresses might not receive the request and thus might have no idea that their Medicaid benefits are in jeopardy.[8]

Similarly, for low-income individuals without stable housing, the notice may arrive at a location where the recipient only sporadically or no longer resides, delaying receipt of the notice and narrowing, if not closing, the window to respond. *See* Boozang, *supra*. (noting that federal regulations require only that a state wait 30 days for a response to a renewal form and that states generally give beneficiaries 10 to 15 business days to provide other eligibility information).

Once recipients receive a renewal notice, they may find unclear instructions on how to satisfy renewal requirements. Texas's renewal notice, for example, lists 13 types of documents the beneficiary must provide, but only if they "apply to [the recipient's] case." *Sample Renewal Notice*, *supra*, at 2. The form offers no guidance for determining when documents "apply" to one's case, so beneficiaries may make incorrect

[8] "Many state Medicaid and CHIP agencies do not, as a standard practice, follow-up on returned mail but rather terminate eligibility for individuals whose addresses no longer appear valid." Patricia Boozang et al., *Maintaining Medicaid and CHIP Coverage Amid Postal Delays and Housing Displacements*, St. Health & Value Strategies (Sept. 24, 2020), https://www.shvs.org/maintaining-medicaid-and-chip-coverage-amid-postal-delays-and-housing-displacements/.

assumptions and lose coverage as a result. And "language or literacy challenges" increase the already-high risk that a beneficiary will misunderstand instructions. *Cf.* Samantha Artiga & Olivia Pham, *Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage*, KAISER FAM. FOUND. 4 (Sept. 24, 2019), http://files.kff.org/attachment/Issue-Brief-Recent-Medicaid-CHIP-Enrollment-Declines-and-Barriers-to-Maintaining-Coverage.

While federal guidelines direct states to provide an online renewal option, 42 C.F.R. § 435.1200(f)(1)(ii), the guidelines do not prescribe accompanying instructions or procedures. *See id.* § 435.1200(f)(2) (requiring only that the website "be in plain language" and "accessible to individuals with disabilities and persons who are limited English proficient"). And states' online instructions are not all models of clarity. Texas's renewal notice does not indicate that supplemental documents can be uploaded online; it instructs beneficiaries to "[b]ring or mail copies of" those documents to the state. *See Sample Renewal Notice*, *supra*, at 2. And despite instructing beneficiaries to "bring" documents, the form does not specify where to bring them—in fact, the form does not even offer in-person renewal as an option. *See id.*[9]

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[9] Some states do offer in-person renewal. *E.g., Renewing Your Health Plan*, COVERED CAL., https://www.coveredca.com/members/renewal/ (last visited Feb. 16, 2021); *How to Renew Your Benefits*, EMPIRE BLUE CROSS BLUE SHIELD, https://mss/empireblue.com/ny/enrollment/renew.html (last visited Feb. 16, 2021).

In addition, administrative hurdles may arise more often than the annual renewal. For select groups, such as families with children on Medicaid, states redetermine eligibility much more frequently. In Texas, the state automatically receives information electronically about unemployment insurance applications and benefits, work and federal taxes, and credit score and history, enabling it to conduct redeterminations five times in 12 months—including four months in a row. *See* TEX. ADMIN. CODE ANN. § 358.545. Redeterminations are indexed to each individual, which means that if household members, usually children, enrolled at different times, renewal notices may come as often as monthly. *See, e.g.*, Shefali Luthra, *In Texas, People with Fluctuating Incomes Risk Being Cut Off From Medicaid*, NPR (June 14, 2017), https://www.npr.org/sections/health-shots/2017/06/14/532816157/in-texas-people-with-fluctuating-incomes-risk-being-cut-off-from-medicaid.

Individuals receiving such notices have only 10 days to resolve an alleged discrepancy. *See* TEX. ADMIN. CODE ANN. § 357.11. Moreover, some recipients' only notice of ineligibility comes at a doctor's office, when they must decide between incurring a bill they cannot pay and foregoing needed care. *See*, *e.g.*, Elizabeth Byrne, *Texas Removes Thousands of Children from Medicaid Each Month Due to Red Tape, Records Show*, TEX. TRIB. (Apr. 22, 2019), https://www.texastribune.org/2019/04/22/texas-takes-thousands-kids-medicaid-every-month-due-red-tape/.

Just as applicants who are initially deemed ineligible can appeal the decision, beneficiaries who are found ineligible during renewal or redetermination of eligibility can request a hearing. *See* 42 C.F.R. § 431.220(a)(1). If individuals submit renewal forms within at least 90 days of having eligibility terminated for failing to satisfy renewal requirements, the state must reconsider their eligibility. *Id.* § 435.916(a)(3)(iii). But many of the same logistical hurdles that impede the application-appeal process similarly impede successful appeals of disqualifications during renewal. *Cf. supra* Part I.C.

This is not an exhaustive list of the administrative barriers to care that exist in Medicaid systems across the country. What is clear, however, is that fundamental obstacles—an applicant's lack of access to a computer, misunderstanding of the application, or inability to navigate the appeal or renewal process—inhere in the current Medicaid administrative system. And the cumulative effect of multiple administrative hurdles, faced by populations with few resources to tackle them, undermines the system's ability to fulfill its purpose of enhancing access to healthcare coverage. *See* Pet. App. 9a-10a.

The reporting requirements associated with work programs will increase the obstacles to healthcare coverage that eligible recipients face. The federal government should not authorize states to engage in these types of coverage-defeating experiments.

II. The Life Experiences of Medicaid Patients And The MLP Clinicians And Attorneys Who Assist Them Illustrate How Administrative Hurdles Impede Access To Coverage.

Abstract discussions of forms and requirements offer a glimpse into the complexities of Medicaid's administrative system, and the real-world experiences of MLP attorneys, healthcare providers, and Medicaid applicants and recipients confirm how difficult, and at times inscrutable, the process can be. Even professionals who interact regularly with the Medicaid system sometimes hit administrative walls that jeopardize or eliminate coverage for which individuals qualify under the substantive parameters of the Medicaid program.

Sara Espahbodi, a Staff Attorney with the Legal Hotline for Texans at the Texas Legal Services Center, has witnessed her clients encounter the many administrative pitfalls in the Medicaid system. Narrative of Sara Espahbodi, Staff Att'y, Legal Hotline for Texans at the Tex. Legal Servs. Ctr., Austin, Tex. (email received Feb. 2, 2021). She has seen clients confused about which household members and medical needs to include in the application—and that confusion often results in applicants' failure to supply necessary medical documentation for the specific need on which the application should have focused.

Leslee Perez, a Licensed Clinical Social Worker and therapist with the People's Community Clinic, echoed Espahbodi's paperwork concern, noting that

this aspect is particularly challenging for applicants who lack stable housing and cannot carry around extensive documentation. Narrative of Leslee Perez, MLP Licensed Clinical Social Worker, People's Cmty. Clinic, Austin, Tex. (email received Jan. 8, 2021). Ben Steele, a healthcare worker with Austin's KIND Clinic, further observed that some obstacles are beyond patients' control: Farm workers, for example, have employers who may not regularly document income. Narrative of Ben Steele, Patient Navigator, Tex. Health Action d/b/a KIND Clinic, Austin, Tex. (email received Jan. 15, 2021). Because the application process is so difficult, Espahbodi recognizes that "getting assistance is the best way to get Medicaid quickly" and that, without outside help, many applicants face "at best" a long wait before receiving benefits. Espahbodi Narrative, *supra*.

Medicaid applicants' widespread need for assistance in navigating the system results in some healthcare providers performing "double duty," treating applicants' medical needs while also attempting to decipher Medicaid requirements and coach patients through the administrative process. One adolescent-medicine physician recalls spending half an appointment attempting to explain to a soon-to-be nineteen-year-old patient how to seek a continuation of benefits based on her own situation as opposed to parents' or guardians' household income, which previously would have controlled. Narrative of Adolescent Med. Physician, Austin, Tex. (email received Jan. 9, 2021) (contributed on condition of anonymity). Because the

patient was at risk of losing access to care, this physician took time earmarked for treating medical needs and spent it, instead, helping the patient work through administrative hurdles to securing ongoing Medicaid coverage.

It is experiences like this that have spurred the development of MLPs. MLPs take a holistic, team-based approach to treating individuals who are often within Medicaid's target population. The integrated services allow clinicians to focus on providing healthcare while attorneys and administrative support staff help patients with other challenges, such as obtaining and maintaining the Medicaid benefits for which they are eligible.

Regina Rogoff, Chief Executive Officer of the People's Community Clinic, recalled an MLP success story involving a patient who lost access to health coverage for months despite being eligible. Narrative of Regina Rogoff, Chief Exec. Officer, People's Cmty. Clinic, Austin, Tex. (email received Dec. 6, 2020). The patient's mother had missed the deadline to renew—a difficult process, *see supra* Part I.C. For months, the mother filled out paperwork to reapply for Medicaid, called Medicaid officials, and even attended two hearings to renew her disabled, adult child's coverage. Eventually, the MLP attorney who had been assisting with the appeals process identified an alternative strategy to maintain the daughter's coverage. Without that attorney's expertise, however, that family would not have even been aware of the alternative pathway.

Even if a would-be Medicaid recipient has the good fortune to locate an MLP, it may be too late in the process to correct administrative errors by the patient or erroneous denials by the state Medicaid agency. Daphne McGee, a staff attorney with the Texas Legal Services Center who works in its MLP with the HOPE Clinic is often unable to assist clients who come to her confused about denied or terminated Medicaid benefits simply because the clock has run out on the time to appeal. Narrative of Daphne McGee, Staff Att'y, Tex. Legal Servs. Ctr. & MLP Att'y, Asian Am. Health Coalition of the Greater Hous. Area d/b/a HOPE Clinic, Hous., Tex. (email received Jan. 29, 2021). McGee notes that when she first meets clients, they often have no idea that a right to appeal even exists. As a result, this first meeting may occur long after the window has closed for any appeal of a denial of eligibility or treatment. MLPs seek to mitigate this situation by integrating attorneys at the point of care, enabling clinicians to request that an attorney join the care team for a given patient. But if clients have no idea appeal options exist, they may not mention their Medicaid denials, leaving little that even an inter-professional team can do to help.

Even with timely MLP assistance, some patients who meet substantive Medicaid eligibility requirements lose benefits due to the inscrutability of the Medicaid administrative system. Wesley Hartman, a staff attorney with the Texas Legal Services Center who works in its MLP with the KIND Clinic, recalls being unable to resolve an administrative obstacle faced by a

sixteen-year-old client. *See* Narrative of Wesley Hartman, Staff Att'y, Tex. Legal Servs. Ctr., & MLP Att'y, Tex. Health Action d/b/a KIND Clinic, Austin, Tex. (email received Jan. 29, 2021). The client's application had been granted initially under the name of her mother—with whom she no longer lived nor had contact. Medicaid repeatedly denied the client's attempts to obtain coverage under her own name. Although Hartman worked with her to challenge the denials, their efforts were unsuccessful. As a result, the client lost two years' worth of Medicaid benefits. To this day, Hartman states, it is "still unclear what . . . happen[ed]."

Not every Medicaid applicant can be an MLP client. And, as the preceding narrative shows, having that type of legal support does not guarantee a successful administrative result. For the vast majority of would-be Medicaid recipients who pursue coverage without professional assistance, the demands can feel overwhelming and insurmountable. Dr. Feba Thomas, a physician at the People's Community Clinic, previously had perceived Medicaid as a "lost cause" because she saw how "countless" patients struggled to navigate the Medicaid administrative system on their own, too-often losing desperately needed care despite meeting substantive eligibility requirements. *See* Narrative of Feba Thomas, MLP Physician, People's Cmty. Clinic, Austin, Tex. (email received Dec. 23, 2020). In particular, Dr. Thomas has witnessed that individuals "who struggle to make rent, transition from couch to car, live in friend's houses, or live on

the street often have the most difficulty gathering documents"; and for those "with mental health or complex medical issues, it's often hard for them to even keep deadlines in mind." These realities of patients' lives exacerbate the administrative challenges of accessing Medicaid benefits for which they are eligible.

One People's Community Clinic employee (who is not an attorney) experienced confusion and hit administrative walls while attempting to navigate the Medicaid system on behalf of her own daughter, who suffered from asthma and had been hospitalized multiple times. Narrative of Lina Diaz, MLP Nationally Registered Certified Med. Assistant, People's Cmty. Clinic, Austin, Tex. (email received Jan. 6, 2021) (recounting colleague's experience). Although the mother worked in the healthcare field at a clinic that specializes in treating Medicaid's target population, she was uncertain how to appeal a Medicaid denial, and she also did not realize that her daughter could qualify for other programs. After re-applying and receiving another denial on the basis of her income, the daughter ultimately qualified for CHIP coverage when the household expanded after the mother had another child.

Heidi Russell, an MLP oncologist at Texas Children's Hospital who teaches health policy to medical and graduate students, shared a revealing anecdote. *See* Narrative of Heidi Russell, MLP Oncologist, Tex. Child. Hosp., Hous., Tex. (email received Jan. 20, 2021). As an exercise, she asked her students—all senior undergraduates and students

pursing advanced degrees—to fill out a Medicaid application so that they could experience firsthand what their patients encounter. She recalls that it was "nearly impossible" for most of them to complete the task successfully. In fact, only one or two students found the proper form for assessing their own eligibility. And when asked to complete forms as though they were primarily Spanish-speaking individuals, students found that websites were "almost entirely" in English despite the students' following Spanish prompts.

These firsthand accounts from MLP clinicians, staff, and lawyers confirm the complexities of the Medicaid system and the very real administrative hurdles that impede access to care in a variety of ways. Additional burdens in the form of reporting requirements for work programs are likely to make this problem even worse.

III. Work Programs' Reporting Requirements Add Administrative Obstacles To Coverage That May Disqualify Otherwise-Eligible, Working Recipients And Undermine Holistic Efforts To Ameliorate Health Disparities.

Medicaid's existing administrative components present significant obstacles to healthcare coverage for eligible applicants, primarily in the form of large amounts of paperwork, assumption of applicant access to technology or transportation, and confusing application requirements. Work programs' reporting

requirements would substantially exacerbate these already-present problems, causing even more eligible recipients to lose coverage for non-substantive reasons. And that result cannot be squared with Medicaid's purpose, as the court below correctly concluded. *See* Pet. App. 9a-10a, 19a.

Work-requirement systems implemented by states like Arkansas comprise two distinct requirements. First, Medicaid recipients who are not otherwise exempt cannot maintain monthly coverage without clocking a set number of hours working or participating in specified activities, such as community service or job training. Sommers et al., *supra*, at 1522. Second, those workers must report the number of qualifying hours of work or participation. *Id.*[10]

Recent research has shown that the vast majority of Medicaid recipients are already working sufficient hours to satisfy the work requirement or are otherwise exempt from the work and reporting requirements. *Id.* at 1526; Lee, *supra*. Indeed, estimates suggest that 95% of Medicaid recipients in Arkansas and 94% of Medicaid recipients nationally either have sufficient hours of work or qualifying activities or would be exempt from reporting. Sommers, *supra*, at 1526;

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[10] In some cases, state officials used existing data sources to confirm employment status and exempt recipients from reporting requirements, but not work requirements. *See* Robin Rudowitz et al., *February State Data for Medicaid Work Requirements in Arkansas*, KAISER FAM. FOUND. 3 (Mar. 2019), http://files.kff.org/attachment/State-Data-for-Medicaid-Work-Requirements-in-Arkansas.

Lee, *supra*. For the more than 60% of Medicaid recipients who already are working full-time or part-time, *see* Lee, *supra*, the work requirement would have no impact on daily life. But the *reporting* requirement could create a substantial possibility of lost coverage. Garfield, *Implications*, *supra*, at 4.

First, many recipients are likely to be confused about whether and how work requirements apply to them. Ian Hill et al., *New Hampshire's Experience with Medicaid Work Requirements*, URB. INST. 11 (Feb. 2020), https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf (recipients unaware of work and reporting requirements cited illiteracy, homelessness, and inability to understand complex language);[11] *see* Sommers, *supra*, at 1529 ("[M]isinformation and confusion" impeded successful implementation of Arkansas's work requirements.). Second, the reporting process is likely to challenge many recipients. For example, to satisfy Arkansas's reporting requirement, recipients needed to document qualifying hours online each month. Sommers, *supra*, at 1522. And, as previously discussed, access to a computer and stable internet connection is not something all Medicaid recipients have at home. *See supra* Part I.

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[11] This was a particular problem in New Hampshire, where an inconsistent rollout of the work requirement system in 2018 resulted in at least two recipients receiving letters from the state that contradicted each other as to whether the recipient was exempt from the requirements. Ian Hill, *supra*, at 11.

Evidence shows that these two burdens result in lost coverage by recipients who in fact satisfy work requirements or are exempt. In Arkansas, the number of recipients who lost coverage after the work requirements were imposed was substantially more than the number of non-working and non-exempt recipients who previously had been covered, suggesting that "barriers to reporting data to the state . . . were the main cause for coverage losses in 2018." Sommers, *supra*, at 1529.

Work and reporting requirements also threaten to frustrate federal initiatives, such as Federally Qualified Health Centers (FQHCs), that take a holistic approach to mitigating health disparities in vulnerable populations, including those covered by Medicaid. FQHCs provide primary health services for the medically underserved, including more than one in six Medicaid beneficiaries nationally. *See* Sara Rosenbaum et al., *Community Health Centers: Growing Importance in a Changing Health Care System*, KAISER FAM. FOUND. (Mar. 9, 2018), https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/. They also are required by law to assist patients in establishing eligibility for federal, state, and local programs that provide or support medical, social, housing, educational, and other related services. *See* 42 U.S.C. § 254b(b)(1)(A)(iii), (iv). To fulfill those federal mandates, FQHCs integrate legal services like those collaboratively practiced by *amici* MLPs. *See Service Descriptors for Form 5A: Services*

Provided, HEALTH RES. & SERVS. ADMIN. 23-24, https://bphc.hrsa.gov/sites/default/files/bphc/program requirements/scope/form5aservicedescriptors.pdf (last visited Feb. 21, 2020). The administrative burdens that inhere in work programs—and often require professional assistance to ensure compliance—would deplete integrated services that could instead be used to ameliorate healthcare disparities experienced by FQHC patients. FQHCs can better fulfill federal objectives by focusing, for example, on obtaining healthy living conditions for a child with asthma worsened by the presence of mold in the home, rather than assisting appeals of Medicaid benefits terminated due to administrative-compliance barriers in work programs.[12]

Regardless whether a work requirement would increase employment among Medicaid recipients or improve "mental, physical, and emotional health," CMS LETTER SMD 18-002, *supra*, it is clear that *reporting* requirements will substantially impede access to care. Given the vulnerability and serious medical needs of Medicaid's target population, the

[12] Diverting integrated resources to administrative tasks also would undermine evolving forms of Medicaid financing that reflect increasingly prevalent initiatives to improve health outcomes and value-based care by considering "social determinants of health"—the conditions in which patients live, work, learn, and play. *See generally, e.g.*, Jennifer Trott et al., *Financing Medical-Legal Partnerships: View from the Field*, NAT'L CTR. FOR MEDICAL-LEGAL P'SHIP 1 (Apr. 2019), https://medical-legal partnership.org/wp-content/uploads/2019/04/Financing-MLPs-View-from-the-Field.pdf.

federal government should not encourage states to experiment with requirements that threaten to exacerbate the problem of lost coverage for reasons unrelated to beneficiaries' actual eligibility.

CONCLUSION

The judgment of the United States Court of Appeals for the District of Columbia should be affirmed.

Respectfully submitted,

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